Coalition Building and Functioning

Selecting, implementing, and evaluating teen pregnancy prevention interventions: Lessons from the CDC’s Community Coalition Partnership Programs for the Prevention of Teen Pregnancy

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Abstract

Purpose: To summarize 13 communities’ experiences with selecting, implementing, and evaluating teen pregnancy prevention interventions within the CDC Community Coalition Partnership Programs for the Prevention of Teen Pregnancy. The study focuses on decision-making processes and barriers encountered in five categories of interventions: reproductive health services, reproductive health education, parent-child communication, male involvement, and programs for pregnant and parenting teens.

Methods: Telephone interviews were conducted with program directors, lead evaluators, and community coalition chairpersons in each of the 13 communities. The descriptive analysis explored factors that influenced community decisions to develop or not to develop interventions. These factors were analyzed by type of intervention.

Results: Each community implemented an average of six interventions and operated them with a variety of funding sources. Interventions were selected on the basis of need, and the community needs and assets assessment process was “very important” for most reported interventions. Decision-making was influenced most often by project staff, the coalition, or related work groups. Teens were infrequently viewed as primary decision-makers in the selection of interventions. Communities with family planning services as hub agencies were more likely to address reproductive services and reproductive health education. Communities with child advocacy or youth-serving agencies were more likely to focus on other intervention categories. About two-thirds of the interventions were evaluated by either process or outcome measures, or by both.

Conclusions: This study highlights important lessons learned that should be considered in examinations of the overall effectiveness of this community coalition approach to the prevention of teen pregnancy. © 2005 Society for Adolescent Medicine. All rights reserved.

Keywords: Decision-making; Intervention selection; Teen pregnancy prevention
communication, resource development, and staffing [10], the practice and research literature has primarily described coalitions in terms of governance, planning, resource development, and structure [11–14]. Little attention has been paid to the decision-making aspects of coalitions. Given the major role of coalitions in community health promotion as currently practiced in the United States, it is surprising how limited is the empirical knowledge about this approach [4]. There is a need for more theory, research, and discourse on how community coalitions function and make decisions about their efforts.

This article describes some of the decision-making characteristics and approaches employed by 13 community coalitions in planning, implementing, and evaluating interventions related to reproductive education or to development-related activities whereas others put into practice interventions aimed at deepening comfort levels, increasing frequency, and improving parents’ communications with teens; provision of sexuality-related information is also part of such programs.

Background

Between 1997 and 2001, 13 grantees of the Community Coalition Partnership Programs for the Prevention of Teen Pregnancy were given funding, after a two-year planning phase, to implement and evaluate interventions and community activities identified in their action plans. The community coalition was the vehicle by which the youth development and teen pregnancy prevention interventions and community activities were put into action. Communities were given considerable freedom in the types of interventions and community activities they could implement with the proviso that the CDC funding could not be used to execute direct services.

A previous CDC-funded inventory and study conducted by the authors in 2000 [15] showed considerable diversity in the types of interventions employed by the 13 communities. Some communities focused efforts exclusively on youth development-related activities whereas others put into practice interventions related to reproductive education or to improving parent and child communications. The selection criteria or rationales used by the communities or their coalitions were not evident in secondary information sources such as their semi-annual reports to CDC. The purpose of this study was to collect primary data to investigate the decision-making processes used by each community to prioritize, select, carry out, and evaluate their interventions and to describe the barriers experienced and lessons learned by the communities during the implementation and evaluation phase of the Partnership Initiative. Study questions included the following:

- What factors influenced community decisions to develop or not to develop interventions within five categories: reproductive health services, reproductive health education, parent-child communication, male involvement, and programs for pregnant and parenting teens?
- How important were community needs and assets assessments in the selection of interventions?
- Who were the key entities in decision-making about intervention selection?
- What barriers were encountered in the implementation and evaluation of interventions?

Methods

Definitions

Interventions, not activities, were the focus of the study. An intervention was defined as “a program with a set of components or services designed and implemented to achieve specific outcomes.” Examples of such programs are Postponing Sexual Involvement, Teen Outreach Program, and Girls, Inc., along with condom distribution and family life education. An activity was defined as “a task, usually of short duration or single occurrence, undertaken as part of a program component.” Examples of activities are the development of educational materials, publicity-related efforts, and the organization of community forums.

The study team had identified five intervention categories in a previous analysis of three years’ worth of semi-annual progress reports submitted by the 13 programs to CDC [15]. The categories represent interventions often reported by teen pregnancy prevention programs [16]. The five intervention categories were defined as follows:

- Reproductive health services (RHS): interventions intended to directly modify teen sexual behavior through the provision of clinic-type services.
- Reproductive health education (RHE): interventions intended to directly modify teen sexual behavior through the provision of sexuality-related education.
- Programs for pregnant and parenting teens (PPT): interventions that assist pregnant and parenting teens medically and educationally and that aim to prevent subsequent pregnancies before teens reach milestones, such as high school graduation. (Secondary pregnancy prevention was not a focus of Community Coalition Partnership Program but was still included as an intervention category.)
- Male involvement (MI) programs: interventions aimed directly at young males.
- Parent-child communication (PCC) programs: interventions aimed at deepening comfort levels, increasing frequency, and improving parents’ communications with teens; provision of sexuality-related information is also part of such programs.

Study population

Participants were 39 present and past directors, evaluators, and coalition chairpersons from the 13 communities of
the Community Coalition Partnership Program. They were identified with the assistance of CDC staff.

**Procedures**

A questionnaire was developed to ask the study participants to identify all interventions at their sites in each of the five categories. If interventions had components that related to multiple categories, then respondents were asked to place the intervention in the one category it fit best. The questionnaire explored factors that influenced decisions whether to develop interventions within particular categories, including the key entities in the selection process and the relationship of such decisions to the sites’ needs and assets assessments and their community action plans. It also addressed the current status of the intervention and reasons why some interventions had been discontinued or dropped, sources of funding, plans for evaluation, and specific barriers encountered in the implementation and evaluation of each intervention. A final question addressed lessons learned or suggestions that could be given to other communities involved in similar projects. Study questions were designed to produce a mix of open- and closed-ended responses.

Between August and October 2001, two members of the study team collected information through telephone interviews. Thirty individuals were interviewed. The number of individuals interviewed at each site ranged from one to three. A current or former project director was interviewed for each site except one—there the project’s principal investigator responded because the director was no longer with the project and had not been replaced. The principal investigator was identified as the individual having the most knowledge about the project at the time of the interview. In our analyses, this principal investigator is grouped with the project directors. An evaluator was interviewed for 12 of the programs, but there were only five coalition chairpersons who responded. This latter group was difficult to contact and was less likely to respond to reminder e-mails and phone calls. The median number of months that the respondents had been with the project was 50. Coalition chairs and evaluators tended to have been with the projects longer than directors.

**Data analysis**

The research team wanted to learn more about the diversity of interventions developed by the 13 community programs. Data for this descriptive study were collected from phone interviews with a volunteer sample of 30 respondents. The interviews assessed each community’s experiences with selection, implementation and evaluation of their interventions. Diversity in these experiences was examined by type of community hub agency and by type of intervention category. Analyses were conducted in several steps. First, frequency distributions were run for each survey question. Second, these data were analyzed by type of respondent—director, evaluator, or coalition chairperson. Percentages were calculated with the total number of responses within a response category as the numerator and the total number of all responses as the denominator. If a respondent did not answer a question, then in effect zero was added to the numerator. There were only minor differences among responses of program directors, evaluators and coalition chairs. These data were also analyzed by type of intervention (RHS, RHE, MI, PPT, or PCC). Analyses of intervention type were done for the 13 directors’ responses only. Third, the data were examined with each intervention used as the unit of analysis, rather than each respondent’s response to a question. This procedure addressed difficulties encountered in the first two levels of analysis in which responses were not independent of one another and could not be tested for statistical significance. The relationship between each intervention category and the directors’ responses was examined to determine the strength of each relationship. Because of the small sample size (30 respondents), a less rigorous level of statistical significance was considered. Probabilities less than .05 were accepted as demonstrated, statistically significant associations. Probabilities between .05 and .10 were considered marginally significant. Contingency tables were developed and chi-square analyses were conducted for the nominal variable responses to examine the distributions of various decision-making, implementation, and evaluation activities among the five intervention categories.

**Results**

The 30 respondents collectively mentioned 82 interventions in the five categories, an average of about six interventions per site. Almost all of the sites had interventions in RHE (92% of sites) and most had them in PCC (77%); fewer sites had interventions in MI (54%), RHS (46%), and PPT (39%). The number of interventions per category followed a similar order, with the highest number of interventions being in RHE and the lowest number in PPT. Over two-fifths of all 82 interventions were in RHS (43%); the second highest was PCC (24%). The category with the smallest number of interventions was PPT (7%) (Table 1).

**Intervention selection process**

The intervention selection questions focused on entities involved in decision-making, the role of the needs and assets assessments, the reasons for selecting a particular intervention, and the reasons for not selecting any intervention within a category.

**Key entities in decision-making**

All respondents were asked to identify the key entities or individuals that participated in the decision to select an intervention for implementation. Answer choices were (a)
the entire community coalition, (b) a work group or sub-committee of the coalition, (c) teens and youth, (d) project staff, (e) groups outside the coalition, or (f) other entities, such as hub agency, state agencies, focus group, or university partners. Overall, 318 key entities were identified for the 82 interventions. Collectively, the respondents most frequently identified project staff as the key entity involved in intervention selection, and they least frequently identified teens and youth or groups outside the coalition.

In the analysis by intervention category, the directors identified key entities for 58 of the 70 interventions. In some cases the directors said they did not know enough about or feel comfortable in responding to a particular intervention; therefore key entities were not reported for all 70 interventions. Project staff was mentioned most often and teens and youth least often. However, the relationship between the key entities in decision-making and intervention category was not statistically significant.

Although respondents were not asked about the influence of the hub agency, the type of agency appeared to affect the selection of both the number and the categories of interventions. Collectively, the responses showed that 26% of the interventions were reported by respondents from family planning agencies, 23% from health departments, 20% from child advocacy agencies, and 32% from other agencies—namely, two universities, a mayor’s council on teen pregnancy, and a YWCA.

Analyses of hub agency type by intervention category showed family planning and health department hub agencies had more RHS interventions than did other types of hub agencies. RHE interventions were reported across all of the hub agency types. PCC and MI interventions were reported more often by directors in “other” hub agencies. The relationship between hub agency type and intervention category was marginally significant ($\chi^2 = 19.6, df = 12, p = .08$) (Table 2).

### Needs and Assets assessment

All respondents were asked whether the needs and assets assessment (NAA) was *very important*, *somewhat important*, or *not important* in the decision to select each intervention. Almost two-thirds (64%) of all respondents thought that the NAA was *very important* in relationship to the intervention needs that they selected. Several respondents commented that their NAA provided a strong message for their programs, for example:

“*Our NAA showed us the great importance of a collaborative effort needed to ‘de-glamorize’ teen pregnancy.*”

“The strong message from our NAA was that we need to start [intervention] early and we need to involve parents.”

In the analyses by intervention category, the directors reported that the NAA was *very important* most often in regard to RHE interventions and *somewhat important* most often for PPT interventions. The relationship between importance of NAA and intervention category was marginally significant ($\chi^2 = 15.2, df = 8, p = .06$) (Table 3).

### Table 1

<table>
<thead>
<tr>
<th>Intervention category</th>
<th>No. of sites with interventions in this category (%) (n = 13)</th>
<th>Reported by all respondents</th>
<th>Reported by directors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of interventions (%) (n = 82)</td>
<td>No. of interventions (%) (n = 70)</td>
<td></td>
</tr>
<tr>
<td>Reproductive health services (RHS)</td>
<td>6 (46)</td>
<td>11 (13)</td>
<td>8 (11)</td>
</tr>
<tr>
<td>Reproductive health education (RHE)</td>
<td>12 (92)</td>
<td>35 (43)</td>
<td>31 (44)</td>
</tr>
<tr>
<td>Male involvement (MI)</td>
<td>7 (54)</td>
<td>10 (12)</td>
<td>9 (13)</td>
</tr>
<tr>
<td>Pregnant and parenting teens (PPT)</td>
<td>5 (39)</td>
<td>6 (7)</td>
<td>6 (9)</td>
</tr>
<tr>
<td>Parent and child communication (PCC)</td>
<td>10 (77)</td>
<td>20 (24)</td>
<td>16 (23)</td>
</tr>
</tbody>
</table>

### Table 2

<table>
<thead>
<tr>
<th>Intervention category</th>
<th>No. of reported interventions</th>
<th>Family planning</th>
<th>Health department</th>
<th>Child advocacy</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Reproductive health services (RHS)</td>
<td>8</td>
<td>4 (31)</td>
<td>4 (21)</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Reproductive health education (RHE)</td>
<td>31</td>
<td>3 (23)</td>
<td>9 (47)</td>
<td>10 (67)</td>
<td>9 (39)</td>
</tr>
<tr>
<td>Male involvement (MI)</td>
<td>9</td>
<td>1 (8)</td>
<td>2 (11)</td>
<td>1 (7)</td>
<td>5 (22)</td>
</tr>
<tr>
<td>Pregnant and parenting teens (PPT)</td>
<td>6</td>
<td>2 (15)</td>
<td>2 (11)</td>
<td>1 (7)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Parent and child communication (PCC)</td>
<td>16</td>
<td>3 (23)</td>
<td>2 (11)</td>
<td>3 (20)</td>
<td>8 (35)</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>13 (19)</td>
<td>19 (27)</td>
<td>15 (21)</td>
<td>23 (33)</td>
</tr>
</tbody>
</table>
Some respondents provided reasons for reporting that the NAA was not important to intervention selection. For example, one said the NAA was completed too early in the planning phase of the program and was not current or appropriate when the time came to make decisions about selection and implementation of interventions. As a result, the site resorted to conducting a “mini-needs assessment” with its coalition member agencies and programs later in the selection process.

Reasons for selecting an intervention category

Respondents were asked what influenced the site’s decision to select each of the categories in which they had an intervention. Responses were coded as (a) identified in NAA or CAP, (b) complemented other agency efforts, (c) parent/teen supported, (d) community supported, and (e) other. Collectively, the respondents most often identified the NAA/CAP as the reason an intervention category was selected, and community support was the second most common reason. The following comments illustrate the respondents’ views:

This [category] was identified as a serious gap and need in the community.

We wanted interventions that would enhance the community’s capacity by creating and involving more caring adults, as identified in our NAA.

There is a belief in our community that knowledge is important. Parents want their kids to have comprehensive education.

Over a fifth of the responses were in the “other” category and represented a range of reasons, from a relationship between a particular category and identified mission of an agency to a matter of convenience. Following are examples of these responses:

We decided early on to address male and female issues equally, hence we had to include male involvement as a category.

This intervention category was on our state health department’s ‘approved’ menu of services that they would fund.

Our hub agency has a long history of providing [these types of] interventions and services.

Reasons for selecting a particular intervention

The reason for selecting an intervention was asked as an open-ended question, and responses were grouped into categories. Interventions were selected for a variety of reasons, but the most common was that the intervention was an established or evaluated model. Second was identified need. The track record of a particular approach or program was often cited, e.g., “It had been implemented at other sites and was proven to be effective.”

The unique characteristics of the intervention or approach were also mentioned as a reason for its selection.

We felt this [intervention] was of great potential to generate referrals and would be a jumping-off point for other intervention services.

This [intervention] addressed two of the nine key assets: service to others and decision-making.

Availability of an opportunity was cited less often, but this response provides additional insight into the rationale for some decisions.

It was an opportunity to get funds for a pilot from the State Health Department.

This came to us as a ‘freebie.’ One of our partners got funding from a corporation and included us.

Several respondents described perceptions of the role and support provided by CDC and its project staff as being overly specific and directive about particular interventions and evaluations of their interventions, for example:

CDC guidance was to use only evaluated and validated programs.

CDC was in favor of this particular intervention.

We got a lot of hype from CDC on this curriculum.

Others reported that they were glad they waited before implementing interventions because CDC appeared to ease up or relent on some of its earlier restrictions about the types of interventions that could be implemented. They felt these changes in the CDC’s position was to their advantage. Some reasons cited by the directors appeared spontaneous or non-specific and not necessarily based on underlying assumptions or need. Such responses occurred most frequently in the RHS category and included opportunities to link with
other initiatives such as HIV prevention or to address problems in family planning clinics such as flexibility of hours.

In the analysis by intervention category, the relationship between decisional rationale for selection and intervention category approached marginal significance ($\chi^2 = 28.1$, df = 20, $p = .11$) (Table 4). Directors gave an established or evaluated model as their most frequent reason, particularly for MI. Identified need was an especially important reason in the selection of RHE interventions. The responses suggest that the needs addressed by these interventions went beyond the needs identified in the community NAAs. This was specifically requested by a group of community leaders and churches.

Early childhood was a major initiative and priority promoted by community leaders so we just capitalized on it. We had phone calls from parents, school counselors, and even the court system requesting that we conduct this program.

Available opportunity was cited as a reason for selection only for interventions in the RHE category. The directors infrequently cited CDC influence or support as a reason for selection (8%).

### Intervention implementation experiences

For each intervention, respondents were asked about the circumstances under which the intervention started, the current status and length of operation of the intervention, and its funding sources. In addition, they were asked about barriers to implementation generally.

### Circumstances for initiation

Overall, respondents reported that 71% of the interventions were the result of coalition and project efforts, 23% were already in place, and 6% were related to other circumstances. In the analysis by intervention group, directors reported that coalition and project efforts were particularly instrumental in initiating PCC and RHE interventions.

Nevertheless, the directors reported that over a fourth (27%) of the interventions were already in place. This was particularly true for MI interventions. Other reasons for project start-up included an expressed need for the intervention, a request by a group of concerned citizens who approached the coalition, initiation by the hub agency, or implementation through another grant effort. The relationship between circumstances for initiation and intervention category was not statistically significant.

### Status and length

Overall, 75% of the responses indicated that the intervention was still in place, 10% reported that an intervention had been discontinued, and 16% reported an intervention as pilot tested only. The most common reasons cited for discontinuing interventions were a lack of participation, including poor turnout, and funding difficulties. Analysis by intervention group was not statistically significant. The median duration of all interventions reported in this study was two years. No attempt was made to follow up to determine the status of the interventions at the end of the TPPP.

### Funding

Identified funding sources were categorized as (a) individual agency contributions, (b) project funds, (c) additional funds, or (d) none needed. Overall, CDC project funds were the most commonly reported source of project support; second were additional funds. Individual agency contributions were reported used in a fifth of the interventions. In many cases, individual agency contributions were in the form of in-kind services or donation of resources rather than monetary contributions. In the analysis by intervention group, the directors reported that project funds were most important for RHS, RHE, PCC, and MI, and that individual

<table>
<thead>
<tr>
<th>Intervention category</th>
<th>No. of reported interventions</th>
<th>Identified need</th>
<th>Opportunity available</th>
<th>Established or evaluated model</th>
<th>Agency/provider supported</th>
<th>CDC influence or support</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health services (RHS)</td>
<td>8</td>
<td>1 (6)</td>
<td>—</td>
<td>2 (11)</td>
<td>—</td>
<td>1 (20)</td>
<td>4 (40)</td>
</tr>
<tr>
<td>Reproductive health education (RHE)</td>
<td>24</td>
<td>9 (56)</td>
<td>4 (100)</td>
<td>5 (28)</td>
<td>4 (50)</td>
<td>—</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Male involvement (MI)</td>
<td>10</td>
<td>1 (6)</td>
<td>—</td>
<td>6 (33)</td>
<td>1 (13)</td>
<td>1 (20)</td>
<td>1 (10)</td>
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<tr>
<td>Pregnant and parenting teens (PPT)</td>
<td>4</td>
<td>1 (6)</td>
<td>—</td>
<td>2 (11)</td>
<td>1 (13)</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Parent child communication (PCC)</td>
<td>15</td>
<td>4 (25)</td>
<td>—</td>
<td>3 (17)</td>
<td>2 (25)</td>
<td>3 (60)</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Total</td>
<td>61</td>
<td>16 (26)</td>
<td>4 (7)</td>
<td>18 (30)</td>
<td>8 (13)</td>
<td>5 (8)</td>
<td>10 (16)</td>
</tr>
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</table>

* Responses were not mutually exclusive. More than one reason for intervention selection could be given.
agency contributions were most important for PPT interventions. These differences were not statistically significant.

Respondents frequently reminded interviewers that they were prohibited from using CDC funds for direct services, except when pilot testing a new intervention. Only then could they use CDC funds to support staff time, evaluation, or development of promotional materials. Several sites applied CDC funds to develop pilot interventions that were subsequently used to leverage funding from federal programs, such as Temporary Assistance for Needy Families, Title X family planning funds, Center for Substance Abuse Programs, and the Office of Populations Affairs; from state and local agencies; and from national foundations, such as Annie E. Casey. Most interventions had multiple funding sources. However, the data did not allow examination by amount of funding.

**Barriers**

Respondents were asked an open-ended question about the barriers they experienced in implementing each intervention. Responses were categorized as (a) internal barriers, (b) external barriers, (c) financial barriers, and (d) other barriers. Internal barriers were most frequently reported by the respondents collectively (53%) and included training, turnover and other staff issues, transportation, coordination and space difficulties, and participant recruitment and attrition. Retention of staff was an important internal barrier. Respondents reported retention and staff difficulties:

- Agency staff turnover was continuous. . .all (our) trained staff have left.
- Even though we required additional counseling or teaching experience we still had a problem with attrition of our trainers.
- Staff at the agency that agreed to take over this intervention did not follow through because this was not a formal part of their job.
- Some of the implementation organization’s staff tried to sabotage the program. They bad-mouthed the agency and told parents not to bring their children.

Recruitment and retention of participants was another frequently reported barrier:

- Parent attrition was tremendous. They did not seem to respond to incentives—even getting a free video camera!
- The poorer the family, the more problems they have and the harder you have to work to get and keep their involvement.
- The mobility of the client population made attrition of participants a major problem.

External barriers (31%) followed internal barriers in order of frequency. These included community and cultural barriers and difficulty working with schools and other agencies. Respondents reported difficulties with agency partners:

- We have no direct control over implementing agencies; hence we have no control over the quality of the intervention.
- In many cases [the agencies we contracted with] did not follow through with the protocol and sometimes took money for positions but made the staff do other work.
- There were territorial issues of ownership internally (i.e., coalition members) over who would get credit and whom the materials belonged to.
- We have an educational system that is broken and with so many needs this one [teen pregnancy prevention] gets lost. This type of barrier is pretty overwhelming.

Financial barriers reported in 15% of responses were related to lack of sufficient resources, problems dealing with federal, state, and local funding streams, release of funds, and coordination of financial responsibility among partner agencies. Differences by intervention group were not significant.

**Evaluation process**

The respondents were asked about plans to evaluate their interventions. Response choices were (a) evaluations planned and conducted, (b) planned but not conducted, or (c) not planned. Respondents were also asked to identify evaluation methods—(a) process evaluation only or (b) process and outcome evaluation methods—and the barriers they had experienced in conducting evaluations (open-ended question). That 6 of the 13 sites had received additional CDC funding to conduct enhanced evaluations affected responses to questions. Overall, 76% of the reported interventions had conducted or were conducting evaluations, 10% had evaluations planned but not yet conducted, and 14% had none planned. The analysis by intervention group showed no significant difference. Some 72% of the evaluations were employing outcome measures as well as process measures, and the remaining 28% used process measures only. Although an analysis was not conducted for programs with enhanced evaluation funding, these projects more frequently reported use of outcome evaluations.

A brief examination of the scope of outcome-based evaluation strategies showed considerable diversity in design. Some employed pre- and post-intervention surveys of mostly process-oriented information, whereas others conducted focus groups or surveys of former participants. Some sites with funding for enhanced evaluation were conducting longitudinal follow-up studies with a subset of their intervention participants.

**Discussion**

The results of this study indicate considerable differences among the 13 communities in decisions and experiences related to selection, implementation, and evaluation of their interventions. Respondents, even within the same
community, sometimes viewed these processes differently. The response variation may relate to the length of time respondents had worked in the program and their particular program responsibilities. Overall, the variation suggests that information provided by one type of respondent—for example, an evaluator—may not accurately reflect how a decision is made or perceived by others. By examining responses of only the program directors, the study findings showed that decision-making processes and implementation and evaluation experiences varied somewhat by category or type of intervention.

**Intervention selection**

Although respondents did not report that their community used a methodical way to select categories of interventions or specific interventions—such as a model that (a) identifies a problem, (b) examines alternatives and consequences, (c) identifies solutions existing in the community, and (d) brainstorms new solutions [17]—they reported a heavy reliance on and use of their needs and assets assessments when making decisions. Two-thirds of the respondents thought their community’s NAA played an important role in their decisions about intervention selection. This was a consistent finding across most intervention categories, with the exception of working with pregnant and parenting teens, which was an intervention area reported by some communities as already well established.

The reason why respondents thought the NAA was so important is not clear because the study survey did not probe into the responses. One plausible explanation is that each of the 13 communities devoted two years to the planning phase of their community coalition partnership program. Much of the time, resources, and energy expended during this period related to data collection activities for the NAA. CDC required this effort for all of the communities and was quite explicit about the data that were to be identified. The nature and magnitude of this investment effort may have influenced the communities’ perception of the importance the NAA had in their selection decisions. We cannot be reasonably certain that the NAAs actually informed the selection of the interventions. Nor can we assume that the NAAs were simply used by hub agencies to justify what they wanted to do and had the CDC resources to do anyway. In another study by the authors, one in which respondents were asked about their data collection and analysis activities, less than half of the respondents agreed that they had been able to collect all of the data required for their NAA tasks [18]. This finding suggests that, in spite of the perceived importance of a NAA, program leaders had concerns about the completeness of the information. A comparison of the data that each community collected specific to its NAA with the selected intervention categories and implemented interventions might shed more light on the accuracy of these perceptions.

The data show that another important influence on decisions related to selecting interventions involved the project staff and the community coalition or its related work groups. Teens were rarely used or viewed as primary decision-makers despite CDC’s stated preference for a youth development approach to teen pregnancy prevention. Teen involvement in decision-making about programs that target their peers is viewed as important by some experts. For example, in a study of problems encountered in implementing change via community coalitions, White and Wehlage [19] report that the teen pregnancy prevention efforts of the Annie E. Casey Foundation’s “New Futures” program had little impact. Despite the Foundation’s emphasis on inclusiveness and collaboration, the authors noted a disjuncture between theory and practice. Adult decision-makers in the New Futures program viewed the complexity of teen pregnancy from their own perspective and believed they understood what was needed. Teens viewed teen pregnancy from a very different perspective but were not present to contribute to the discussion. The authors suggest that the top-down organization of the New Futures coalition is an important factor that can keep the complexity of teen pregnancy from emerging. In the CDC Partnership Initiative teens may have been represented on the coalitions, and in some cases were even paid to participate, but the study respondents did not perceive that teens had contributed to decision-making. Involvement of consumers for whom programs are designed is now standard practice for most program planning and development efforts. Articulate consumers have successfully challenged the thinking and attitudes of professionals and planners to adopt a “not for us, but with us” philosophy. We are concerned that this philosophy was not observed in this study and may not have been communicated well to teens in the CCPP.

The statistically significant relationship between the type of hub agency and type of interventions selected for implementation was an unexpected finding. Family planning and health-oriented hub agencies addressed reproductive services and reproductive health education more frequently than other hub agencies. Child advocacy or youth-serving agencies focused on other intervention categories. Chavis [1] describes the cooperative relationship between the coalition and the lead agency as an inherent paradox. Although the lead agency and the coalition members may stress the independence of the coalition when making choices, in reality it is highly dependent on the regulations and expectations of the lead agency. This lead agency-coalition relationship has particular implications for decision-making because it is a process that takes considerable time. In the absence of sufficient time to adequately explore options, the decision-making process may be unwittingly compromised or influenced by the coalition leadership or the lead agency in an effort to stay “on task” or to show the coalition membership that something tangible is occurring in the community. This is more likely to occur early in the devel-
development of a program when the coalition has not yet “jelled” or adapted to its consensus-building, decision-making role.

An interesting question not addressed by this study of intervention selection is whether the lead agency in each community would have conducted the selected interventions anyway. Instructions from CDC were clear that project funds could not be used for direct services. However, if services were already in place in the community or developed and supported under the auspices of the lead agency mission, it would seem a safe assumption that communities would capitalize on this and use CDC money to expand, augment, or evaluate the lead agency services, which some of the communities did indeed describe in this study. Twenty-three percent of the interventions were reported as already in place before the CCPP, supporting this possible explanation. It is unfortunate that the study interview did not specifically address the hub agency’s influence on decisions related to selecting interventions.

Perceptions of the role and support provided by CDC and its project staff was cited as an influence in the selection and implementation of particular interventions, although opinions varied among the communities. Some felt that the CDC was overly specific and directive about particular interventions and evaluation efforts. Others reported that the CDC appeared to change direction over time and eased up or relaxed on some of its earlier restrictions. Federal agencies have made increasing efforts to encourage communities to select prevention interventions with proven effectiveness, even going so far as to provide them with lists of “evidence-based” programs [20]. However, if a community coalition and its broadly based constituency of service providers, academics, and lay citizens are not provided technical assistance to understand these issues at multiple levels the result can be what one respondent described:

CDC banned direct services, which is what we do best. Then we got a lot of hype from CDC on this [program]. We felt our options were pretty much narrowed down to this [program], even though it wasn’t our strong suit.

**Intervention implementation**

The findings associated with implementation experiences were less dramatic, though important for reviewing the outputs of the overall Teen Pregnancy Prevention and Community Coalition Partnership Programs. Applying the definitions and criteria of this study, grantees implemented an average of six interventions per community and operated them with a variety of funding sources. They frequently used the funds from CDC to leverage additional funding from national, state, and local sources, but the level of additional funding was not determined in this study. Experts suggest that a mark of successful community coalitions is that they are able to combine resources and to foster unique relationships. Successes have been largely due to the coalitions’ ability to mobilize and focus financial and manpower resources [1].

The mean duration of interventions reported by the communities was two years. This finding included interventions that ended before respondents were interviewed as well as those that were still in place at the time of the interview in 2001. The time frame for CCPP implementation was between 1997 and 2002. Study data were collected during the fourth year of implementation. Because no attempt was made to follow up to see if interventions were still in place at the end of the program, the findings no doubt underestimate the length of the interventions. Although the communities reported many barriers associated with implementation of interventions, no discernable pattern or association could be determined from the data to suggest that one category was more difficult to implement than another. Over half the barriers were internal in nature and included difficulties with staff turnover, training limitations, and problem employees. External barriers included problems with other agencies. The two agencies cited most frequently were schools and their administrators and CDC. Following is a sample of comments:

The coalition saw schools as the logical place to target interventions. The schools were too overwhelmed or preoccupied with their own problems to give us the time of day. We were hardly a blip on their radar screen.

CDC was our barrier. Their many staff changes, changes on positions and expectations related to the intervention, their lack of understanding about how communities work, lack of clear expectations, and slowness to release funds made our efforts a nightmare.

In the Casey Foundation’s New Futures program, evaluators noted that coalitions had to rely on a weak, loosely coupled organizational form that had few sanctions to hold members accountable for the work that was being implemented [19]. Coalitions require people and organizations with limited time and resources to commit themselves to another organization. The barrier of limited school participation identified in our study may reflect issues similar to those in the New Futures program.

School staff and administrators are more worried about losing their jobs because of emphasis on grades and student test scores than they were in helping to maintain a lunch program intervention.

Constant changes in local school structures was a barrier. This caused a great turnover in school staff, especially principals. You get a lot of promises one year but it is all changed the next year when you go to implement it.

School curricula and school days are overcrowded as it is. Teachers view our curriculum as one more thing that makes their life miserable. This will only get worse as schools move toward test-based standards as their only measure of effectiveness.
If coalition members are asked to contribute more than they receive [1], they may quickly become burned out or passive, in spite of giving the appearance of active involvement. Such limitations may explain the actions of some community partners as reported in this study.

The project developed exclusive plans but the agency that took over implementation said it was their project and they did not have to be accountable to the TPPP.

We subcontracted to youth serving agencies in the community. In many cases they did not follow through with the protocol and sometimes took money for positions but made the staff do other work.

Some coalition partnership programs in this study recognized difficulties and offered advice about lessons they had learned as a result of encountering these types of barriers.

We learned that there needs to be a firm commitment (a signed commitment is best) from the agency CEO to ensure support for the implementation of [the intervention].

When working with partner agencies (we learned that) it is critical to get buy-in from upper level management via an MOU (memorandum of understanding). Without this and a plan in place there is less chance of follow through.

Be prepared to provide a lot of support, nurturing, and hand holding to partner agencies if you expect successful implementation.

Many studies of barriers to pregnancy prevention programs have found that opposition from politically influential segments of the community can prevent the community from implementing potentially effective programs. No respondents identified this as a barrier to implementation, perhaps, except to say things such as “We are in a conservative state and were restricted on the information we could provide to teens. This limited what we could do and it was counterproductive to our purpose (of preventing teen pregnancy).” It is likely that some of the CCPPs and the unique constellation of their coalition membership may have prevented the emergence of opposition barriers by avoiding certain categories of interventions. Study data from a question about why a particular category of interventions was not selected would support this notion:

We did not select any interventions related to reproductive health clinical services because it is such a controversial area. We knew the coalition would not have been successful if we went down that road.

We knew that we had to find a common ground on which our partners could agree and work. This category [RHC] would have caused some not to participate.

Anecdotal evidence suggests that communities and their coalitions in the CCPP viewed teen pregnancy prevention as multifaceted. Preventive interventions associated with areas such as job training or youth development were more likely to be acceptable to a divided community than were sex education or condom distribution. To avoid opposition, community programs eliminated those facets of the program that would be problematic. One respondent reported that, after an ugly incident that resulted in serious political fallout within their community several years before the CCPP, they were very careful not to have a “sex-oriented” image for their program/coalition. They were very cautious regarding all manner of staff activities as well as interventions.

**Intervention evaluation**

This study found that two-thirds of the 82 identified interventions were evaluated by either process or outcome measures, or by both. This finding was not a surprise given that each of the 13 communities was instructed by CDC to employ a local evaluator with funds from their overall grant awards. Moreover, 6 of the 13 sites received additional CDC funding to conduct enhanced evaluations. Considerable diversity existed in the nature of the outcome-based evaluations. Some employed pre- and post-intervention surveys of mostly process-oriented information, whereas others conducted focus groups or surveys of former participants. Several communities with enhanced evaluation funding were able to conduct longitudinal follow-up studies with a subset of their intervention participants.

In spite of the tremendous effort invested in the 82 interventions, respondents did not feel these efforts adequately reflected their investment of time and money. Many emphasized that their community had been highly successful and productive in their community-mobilizing and community-awareness efforts and expressed regret that this study on intervention selection and implementation was not evaluating their efforts in these areas. The mention of evaluation of programmatic outcomes left the respondents concerned that CDC would take a similar approach in its evaluation of the entire CCPP. Others expressed concern for potentially negative results from CDC’s overall project evaluation because they believed that more emphasis was being placed on outcome than on process. In fact, CDC did what respondents wanted through its MACRO contract and as described in another article in this issue.

**Conclusion**

This study provides insights into who made the primary decisions about which interventions to implement and into experiences related to interventions that were actually implemented. Selection decisions of the CCPPs were heavily influenced by their community needs and assets assessment as well as by the nature of their lead agency. The authors therefore conclude that the actions of a coalition may depend heavily on the regulations, mission, and expectations of the organization that provides leadership to them. Given the increasing reliance on community-wide coalitions to...
address a variety of social and health-related issues affecting adolescents, this study has important implications for further study of this unique relationship. Another contribution is the insight it offers into measuring the effectiveness and outcomes of community coalition programs.

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References