Preface

All of us working to prevent teen pregnancy ask ourselves: *Are we making a difference*? We want to achieve **outcomes**[1] regardless of whether we are working at the school, neighborhood, community or state level. In fact, *outcomes, results, impacts,* and *accountability* represent a common language that is part of the prevention landscape in any arena. Whether our focus is to prevent substance abuse, HIV, heart disease, unintentional injuries, or teen pregnancy, it is imperative that we impact outcomes. Of course, we want to obtain and retain funding, but more importantly, *we need to make a difference.*

The Centers for Disease Control and Prevention is committed to improving the health of our nation and preventing disease, injury, and disability. This guide represents an effort to help a wide audience of teen pregnancy prevention practitioners employ science-based approaches as they consider, set goals for, and plan prevention programs; develop and conduct process and outcome evaluations of programs; and learn ways to improve and sustain programs that are reaching outcomes.

In the field of teen pregnancy prevention, many effective prevention programs are available, but adoption of these programs is slow and inconsistent at the community level. Knowledge about evidence-based programs is a necessary but insufficient condition to achieve outcomes. If you operate in the everyday world of putting programs into place, you are probably familiar with the essential elements for effective prevention:

- Perform a needs and resource assessment
- Develop clear goals and objectives
- Employ science-based practices
- Become culturally competent
- Build the organizational capacity to do prevention well
- Make high-quality implementation plans
- Implement your plan and perform process and outcome evaluations
- Use evaluation findings to continually improve your work
- Sustain your work

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[1] Terms defined in the glossary located at the end of the Introduction, display in **bold face** the first time they appear in the text.

Effectively employing all of these elements in your work can be a daunting proposition. This guide describes the model known as *Promoting Science-Based Approaches-Getting to Outcomes-Teen Pregnancy Prevention* (PSBA-GTO-TPP), a comprehensive model that combines all of the aforementioned elements with the teen pregnancy prevention knowledge base. PSBA-GTO-TPP integrates the ten-step Getting to Outcomes process (Chinman, Imm & Wandersman 2004; Fisher, Imm, Chinman & Wandersman 2006) with the concepts, content, practices, and experiences shared by partners who worked in a CDC PSBA project to promote the use of science-based approaches to teen pregnancy prevention from 2005-2010. Thus, PSBA-GTO-TPP offers local practitioners a succinct and clear process for applying a science-based approach to their teen pregnancy prevention programs.

This PSBA-GTO-TPP guide also draws from three other completed GTO books in diverse areas of public health:

- Chinman, M., Imm, P. & Wandersman, A. (2004). *Getting To Outcomes: Promoting Accountability Through Methods and Tools for Planning, Implementation, and Evaluation*. RAND Corporation. It is available for free at: **www.rand.org/publications/TR/TR101**.

- Fisher, D., Imm, P., Chinman, M. Wandersman, A. (2006). *Getting to Outcomes with Developmental Assets: Ten Steps to Measuring Success in Youth Programs and Communities.* Minneapolis: Search Institute.

- Imm, Pamela, Matthew Chinman, Abraham Wandersman, David Rosenbloom, Sarah Guckenburg and Roberta Leis. Preventing Underage Drinking: Using Getting To Outcomes™ with the SAMHSA Strategic Prevention Framework to Achieve Results. Santa Monica, CA: RAND Corporation, 2007. Available for free at: **http://www.rand.org/pubs/technical_reports/TR403.html**.

Social research has shown that the GTO model improves individual capacity and program performance and facilitates the planning, implementation, and evaluation of prevention programs (Chinman et al.[2]). In the study by Chinman, et al., the GTO guide was supplemented with training and technical assistance. Likewise, we recommend that you supplement this

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[2] Chinman et al.: A novel test of the GTO implementation support intervention in low resource settings: Year 1 * Correspondence: chinman@rand.org findings and challenges. Implementation Science 2015 10(Suppl 1):A34.

guide with training and technical assistance so that you and your program may achieve the maximum impact in teen pregnancy prevention.

Acknowledgments

Introduction

Science-Based Approaches to Teen Pregnancy Prevention

Although there have been significant declines in the pregnancy and birth rates of teens, teen pregnancy is still a major public health concern in many communities around the country. *Pregnancy* data from 2010 (the sum of live births, fetal losses, and induced abortions) indicate a rate of 58.9 pregnancies per 1,000 girls aged 15-19 years old, a 50% decline from the 1990 peak and a historic low for the nation.[3] Similarly, *birth* data for 2014 indicate a continuation of the decline that began in 1991[4]-- a 61% decline, from 61.8 births per 1,000 female teens aged 15-19 years old in 1991, to 24.2 in 2014.
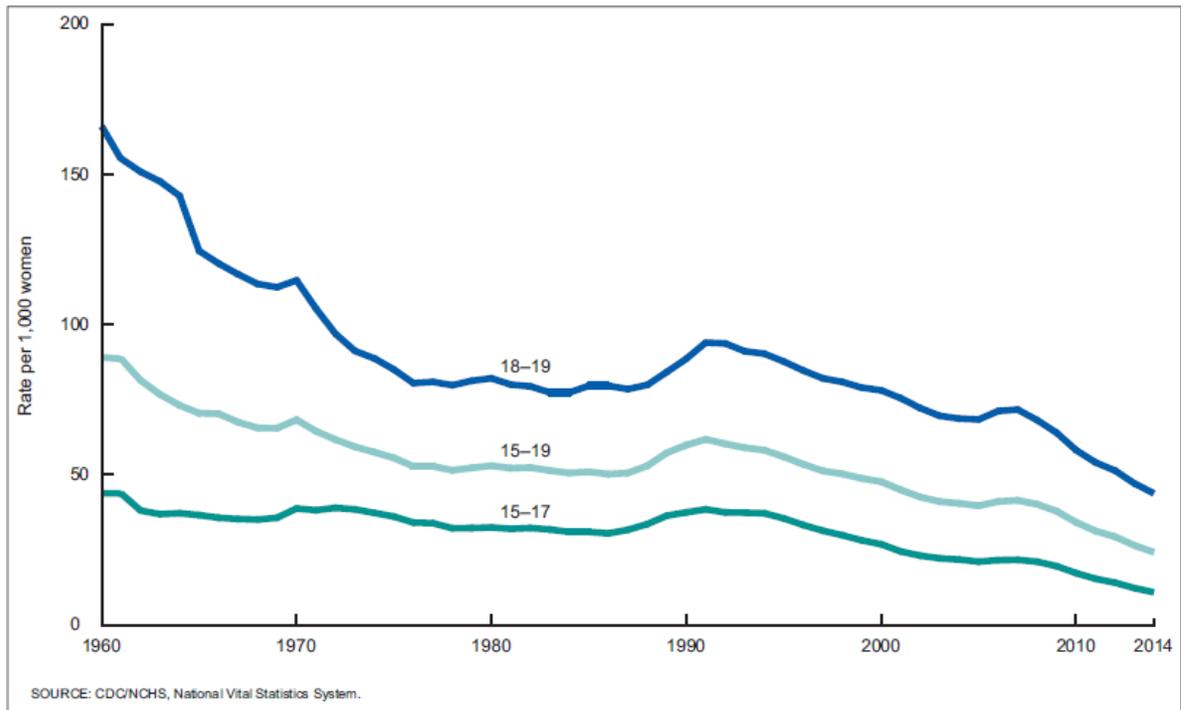
Figure 1. Birth rate for females aged 15-19, by age; United States, 1960-2014

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[3] Curtin SC, Abma JC. 2010 pregnancy rates among U.S. women. National Center for Health Statistics. December 2015. Available from:
http://www.cdc.gov/nchs/data/hestat/pregnancy/2010_pregnancy_rates.htm .

[4] Hamilton BE, Martin JA, Osterman MJK, et al. Births: Final data for 2014. National vital statistics reports; vol 64 no. 12. Hyattsville, MD: National Center for Health Statistics. 2015.

Yet, in 2014, teenagers gave birth to almost 250,000 infants. While the trends are encouraging, the numbers clearly highlight the fact that teen pregnancy remains an enormous problem.

International comparisons continue to suggest that the U.S. could do much better in reducing teen pregnancy and birth rates. Sedgh et al. examined pregnancy and birth rates among 15- to 19-year-olds in the 21 countries categorized as having liberal abortion laws and complete teen pregnancy estimates for 2008-2011 (2015). They found that, outside the former Soviet bloc, the United States has the highest teen pregnancy rate in the developed world, despite the declines since 1991. The *pregnancy* rate ranged from a low of 8 per 1,000 females aged 15-19 in Switzerland to a high in the United States of 57 pregnancies per 1,000 females aged 15-19 in 2010[5]. The *birth* rates in these countries ranged from 2 per 1,000 females aged 15-19 in Switzerland, to 34 in the United States. The Healthy People 2020 goals for behaviors associated with sex and actual rates, according to recent U.S. data, are shown in Table 1.

Sexual behaviors that put teens at risk for pregnancy also put them at risk for HIV/AIDS and STIs. An estimated 9,961 teens and young adults 13-24 years old were diagnosed as living with HIV in 2013[6]. In 2010, 12,200 young people 13-24 years old accounted for 26% of all new HIV infections (12,200/47,500), even though they accounted for only 17% of the U.S. population[7].   Although they represent only 25% of the sexually experienced population in the U.S., young people (ages 15-24) account for half (50%) of all new sexually transmitted infections (STIs).[8]. Clearly, the magnitude of the consequences of sexual risk behaviors among youth requires new efforts to improve the reproductive and sexual health of our youth.

There are many costs associated with these high rates of teen pregnancy. Teen pregnancy is linked to adverse consequences for teen mothers, fathers, and their children. It is also extremely expensive to federal, state, and local governments, and, therefore, to the supporting taxpayers. According to the National Campaign to Prevent Teen Pregnancy, teen childbearing costs taxpayers at least $9.4 billion in 2010. That makes teen pregnancy a public health concern of major consequence.

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[5] Among the 21 countries with liberal abortion laws and complete teen pregnancy estimates for 2008-2011.

[6] CDC. Diagnoses of HIV Infection in the United States and Dependent Areas, 2013(http://www.cdc.gov/hiv/library/reports/surveillance/2013/surveillance_Report_vol_25.html). *HIV Surveillance Report* 2015;25.

[7] CDC. Estimated HIV incidence in the United States, 2007-2010. HIV Surveillance Supplemental Report 2012; 17(No. 4).

[8] Satterwhite CL, et al. Sexually transmitted infections among U.S. women and men: Prevalence and incidence estimates, 2008. *Sex Transm Dis* 2013; 40(3): pp. 187-193.

Table 1: 2020 goals and baseline incidences of teen experiencing sex-linked behaviors

Outcomes	HP 2020 Goal* (rate per 1,000 population)	2005 (rate per 1,000 population)	2009 (rate per 1,000 population)
Reduce pregnancies among females aged 15 to 17 years	36.2	40.2	36.4
Reduce pregnancies among females aged 18 to 19 years	105.9	116.2	106.3

Behavior	HP 2020 Goal* (% of population)	2006-2010 (% of population)	2011-2013 (% of population)
Increase the proportion of females aged 15 to 17 years who have never had sexual intercourse	80.2	72.9	69.6
Increase the proportion of males aged 15 to 17 years who have never had sexual intercourse	79.2	72.0	65.6
Increase the proportion of sexually active females aged 15 to 19 years who use a condom at first intercourse	74.8	68.0	72.4
Increase the proportion of sexually active males aged 15 to 19 years who use a condom at first intercourse	87.6	79.6	78.1
Increase the proportion of sexually active females aged 15 to 19 years who use a condom at last intercourse	55.6	50.5	54.8
Increase the proportion of sexually active males aged 15 to 19 years who use a condom at last intercourse	81.5	74.1	77.3
Increase the proportion of sexually active females aged 15 to 19 years who use a condom and hormonal or intrauterine contraception at first intercourse	15.4	14.0	**16.1**
Increase the proportion of sexually active males aged 15 to 19 years who use a condom and whose partner used hormonal or intrauterine contraception at first intercourse	17.3	15.7	**20.6**
Increase the proportion of sexually active females aged 15 to 19 years who use a condom and hormonal or intrauterine contraception at last intercourse	20.1	18.3	20.0
Increase the proportion of sexually active males aged 15 to 19 years who use a condom and whose partner used hormonal or intrauterine contraception at last intercourse	35.3	32.1	**36.9**

* HHS, Healthy People at www.healthypeople.gov/2020; **www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives; NOTE: Numbers in bold indicate the HP 2020 Goal has been achieved.**

Risk and protective factors affecting teen pregnancy, STI, & HIV

Determinants defined in this guide are the factors that affect whether individuals, groups, or institutions engage in specific behaviors. Determinants can be broken into two groups: **risk factors** and **protective factors**.

Risk factors are associated with increased risk for a disease or condition. Examples of risk factors include being behind in school or having school problems, limited **health literacy**, alcohol use, and a history of sexually transmitted diseases. It does not mean that any of these factors cause someone to become pregnant or get someone pregnant but teens that have these risk factors are more likely to get pregnant or get someone pregnant.

Protective factors are associated with increased protection from a disease or condition. Some examples of protective factors are greater parental oversight, high educational aspirations and plans for the future, and discussing pregnancy and STI prevention with a partner. Again, these protective factors will not necessarily prevent a given person from becoming pregnant or getting someone pregnant, but youth who have some of these protective factors are less likely to become pregnant or get someone pregnant.

Note

Ideally, youth would have many protective factors and few risk factors in their lives. Teen pregnancy prevention programs aim to reduce the risk factors and strengthen the protective factors among youth participants.

Risk and protective factors can be categorized. Kirby (2005) has categorized determinants as environmental (e.g., community, family, peers), partners, or teen individual factors. The many determinants Kirby notes point to the complexity of helping youth develop a healthy sexuality and to the many areas where programs can have an impact. Though determinants are varied, culture can have an impact on their identification as negative or positive. For example, one assumed protective factor is a youth's perception that becoming pregnant would be a negative consequence of having sex. This is true in some cultures; however in others, becoming pregnant at an early age is not always perceived as a negative outcome.

Kirby's list of determinants indicates that some groups are at higher risk for teen pregnancy. For example African-American and Latino youth are at a higher risk for becoming pregnant than are white youth. Socio-economic status also plays into teen pregnancy rates. Youth are less likely to become pregnant if their parents have a high level of education or if youth live with two biological parents. Greater community disorder (e.g., greater rates of substance use, violence, and food insecurity) has also been associated with a higher risk for teen pregnancy.

Family and peer norms, medical and service providers, knowledge and self-efficacy, lack of knowledge, and the understanding of and familiarity with available services and how to access them are just a few of the many influences on youth sexual behavior. We also need to recognize that teen pregnancy (and teen fatherhood) is often interrelated with a host of negative outcomes and behaviors such as lower levels of academic success, delinquency, skipping school, drinking alcohol and/or experimenting with illicit drugs, among others.

Sexual behavior is complex—but giving youth the best chance to make informed and responsible decisions about sex lies at the heart of many prevention programs. As we consider the complexity of influencing sexual behavior and the connection between sexual risk behaviors and other negative outcomes among youth, it is clear much work has been done in this area of prevention.

The first of CDC's capacity building efforts to improve local-level prevention programming were supported by CDC's grant, "Coalition Capacity Building to Prevent Teen Pregnancy" (CCB). CCB, conducted from 2002-2005, aimed to increase the capacity of local coalitions and organizations to use **science-based approaches (SBA)** in their teen pregnancy prevention programs (see Table 2). Grantees and their partners learned a great deal about helping local prevention programs improve their work using SBAs. The CCB project also encountered barriers such as lack of awareness of SBAs, perceived incompatibility between prevention programs and their communities, fear of political controversy, and the complexity of implementing evidence-based programs (Philliber, Nolte, 2008).

Addressing these barriers and building on the successes of the CCB project, CDC launched the 2005 – 2010 effort known as "Promoting Science-based Approaches

to Teen Pregnancy Prevention" (or PSBA project) and adapted Getting To Outcomes for the field of teen pregnancy prevention, creating PSBA-GTO to help local practitioners select, implement, and evaluate teen pregnancy prevention programs using science-based approaches.

Table 2: Components of science-based approaches

Science-Based Approach (SBA) Components
Uses demographic, epidemiological and social science research to identify populations at risk of early pregnancy and/or sexually transmitted infections, and to identify the risk and protective factors for those populations.
Uses health behavior or health education theory to guide the selection of risk and protective factors that will be addressed by the program, and to guide the selection of intervention activities.
Uses a logic model to link risk and protective factors with program strategies and outcomes.
Selects, adapts if necessary, and implements programs that are either science-based or have many of the characteristics of evidence-based programs.
Conducts process and outcome evaluation of the implemented program, and modifies the approach based on results.

PSBA-GTO-TPP also promotes the use of evidence-based programs. In 2009, HHS undertook a process to identify evidence-based teen pregnancy prevention programs that had documented positive impact on teen pregnancy and related factors through rigorous evaluation[9]. This process included a systematic, comprehensive review of the literature on teen pregnancy, STIs, and sexual risk behaviors, known as the **HHS Pregnancy Prevention Evidence Review**[10]. The Evidence Review initially identified 28 evidence-based programs. Subsequent reviews have been conducted periodically and, as of the February 2015 review, 35 programs have been identified. The Evidence Review includes programs using a number of approaches: abstinence-based, sexual health education, youth development, and programs for delivery in clinical settings and for special populations.

Following the Evidence Review, HHS Office of Adolescent Health (OAH) issued two separate funding opportunity announcements (FOAs) in April 2010. The first, known as Tier 1, focused on the replication of evidence-based programs. The second FOA, known as Tier 2, was to fund research and demonstration

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[9] Kappeler EM, Farb AF. Historical context for the creation of the Office of Adolescent Health and the Teen Pregnancy Prevention Program. J Adolesc Health 2014; 54:S3–9.

[10] **http://tppevidencereview.aspe.hhs.gov/ReviewProtocol.aspx**

projects to test additional models and innovative strategies for preventing teen pregnancy.

As part of Tier 2, CDC, OAH, and the Office of Population Affairs, released a 2010-2015 FOA to fund projects to demonstrate the effectiveness of innovative, multicomponent, community-wide initiatives in reducing rates of teen pregnancy and births in communities with the highest rates, with a focus on reaching African American and Latino or Hispanic young people aged 15 to 19 years. Nine state- and community-based organizations and five national organizations were funded through "Teenage Pregnancy Prevention: Integrating Services, Programs, and Strategies through Communitywide Initiatives." A key component of this initiative was to increase the number of youth within the target community exposed to evidence-based teen pregnancy prevention programs and build the capacity of local partners to select, implement, and evaluate these programs using PSBA-GTO-TPP.

Building off the previously described work, this guide offers a clear and succinct process for local practitioners to follow in delivering teen pregnancy prevention programs using a systematic and science-based approach to their work. PSBA-GTO-TPP integrates the process and guidance offered by the 10-step, Getting To Outcomes process (Chinman, Imm & Wandersman 2004; Fisher, Imm, Chinman & Wandersman 2006) with the concepts, content, practices, and experiences shared by partners in the CCB, PSBA, and community-wide initiatives projects to promote the use of science-based approaches to teen pregnancy prevention.

Tip sheet ahead

As you prepare to embark on the PSBA-GTO-TPP process, you can use the tip sheet **Considerations in Advance of the PSBA-GTO-TPP Process** to think about the issues ahead.

Many organizational and environmental issues, challenges, and barriers can negatively influence teen pregnancy prevention programming decisions. While we wish there were easy ways to address all of them, this guide cannot do so. Determine if your organization is ready by considering the following questions *before* moving ahead.

Are we committed to making a difference and reaching our desired outcomes even if that means making changes to our program or the way we do business? The PSBA-GTO-TPP process requires you to look critically at the issue of teen pregnancy in your community and the program that you might implement. In order to reach your desired outcomes, change may be required. Change can seem scary; however, the benefits can improve young people's lives. PSBA-GTO-TPP is a detailed process because it's important to have a well-planned and implemented program to reach your desired outcomes and make a difference.

Do our board and management support the use of PSBA-GTO-TPP to improve our programming? Because PSBA-GTO-TPP might stretch your program in new directions, producing change, it's important to have the support of your board and management. It's especially important to have board and management support during the time it takes to fully pursue the PSBA-GTO-TPP process. Further, continuous quality improvement and sustainability are best achieved with a firm commitment. Therefore, if your board and management know, understand, and support the PSBA-GTO-TPP process from the start, change should proceed more smoothly.

Do we know the community we'll be working in? Who are the key partners? PSBA-GTO-TPP includes a needs and resource assessment step; however, it's helpful to know the community you'll be serving *before* you start the process. If you don't know the community well, it will be even more critical to involve community members in the PSBA-GTO-TPP process. Understanding the community is also critical to understanding health literacy issues.

Is our organization financially stable enough to embark on the PSBA-GTO-TPP process? Even though this guide points you toward ways to build and promote resource sustainability, it requires some financial resources to get started and work through the process. The advice we offer about developing financial and other resources is really about finding resources to implement a program, not to sustain an entire organization.

Do we already have the organizational capacity and infrastructure needed? We assume you are starting this process with the organizational structure already in place to move ahead. This guide will not describe how to set up or structure a community-based organization. PSBA-GTO-TPP does have information on building capacity, but this is specific to the program you will implement.

Do we have adequate staff and expertise to carry out the PSBA-GTO-TPP process? You don't need everyone on board to run a program at the start of PSBA-GTO-TPP, but using this guide does require a staff member or volunteer to head up the process. It's not absolutely necessary but would be helpful to have or involve people with experience in program planning, evaluation, and implementation, including conducting a needs and resources assessment.

Are we in it for the long haul? Deep and lasting change to prevent teen pregnancy requires a long-term commitment, and the PSBA-GTO-TPP process is meant to be useful in accomplishing this vision. It does take time to accomplish the tasks laid out in the guide, and your organization should be realistic about that before you begin.

What is PSBA-GTO-TPP?

Getting To Outcomes (GTO® is a user friendly process for comprehensive planning, implementation, and evaluation of programs and community initiatives. It's designed to help programs and initiatives do exactly what it says: get to desired outcomes. Many of the steps in this GTO process will look familiar because this is just a structured way of approaching the work you're already doing.

The original Getting To Outcomes guide was written in 1999 for drug-free community coalitions to help bridge the gap between research and practice (Wandersman, Imm, Chinman & Kaftarian, 1999). It was updated in 2004 to broaden its scope and applicability to a wider range of programs and organizations (*Getting to Outcomes 2004: Promoting Accountabili*ty *through Methods and Tools for Planning, Implementation and Evaluation;* Chinman, Imm & Wandersman, 2004). Based on established theories of traditional evaluation, empowerment evaluation, results-based accountability, and continuous quality improvement, GTO represents a collaborative effort to synthesize evidence-based knowledge and translate it into evidence-based practice. Combined with promoting science-based approaches (PSBA) to teen pregnancy prevention, this guide puts a practical, powerful set of tools in your hands, which you can use to plan, implement, and evaluate new programs or refine existing ones.

The Ten Accountability Questions

The primary purpose of this guide is to help you improve the quality of your programs aimed at preventing teen pregnancy and reducing risk for HIV/STI among youth. Funders are increasingly mandating "accountability" for the funds they provide by demanding high-quality outcome data to determine the success of programs. This guide's planning, implementation, and evaluation processes are organized according to ten accountability questions, which correspond to the 10 steps of Getting to Outcomes. The structure will help you conduct needs assessments, select evidence-based programs that fit your community, and effectively plan and implement quality programs while collecting solid outcome data. Following all ten steps will increase your chances of success, as well as help you meet widely accepted accountability criteria.

The term **accountability** is basic to an understanding of PSBA-GTO-TPP. We define accountability as the systematic inclusion of critical elements of program planning, implementation, and evaluation in order to achieve results. In PSBA-GTO-TPP, program development and program evaluation are integral to promoting program accountability. Asking and answering the ten questions begins the accountability process. Many excellent resources discuss the importance of each program element, and this guide will direct you to the most relevant ones. By linking these program elements systematically, programs can succeed in achieving their desired outcomes and demonstrate to their funders the kind of accountability that will ensure continued funding.

These are the ten steps and associated accountability questions tailored to the PSBA-GTO-TPP process:

Step 1 Needs & Resources — What underlying needs and resources must be addressed to prevent teen pregnancy in your community?

Step 2 Goals & Outcomes — What are the goals and desired outcomes for your teen pregnancy prevention program?

Step 3 Best Practices — Which evidence-based programs can help you reach your goals and desired outcomes?

Step 4 Fit — What actions should be taken to ensure the selected program fits with your community context?

Step 5 Capacity — What organizational capacities are needed to implement the program?
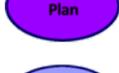
Step 6 Plan — How do you create a clear, rational, and focused plan for a successful teen pregnancy program?

Step 7 Process Evaluation — How will you assess the quality of the program planning and implementation?

Step 8 Outcome Evaluation — Has your program had the desired impact?

Step 9 CQI — How will you continuously improve the quality of the program?
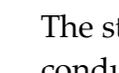
Step 10 Sustainability — If your program is successful, how will it be sustained?

The steps are designed to provide a practical and continuous process for conducting good, long-term programming. To illustrate the point, we've provided an example you may personally relate to, showing how you might answer the questions as if you were planning a vacation. As you read the

example, notice how the steps fall into a sequence of natural groupings, which eventually bring you back to Step 1 - the time to reassess needs and resources.

Tip sheet ahead

The tip sheet **Use GTO to Plan a Vacation** applies the ten steps to a common situation.

⭐ Use GTO to Plan a Vacation

GTO Step	Question	Response
1. Needs/ Resources	How do you know you need a vacation? What resources do you have for it?	You know you need a vacation because you feel exhausted, bored, or restless. You check your bank account to see how much money you can afford to spend and check the amount of vacation time you have available.
2. Goals / Outcomes	What are the goals of your vacation? Who will go with you?	Different kinds of vacations reap different outcomes. You decide what you want based on needs you identified in Step 1. If you're tired, your goals may include catching up on rest. If you're restless, you may pursue adventure and new places. Your goals may suggest you go alone, with a partner, or with the whole family.
3. Best Practices	What are the best ways known to achieve your vacation goals?	Now you want to select the best strategy available to achieve what you want. You may turn to the Internet or travel magazines and books for information. If you decided you want fun for your whole family, you might choose a cruise and research cruise lines with top reputations for pleasing both adults and children.
4. Fit	Does it suit other aspects of your life? Can you adapt it to do so?	Now you consider the best dates for your vacation in light of school, office plans, and such. If you want to go to the Caribbean, you may choose not to go during hurricane season.
5. Capacity	Do you have the necessary capacity to go on the vacation you have chosen?	If you've decided to climb the Rockies (at ~13,000 feet), but your experience is in the Blue Ridge mountains (at ~4,000 feet), you may not have the capacity to hike the Rockies. You may need to adjust the vacation or to develop capacity by training for it.
6. Plan	What is the plan for your vacation?	Once you finalize the destination based on goals, best practices, fit, and capacity, you can plan it (e.g., schedule flights, find directions, reserve rooms, make a packing list). Decide who does what, when.
7. Process Evaluation	The fun part! Did your vacation go as planned?	You actually go on vacation. Along the way, plans may go smoothly, or not. You may need to make adjustments. You note the quality of the airline and hotel service.
8. Outcome Evaluation	Did you achieve the goals of your vacation?	When it's over you evaluate whether the vacation successfully met your goals. Do you feel rested? Did you reconnect with a friend? Did you reawaken your adventurous spirit? What were some outcomes you didn't expect?
9. Continuous Quality Improvement (CQI)	What would you do differently to make the next vacation better?	If you're happy with the outcomes of your vacation, you may want to do it again, perhaps with improvements. If you're disappointed, you can consider what went wrong and correct it next time. Look through all the steps to identify what should stay the same and what should change.
10. Sustainability	How will you make sure you can take more vacations?	You might plan to save money every month so you can go on vacation, again, next year. You might decide to save vacation days so that you can go on an even longer one.

Key features of PSBA-GTO-TPP

The PSBA-GTO-TPP process is designed to be flexible enough to support your work in planning and implementing brand new programs. It can also be used to strengthen existing ones because the same steps and associated tasks can help you improve any current programming in this area. If you are already implementing teen pregnancy prevention programs, you won't need to start over or reinvent work you've already begun. The PSBA-GTO-TPP process provides an opportunity to review, update, and improve your current activities or plans in a structured way.

Memory flash

PSBA-GTO-TPP is a process for selecting, planning, implementing, evaluating, continuously improving, and sustaining evidence-based programs in teen pregnancy and sexual risk behavior reduction.

Whether you are planning a new program or refining an existing one, we encourage you to periodically cycle back through the steps on a regular basis as your work changes and evolves. Responding to change in your community and updating your work accordingly helps keep your work relevant and contributes toward sustaining your successes.

PSBA-GTO-TPP helps you think about and work through the following:

- Focusing on the most important needs in your community related to teen pregnancy as well as on existing resources that could support your work

- Using current research to identify critical risk and protective factors on which to center your work for maximum impact

- Developing a clear and simple logic model that maps out the story of your work through your program and evaluation plans

- Understanding and practicing cultural competence, including development and support of culturally sensitive programs and staff

- Incorporating continuous quality improvement and sustainability practices into new programs from the outset and infusing them into your work if you already have one ongoing

Each step in the guide introduces important content and tasks that logically lead to subsequent steps. Each contains:

- Step-specific table of contents
- Focus question
- Brief overview
- Materials list
- Checklist of key tasks that you'll accomplish
- Tip sheets with support information
- Instructions to complete the step
- Ongoing fictional case study for the *Fayetteville Youth Network* to illustrate the process
- Tools specific to the step
- Key points, reminders, enrichment data
- Section on using the step when you're already implementing a program
- Ideas on the application of continuous quality improvement (CQI) practices and ways to build and promote sustainability
- Preparation hints for the next step

Taken together, the PSBA-GTO-TPP process promotes clarity in your work from the inception of a new program (or targeted improvement of an existing one) all the way through planning, implementation, and evaluation. The process is designed to help you continually improve and sustain your work as an aid to achieving your desired outcomes, all to the benefit of the young people with whom you work and the community where they live.

How to use this guide

The guide is divided into four parts:

Part I: Goal Setting (Steps 1 - 2) starts by guiding you in the identification of specific needs in your community and assessment of existing resources you can bring to bear on those needs in *Step 1 Needs and Resources*. With *Step 2 Goals & Outcomes*, you tie the priorities you develop in Step 1 to goals and desired outcomes that clearly express the direction your work will take. The goals and desired outcomes you develop at this stage form the foundation of the next phase of your work.

Part II: Program Development (Steps 3 - 5) takes those goals and desired outcomes you identified and helps you assess whether you can realistically proceed with a program. *Step 3 Best Practices* walks you through researching and selecting several evidence-based programs to consider; then *Step 4 Fit* helps you decide which one might be the best fit for your community. During Step 4 you might examine reasonable adaptations to an evidence-based program that would increase its fit with your youth and community. Once you have chosen a good candidate program, then *Step 5 Capacity* helps you determine whether you have the necessary **capacities** to fully implement the program.

These three steps help you test any assumptions you have about the right program for your organization. After you assess fit and capacity, you may decide that none of the candidate programs are suitable. You can cycle back to Step 3 to find new candidate programs to consider and proceed to Steps 4 and 5, again. This three-step cycle in the process will save you time since you won't move forward to planning until you're certain you've chosen the most appropriate program.

Part III: Program Planning and Evaluation (Steps 6 - 8) helps you finalize, plan, implement, and evaluate the program. It contains a planning sequence that proceeds across all three steps before you actually implement a program. It starts with Step 6 Plan in which you lay out and document the implementation process in detail. Because you may need to establish the evaluation tasks before, we tell you where to pause in Step 6 Plan, then move briefly ahead to Step 7 Process Evaluation, and Step 8 Outcome Evaluation to be clear about your process before launching your program.

We show you how your plans stay tied to the priorities you identified in Step 1 and the goals and outcomes you specified in Step 2 as your work incorporates some of what you learned in Step 5 about the capacities you'll need to carry out and evaluate your program.

Part IV: Improving and Sustaining Your Program (Steps 9 - 10) is dedicated to the future. Once you've completed the implementation, you spend valuable time in Step 9 CQI, considering how to strategically and continuously improve program performance in future cycles. If all has gone as planned, you will have gathered data in the process and outcome evaluations which demonstrate your success. That success underpins your efforts to sustain the good work and culminates in Step 10 Sustainability.

> Steps 9 and 10 include the latest thinking on CQI and sustainability. Both are written in a way that helps you pull together information you'll be developing along the way in Steps 1-8 so that you won't feel as though you need to start brand new processes for improvement and sustainability.

Between each section, a transition summary describes where you are in the flow of events. It includes an image mapping the steps in the section along with tasks and thumbnail images of tools you'll be completing. These connecting graphics should help you see how the ten-step process builds as you move forward.

Throughout the guide, each step contains signpost images calling your attention to important notes, key ideas, tip sheets, examples, resources, and tools. Meanings associated with the images are show below.

Focus question
The purpose of each step

Checklist
Tasks for the current step

Example
Uses our fictional Fayetteville Youth Network

Note
Extra credit information

Tool
Located on the CD accompanying the guide; print all that you need

Tip sheet
Identifies expanded information

Key point
Extracted from a segment of information

Online
Found on the Internet

Memory flash
Repeat of something mentioned earlier

Collaboration
Help for building and maintaining partnerships

Save it
Need we say more?

CQI and Sustainability
Checkpoints along the way

To better aid your understanding of the PSBA-GTO-TPP process, we developed a fictional organization—the Fayetteville Youth Network (FYN)—that works through all the steps to implement a new teen pregnancy prevention program. The network's story unfolds in each step, accompanied by completed examples of the tools for that step.

Although CQI and sustainability are steps 9 and 10, respectively, these topics are addressed throughout the manual as they can and should be implemented in an ongoing manner. At the end of each step, you'll find the latest information on ways to continuously improve the performance quality of your program as well as actions you can take at each stage to sustain it. CQI and sustainability actions are clearly called out in the text.

Each chapter also contains a section entitled **If you already have a program**. We know that many of you using this guide have been working in the teen pregnancy prevention field for some time, and you may be tempted to jump to the information about implementation and evaluation in Steps 6-7-8. We encourage you to methodically proceed through each step as though you were starting anew. Using this guide to rework steps you've already completed such as needs assessment, goal setting, and planning can help refocus and strengthen your program. Reviewing the steps can also help you avoid selecting or perpetuating unproductive strategies that waste money and resources and do *not* promote desired outcomes. You will also find relevant and important information about CQI and sustainability. The PSBA-GTO-TPP process is cyclical and ongoing, so using the full process will be more beneficial to your programs over the long term. Each step is an important link in the PSBA-GTO-TPP process and critical to using a science- and evidence-based approach to your prevention work.

Getting started with PSBA-GTO-TPP

We've created this guide for program staff using prevention programming to reduce adolescent sexual risk behaviors and pregnancy. You may be providing programs for youth participants (typically thought of as "serving" youth) and you may also be implementing programs more in partnership *with* youth who add their voices to yours to help plan, facilitate, and even evaluate your work. We assume you're starting off with a basic level of overall organizational capacity and infrastructure that will allow you to engage in this process effectively (later in the PSBA-GTO-TPP process, you'll examine capacity specific to a program). If you don't feel you have the capacity to carry out teen prevention programming yet, or are unsure about your capacity, you might consider spending some time examining your organizational capacity *first* to make sure you're ready to move ahead.

Online

If you're concerned about organizational capacity, we recommend you look at these sources before you launch into PSBA-GTO-TPP:

- Information on building organizational capacity can be found at *The Community Toolbox*: **http://ctb.ku.edu/**
- *Get Organized: A Guide to Preventing Teen Pregnancy* **www.thenationalcampaign.org/resources/getorganized/default.aspx**
- In the *Facilitator's Resources* section on the CDC Teen Pregnancy website, there is an assessment tool called "Measuring Organizational Capacity" you might find useful.

For more about youth-adult partnerships, you can visit: **http://www.advocatesforyouth.org/workingwithyouth/910 ?task=view**

First things first

PSBA-GTO-TPP works best when members of a group work through the ten steps together. There are many colleagues, stakeholders, and other participants who may be eager and able to assist you and your organization in this effort. Before moving ahead, we recommend you:

Establish a team or workgroup to lead, implement and monitor the process. A workgroup should include staff, administrators, and volunteers from your

program as well as participants. If you already have an existing work group, you could modify it or form a sub-workgroup to concentrate on working through the process. You'll probably want a team leader or perhaps two co-leaders to take responsibility for guiding the overall process.

Think about who needs to be at the table. Your work group should represent the diversity in your community—that includes parents and youth—and the diversity of other relevant stakeholders—such as people served by your organization, geographic area, community. You want to think ahead to those whose help you might need to implement plans later on, and invite them now to get better buy-in. If you have an evaluator or evaluation team, or funders, having them join you at the table right from the very beginning of your process will be very beneficial.

When considering the overall makeup of your team, look for a good mix of thinkers and doers while keeping the size manageable; you may be able to create sub-committees for specific tasks such as CQI monitoring or developing sustainability plans. Also, don't be afraid to invite people that you haven't worked with before that may serve as new potential partners. Lastly, don't forget to identify potential champions- those in influential roles who can obtain access to difficult-to-get information or help develop broader partnerships.

Develop and agree upon a plan for working together. Keep this simple, but hammer out these important details early on to keep your process on track. Your plan can include such elements as a meeting schedule, the design for your work process, assumptions about roles and responsibilities of the participating individuals and agencies, identifying available technical assistance, and developing a desired timeline for your work together. Before starting work on all the steps:

- Quickly look over the entire guide, perhaps using the section graphics a guide, to get a feel for the overall ten-step process. This will help you see the bigger picture of where you're going.

- Build process monitoring into your work plan. This will help you stay on top of changes and keep you moving in the right direction.

- Ensure that everyone is informed about all stages of the work over time. When not everyone can make face-to-face meetings, for example, make sure there are ways of keeping everyone up-to-date using email, listservs, and other communications channels.

- Agree on a decision-making process. Will you use consensus or voting? The decision making process should be culturally relevant to the community and institutions in your coalition. It will also be important to agree upon when agreements are binding so that someone who misses a meeting can't come back later and un-do what others have decided.

Use PSBA-GTO-TPP as a common framework. This guide is full of tips, templates, tools, forms, and checklists that will help you plan and keep track of your work. It is recommended to have the tools readily available and use them as you work through each step together. This will help you easily integrate the PSBA-GTO-TPP process into your everyday work.

Set up a three-ring PSBA-GTO-TPP binder. Designate someone to be responsible for collecting in one place copies of completed tools and gathered materials, such as program research or evaluation results. In the guide, we remind you about the most critical materials to gather and save, but you can add any other materials to this binder you feel are relevant to your work. As we are building towards CQI and sustainability using the multiple tools and tasks in the guide, having all these materials collected along the way will save you time later on.

We have done all we can to make the PSBA-GTO-TPP process as clear and simple as possible. Looking ahead, it probably looks like a lot of work, but keep in mind that we've written this as a guide. You need to be realistic within the scope of your organization's time and available resources about how much you can do. We recommend you don't skip steps and try to remain true to the key tasks of the ten-step process, but we also recognize that you may need to tailor the process to the unique needs of your organization.

It starts with a vision

Once you establish your workgroup, you need to articulate a vision in partnership with your community. Developing a vision statement is typically done at the beginning of a planning process and is the first step you'll take in writing the *story* of your work. This process should include ideas, insights, and opinions from a diverse group of individuals and stakeholders including people we call *champions*. Champions understand what you're trying to do and help you do it. They may be strategically placed within your own organizations or they might be different kinds of leaders out in the community who want to help you build your efforts on behalf of young people. Working together to develop a

clear vision statement, you will always have a reminder of what the community is trying to accomplish by defining the results to be achieved.

Developing a vision statement can be challenging, but it doesn't have to be. If you are working on a large community planning process, it can take longer to develop a shared vision than if you represent a smaller group that's looking to change the conditions within a more narrowly defined community such as a school.

We recommend a short, strategic process to develop the vision statement if you don't already have one. These guidelines might help you:

1. Discuss the importance of a vision statement in the initial meetings of your group.

2. Obtain buy-in from all members about the need to have a vision statement.

3. Tap qualified people—volunteers or paid professionals—to help you conduct the envisioning process.

4. Determine the best ways to obtain personal visions from the members and key stakeholders in the community.

5. Obtain input from diverse groups of stakeholders.

6. Draft an initial vision statement to be circulated to key stakeholders; revise based on feedback.

7. Finalize the vision statement and share it with the community.

8. Agree upon and finalize a reasonable timeline for developing the vision statement that doesn't go on too long. It's possible to develop a good, working vision statement in a single meeting.

Vision statements can vary in length. Here are a few examples:

Our vision is to promote reproductive health among young people, with a primary focus on preventing teen pregnancy among youth ages 10-24.

Our vision is to address the most important risk factors among young people that contribute to teen parenthood, injury, violence and substance abuse.

Our vision is to provide support to local and national agencies and institutions implementing programs to reduce teen pregnancy in their communities.

Online

You can find more help for developing a vision statement at *The Community Toolbox*, Work Group for Community Health and Development at the University of Kansas:

http://ctb.ku.edu/

PSBA-GTO-TPP assumes that your vision will become central to the work you do. It can be helpful as a touchstone in keeping everyone moving in the same direction as you work through all of the steps and complexities in implementing and evaluating your programs. It's also important to revisit your vision statement regularly, especially as needs and conditions change.

Once the vision statement has been agreed upon, you're ready to move ahead and address the first accountability question.

Glossary

Accountability – the systematic inclusion of critical elements of program planning, implementation, and evaluation in order to achieve results.

Activities are components of the selected curriculum that constitute implementation elements contributing to the desired outcomes.

Adaptation is the process of changing an evidence-based program to make it more suitable to a particular population or an organization's capacity without compromising or deleting the core components.

Assent is the direct written or verbal consent from a minor (under age 18) to participate in a program or research study. Getting assent from minors involves educating them about the program or research study so that they understand what participation entails and, therefore, make informed decisions. Assent should be given freely, without pressure or coercion. It is usually accompanied by the *parental permission* of a parent or legal guardian, however in some cases this requirement may be waived.

Behavior-Determinant-Intervention (BDI) logic model is a type of logic model that links a health goal, behaviors directly related to it, determinants that influence those behaviors, and intervention activities designed to change those determinants.

Capacities are the resources (staff, skills, facilities, finances, and other resources) an organization has to implement and sustain a program (see also **cultural competence, fiscal, resource, and technical capacities, leadership capacity, partnership and collaboration capacities, staff and volunteer capacities**).

Continuous quality improvement (CQI) is a systematic assessment using feedback from evaluation information about planning, implementation, and outcomes to improve programs.

Control groups are samples of test subjects left untreated or unexposed to the process being tested and then compared with the treated subjects in order to measure the value of the process.

Core components are the essential elements of an evidence-based program believed to make it effective that should be repeated or replicated to maintain program effectiveness.

Cultural competence is a specific kind of human capacity defined as a set of congruent skills and attitudes that can enable a person to work effectively with diverse groups and in diverse situations. This could include adapting services or approaches to meet diverse needs.

Desired outcomes are those specific changes that you expect as a result of your actions. These changes should reflect the changes in behaviors and determinants that you desire. Desired outcomes are also sometimes called objectives.

Determinants (of behavior) are risk and protective factors that affect whether individuals, groups or institutions engage in specific behaviors.

Dosage is the amount of time a participant actually receives the program sessions and activities; i.e., hours per session, days per week, etc.

Evidence-based programs have been shown through research to be effective in changing at least one behavior that contributes to early pregnancy and HIV/STIs: delaying sexual initiation, reducing the frequency of sexual intercourse, reducing the number of sexual partners, or increasing the use of condoms and other contraceptives.

Fidelity describes the faithfulness with which an evidence-based program is implemented. This includes implementing a program without removing parts of the program that are essential to the program's effectiveness (core components). This is also sometimes called compliance or adherence.

Fidelity monitoring systematically tracks how closely each intervention activity was implemented as laid out in your final work plan.

Fiscal, resource, and technical capacities encompass adequate funding and other resources needed to implement the program as planned (e.g., transportation, food, printed materials, and evaluation resources); technical capacities constitute the expertise needed to address all aspects of program planning, implementation, and evaluation; access to special materials needed to deliver the program; technology appropriate to the implementation of the program such as computers.

Fit expresses the overall compatibility between a program and the youth, organization and stakeholders, that is, the community served.

Health goal is the overarching, big-picture, desired outcome. Goals reflect the hoped-for impact in the future, such as "to reduce teen pregnancy rates in X county."

Health literacy describes the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decision.

Informed consent ensures that persons of legal age of majority clearly understand what participation in a program or research study involves before agreeing to participate. Consent must be given freely, without pressure or coercion.

Institutional Review Board (IRB) is a group of people responsible for reviewing research procedures and making sure they are ethical, legal, and contain minimal risk to those involved in the research.

Instrument is a stand-alone survey or collection of questions (measures) that are part of an evaluation.

Integrity, with regard to an evidence-based program, refers to a condition of completeness and soundness.

Intervention activities consist of specific activities conducted with an individual or group in order to change behaviors. These are the actual details of what you will do to deliver your programs that are often spelled out in a curriculum or BDI logic model.

Leadership capacity encompasses leaders who understand and support the program including board members as well as those within organizations and in the community who support the program.

Logic model is a visual representation of the sequence of related events connecting the need for a planned program with the program's desired outcomes.

Measures are individual questions or data items gathered on a survey or instrument designed to obtain information/data about the behavior and determinants being examined.

Midcourse correction CQI involves a series of activities for making program improvements as the program unfolds or in the ongoing operations of a program.

Needs and resources assessment is a systematic way to identify current conditions underlying the potential "need" for a program or intervention and to identify related community resources.

Outcome evaluation determines whether a program caused an improvement among its participants on specific areas of interest (e.g., reduction in sexual risk behaviors, fewer teen pregnancies, etc.) and by how much.

Parental permission involves obtaining permission from a child's parent or legal guardian for their child who is not of the legal age of majority to participate in a program or research study.

Partnership and collaboration capacities involve connections with other community partners who can help implement and support the program.

Priority population is the target group to be served by the program interventions that your group eventually plans to institute.

Process evaluation assesses the degree to which your program is implemented as planned. It includes monitoring the activities, who participated and how often, as well as the strengths and weaknesses (quality) of the implementation.

Protective factor is one whose presence is associated with increased protection from a disease or condition.

Qualitative data answers the questions "why" and "how," which usually involve talking to or observing people in focus groups, forums, in-depth interviews, observation (participatory or non-participatory), key informant interviews, or case studies.

Quantitative data answers "who, what, where, and how much." Numerical in form, quantitative data are the result of comparison on a scale or counting people, behaviors, conditions, or events. It can be gathered using written surveys, telephone interviews, in-person interviews, observation and recording well-defined events, experiments, and clinical trials.

Risk factors are those whose presence is associated with and increased risk of a disease or condition.

Science-based approach (SBA) uses research and health education theory to guide the selection of risk and protective factors that will be addressed by a program as well as the selection of intervention activities. This approach includes using a logic model to link factors, strategies, and outcomes; use of evidence-based programs; and use of process and outcome evaluation.

Sexually Transmitted Diseases (STDs) and **Sexually Transmitted Infections (STIs)** are transmitted between humans by means of sexual contact. Many programs and organizations use the term STD; for our guide, we've chosen to use the more comprehensive term STI. You'll often find them used interchangeably.

SMART desired outcome statements articulate strong outcomes structured on five essential components. They are Specific, Measurable, Achievable, Realistic, and Time-bound.

Staff and volunteer capacities refer to staff with appropriate credentials, training, experience, and commitment to the program; trained and committed volunteers.

Stakeholders are the individuals and organizations invested in your program's delivery and results. Stakeholders include participants, their families, program staff and volunteers, funders, and community organizations.

Strategic CQI refers to the systematic assessment and feedback of evaluation information about planning, implementation, and outcomes to improve programs conducted after a round of a program has been implemented.

Sustainability - the continuation of a program after initial funding has ended.

Tasks encompass all of the broader actions needed to prepare for and carry out a program which includes such things as preparation, training, and staff debriefings among others.

Work plan is the organized, formal documentation of components and tasks necessary to implement a program, broken down by resources, personnel, delivery dates, and accomplishments; the work plan specifies who will do what, when, where, and how.