Public/Private Ventures

Plain Talk: Addressing Adolescent Sexuality Through A Community Initiative

A Final Evaluation Report
Prepared for
The Annie E. Casey Foundation

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September 1999

Public/Private Ventures is a national nonprofit organization whose mission is to improve the effectiveness of social policies, programs and community initiatives, especially as they affect youth and young adults. In carrying out this mission, P/PV works with philanthropies, the public and business sectors, and nonprofit organizations.

ACKNOWLEDGMENTS

This study of the Plain Talk Demonstration was funded by The Annie E. Casey Foundation, which developed the Plain Talk initiative.

Throughout the past several years, many P/PV research staff, past and present, have contributed to the research on Plain Talk. Mary Achatz conducted field work through the early years of the initiative and contributed to the first interim report on Plain Talk's implementation. Annick Barker provided valuable assistance in protocol development, data collection and analysis. Danista Hunte and Julie Rainbow also assisted in early data collection. Michelle Gambone was instrumental in working with the communities and provided important insights and analysis in the early years of the study. Wendy McLanahan provided ongoing assistance throughout the initiative in data collection and analysis. Alicia Morales helped develop the first qualitative data analysis coding scheme. Anne Roder conducted field visits and did some preliminary analysis. Carla Herrera wrote the literature review on teen pregnancy and its prevention. Among the many tasks Crystal Wyatt did for the Plain Talk research, she helped refine the coding scheme and maintained the qualitative data base.

Among the key researchers on the project were four ethnographers who worked with us in Atlanta, New Orleans, San Diego and Seattle: Gail Myers, Melanie Harrington, Judy Harper and Suzanne Tedesko. Each ethnographer brought a particular set of skills to the work, and the study would have been far different had they not been involved. Judy Harper contributed extensively to our understanding of the Latino community in San Diego and translated not only language but also the meanings of concepts and behaviors. In New Orleans, Melanie Harrington worked with respect and tact in a vulnerable community.

We would like to thank our P/PV colleagues and a number of external reviewers for their helpful critiques of the manuscript: Gary Walker, Jean Grossman, Linda Jucovy, Frank F. Furstenberg, Jr., Marta Tienda, Isabel Stewart and Charles Bosk. We would also like to thank The Annie E. Casey Foundation staff, in particular Cindy Guy, for helpful comments on the draft and for forwarding the comments of Kristin Moore, Joy Dryfoos, Robert Blum and Sharon Milligan. Linda Jucovy and Natalie Jaffe edited the manuscript, Hilda Rogers proofread the document and Audrey Walmsley processed it for production. We thank them for their support and assistance.

This study would not have been possible without the cooperation of the Plain Talk sites. We wish to thank the core group members, community youth and adults, and agency partners for talking with us about their families, communities, institutions, and their experiences with Plain Talk. It is very difficult for sites to have an ethnographer observing and documenting implementation progress and its inevitable challenges. Despite misgivings, the sites welcomed the ethnographers and suspended distrust, allowing the ethnographers access to their communities and homes.

We are especially grateful to the project managers and Plain Talk staff in each site: Tom Slattery, Lisa Corbin Perry, Tammi Fleming, Petrice Sams-Abiodun, Annika Warren, Enid Torro, Cheryl

Boykins and Jemea Smith. Their cooperation and assistance were instrumental to this study, and they gave generously of their time throughout the years of the study despite demanding schedules. Their openness and candor about the issues facing the Plain Talk initiative provided us with invaluable insights into the challenges that underlie efforts to implement community-based efforts.

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EXECUTIVE SUMMARY

The past 10 years have seen a concerted public effort to reduce high rates of adolescent pregnancy and STD infection in the United States. Throughout the 1980s, to the consternation of social service providers, policy experts and others concerned with adolescent health and well-being, out-of-wedlock births to adolescents rose. Their HIV infections rose as well, especially among minority youth. Both trends have obviously negative consequences for the health and economic well-being of adolescents and their babies.

One recent programming and policy approach has been to think more broadly than in the past about the causes, consequences and possible solutions of high rates of unintended teen pregnancy. Among other activities, people interested in teen pregnancy and STD prevention have looked to Europe for possible solutions. Adolescent women in Europe are much less likely to have babies out-of-wedlock than are their American counterparts, even though similar proportions of adolescent women are sexually active. Reproductive health services are more widely available in Western Europe than in the United States. Also, cultural norms tolerate sexual activity, but not pregnancy, among older adolescents. Observing European attitudes and services, researchers have hypothesized that cultural mores and social supports both contribute to lower birth rates—through higher contraception—among European adolescents than among American adolescents.

In the United States, in contrast, the topic of adolescent sexuality is often taboo. Although the public discourse about adolescent sexuality experiences periodic shifts in emphasis and content—the 1970s were more accepting of adolescent sexuality than are the 1990s—Americans are uncomfortable with frank and serious discussion about sex and adolescent sexuality. For some, sex is an uncomfortable subject, better left to the private world of the individual adolescent and his/her family. For others, discussing the physiology of sex, pregnancy and disease with adolescents is dangerous precisely because in medicalizing the discussion, the moral dimension of adolescent sexuality is omitted.

Concern about teen pregnancy and STD rates, interest in the contrast between the United States and Europe, and speculation that it is possible for American adults to be more helpful in guiding youth's sexual decision-making led The Annie E. Casey Foundation to develop Plain Talk, a unique and controversial approach to teen pregnancy and STD prevention. Plain Talk is unique in enlisting a broad cross section of community adults in the effort to protect teens from pregnancy and disease. The initiative's design called for the creation of community consensus around the needs of youth by focusing on adults, both as recipients of accurate information about the issue and disseminators of that information throughout their communities. Plain Talk is controversial in focusing on the needs of sexually active youth, a design element that grew out of the observation that it is the rates of adolescent pregnancy—and not sexual activity—that vary between the United States and Europe. Specifically, Plain Talk's goals were:

- To create a consensus among parents and adults about the need to protect sexually active youth through encouraging early and consistent use of contraceptives;
- To provide parents and other community adults with the information and skills they need to communicate more effectively with teens about responsible sexual behavior; and
- To improve adolescent access to quality, age-appropriate and readily available reproductive health care, including contraception.

Plain Talk's hypothesis: Increasing the adult-youth dialogue and making contraceptive services physically and psychologically available to sexually active youth would result in earlier and more consistent use of contraceptives, which would, in turn, result in a decrease in the rates of pregnancy and STDs among youth in the community.

The Foundation recognized that its focus on protection for sexually active youth was controversial. A key element of Plain Talk's design, therefore, was the creation of community buy-in to, and acceptance of, what became known as the Plain Talk Message: sexually active youth should be protected from pregnancy and disease. The Foundation directed that the designated local lead agencies, working in concert with community residents, design plans sensitive to the communities' cultures and needs. Therefore, while engaging community residents and seeking their input, Plain Talk sought to influence how they thought about pregnancy and STDs among adolescents. As a result, the design created the need for constant communication and openness to modification.

This report by the project evaluator, P/PV, covers Plain Talk's three-year implementation period in five neighborhoods in Atlanta, Hartford, New Orleans, San Diego and Seattle—and refers to the prior one-year planning period (reported on in *The Plain Talk Planning Year: Mobilizing Communities to Change*, Public/Private Ventures, 1995). Data were collected for the implementation study by on-site ethnographers in all sites but Hartford, and by P/PV research staff during multiple site visits; in-depth interviews with staff, core group members and institutional partners; observations of outreach and education efforts; and review of documentation. An outcomes study, comprising a baseline and follow-up survey of adolescents in three of the sites (Atlanta, New Orleans and San Diego), is currently under way.

OVERVIEW

The implementation research explored questions in three major areas:

- Were the sites able to create structures or processes that seemed promising in creating a community consensus around STD and teen pregnancy prevention? If so, what facilitated their progress? If not, what challenges did they face?
- How effective were the community education strategies used by the sites in educating a large number of community adults?

- How did the sites link with other institutions? Did their efforts result in extra services for people in the community? Did they result in strengthened community support for the Plain Talk Message?

The report answers each of these questions and examines the challenges and opportunities facing the sites in undertaking each of their major tasks: 1) resident recruitment, consensus building, mobilization and outreach; 2) institutional collaboration and outreach; and 3) community education. Their levels of achievement varied, depending on a wide variety of factors: the capacity of the lead agency to complete particular tasks; the experience and expertise of the site staff; the ethnic, racial and cultural backgrounds of the targeted residents; the degree of cohesion within the neighborhoods; and the political and institutional cultures within the cities in which the neighborhoods were located.

The sites' emphasis on resident involvement generally had impressive results in their efforts to spread information about sexuality and the importance of protecting sexually active youth. Neighborhood organizations with relatively small staffs that included health educators and outreach workers were able to mobilize key residents, though the process was time-consuming and arduous, as are all such community efforts. In all sites, staff convened a core group of residents who came to accept the Plain Talk message. In New Orleans and San Diego, residents had roles in the initiative that allowed them to be powerful representatives for the Plain Talk message. It was interesting—although not surprising—to observe that the sites enlisted buy-in to the importance of protecting sexually active youth by respecting the diversity of residents' values about adolescent sexuality. Site staff openly acknowledged that many people prefer to encourage abstinence among adolescents, but they also insisted that youth who were already sexually active needed protection from pregnancy and disease.

Improvements and increases in reproductive health services occurred in all the sites. Clinics increased their hours and became more aware of practices that encourage adolescents to use health care services. Much less change occurred among public schools and social services, businesses and churches. Public schools were willing to have Plain Talk staff use school space for workshops, but they were not willing to include Plain Talk in the educational curriculum. The sites spent a great deal less time on institutional reform than on community mobilization or health services and got to it only late in the implementation period, and therefore our conclusions about the possibility of institutional change are speculative. Nonetheless, the information that was collected suggested that having a neighborhood organization lead efforts to generate broad institutional reform may be an unrealistic goal. Sites had too few staff and resources to launch major efforts. In addition, they were sometimes dealing with institutions that have complex political relationships with a variety of stakeholders (e.g., school systems) and thus may be relatively slow and difficult to change.

What follows is a brief review of the participating sites; the strategies they used to recruit resident participation, overcome cultural barriers, and create and sustain consensus within core groups of residents; the community-education strategies that developed; how residents were trained to disseminate the Plain Talk message; how the dissemination strategies worked and, at times,

changed the message as it was delivered; the delivery of workshops and the effectiveness of residents as lay health educators; the residents' informal education efforts; and attempts to collaborate with other institutions.

THE SITES, LEAD AGENCIES AND STAFF

In 1993, the Plain Talk planning process began in six urban neighborhoods in Atlanta, Hartford, Indianapolis, New Orleans, San Diego and Seattle. Each neighborhood met the following criteria: low income, large numbers of sexually active youth, high rates of teen pregnancy and a demonstrated readiness to confront these problems. As Table 1 indicates, the group of neighborhoods was ethnically diverse, and—at least for sites we have information about—rates of sexual activity varied widely. Sites also varied in their levels of informal and formal social organization. For example, strong informal networks existed among residents in San Diego, and there were a number of small businesses and other institutions within the community. The Atlanta neighborhood, in contrast, had very few institutions. Furthermore, networks among the residents in the Atlanta site appeared to be fairly sparse. The New Orleans neighborhood had a high level of formal organization through the Resident Council. That formal organization, coupled with the relative stability of the local population over a number of years, supported the maintenance of dense networks that facilitated the work of Plain Talk. Both Hartford and Seattle had ethnically diverse populations. In every site, differences within and across the neighborhoods influenced the paths taken in Plain Talk's implementation. Strong networks, both formal and informal, facilitated Plain Talk; weak or sparse networks impeded its progress. Ethnic diversity complicated implementation activities, and cultural differences influenced the ways that staff framed Plain Talk.

Like the target communities, the lead agencies were also very different. They ranged from health or social service agencies in the San Diego and Seattle sites, to a medical school in Atlanta, to organizations committed to social change in New Orleans, Hartford and Atlanta. Staffing patterns, though, were similar throughout: each lead agency hired a project coordinator—with experience ranging from health education to community activism to social service administration—who could foster relationships with institutions beyond the lead agency; outreach workers who could recruit residents to activities; someone to run the day-to-day operations; administrative support staff; and health educators who could facilitate workshops and/or train residents to be facilitators. As implementation progressed, sites added or changed staff as needed. For example, Seattle engaged a Cambodian outreach worker, New Orleans replaced the professional health educator with a community resident and added a male outreach worker, as did San Diego.

During the planning year, the Indianapolis site's lead agency concluded that it could not commit to the Plain Talk message of protecting sexually active youth and withdrew from the demonstration. The five remaining sites completed the planning year and the three-and-a-half-year implementation period.

Table 1
The Plain Talk Communities

Site	Living below Poverty Line*	Ethnicity	Average Household Size**	Rates of Sexual Activity**			Percent of Sexually Active Girls Ever Pregnant**
				12-13 Yrs	14-15 Yrs	16-18 Yrs	
Atlanta	70%	African American	4.3	17%	49%	82%	62%
Hartford	70%	African American & Latino	N/A	N/A	N/A	N/A	N/A
Indianapolis	27%	African American & White	N/A	N/A	N/A	N/A	N/A
New Orleans	86%	African American	4.4	9%	37%	75%	43%
San Diego	44%	Latino	5.6	7%	16%	51%	55%
Seattle	50%	Asian & White	N/A	N/A	N/A	N/A	N/A

*Figures for Atlanta, Hartford, Indianapolis, New Orleans and San Diego are from the 1990 Census. Figures for Seattle are based on the site's estimate.
**Figures are from the baseline survey P/PV conducted in 1994 in Atlanta, New Orleans and San Diego.

RECRUITING RESIDENTS AND SEEKING CONSENSUS: THE PLANNING YEAR

The initiative called for each site to convene a core group composed of both community residents and staff from community agencies. However, in order to maximize resident input and build resident leadership, agency representatives in four sites regrouped into separate advisory committees so that the core groups could be composed entirely of community residents. In Atlanta, a small group of health care providers continued to be part of the core group. In each site, the core group's mission was to create and maintain a shared vision about the need to protect sexually active youth, and then to convey this message to others in the community. The residents were recruited through the *community mapping* process described below, through staff's network of contacts, through existing tenant or resident councils, through word-of-mouth and recruitment drives. In some sites, the size and composition of the resident groups changed constantly over the three implementation years. In others it remained fairly stable.

All the sites succeeded in recruiting a core group of residents and involving them in significant roles. But two of the three sites with diverse ethnic groups had difficulty involving representatives of all groups. The effort had to address language barriers, a dissonance between Plain Talk's message and cultural norms and beliefs, and a history of distrust between groups. Creative staff effort was constantly required, and one site succeeded in recruiting and maintaining representation from its two ethnic groups. Involving men also proved to be a challenge. In most sites, men

focused on employment needs and also tended to regard teen sexuality as an issue best handled by women. Two sites overcame these barriers through intensive outreach and by connecting potential male team members with employment and health services.

Using local data collected through a "community mapping" process was an effective strategy for awakening residents' interest in the initiative. Residents were trained by Philliber Research Associates to conduct surveys of community adults and youth about their attitudes, knowledge and behavior related to adolescent sexuality and contraceptive use, and to assess the contraceptive services available in the community. Philliber then compiled the data and gave the findings to the sites. The findings, according to many residents, had a profound and continuing impact on their understanding of the issue. The mapping process also helped recruit residents to the core groups, forge their commitment to Plain Talk, and increase their sense of ownership of the project.

Demonstrating the problems facing the communities—such as high rates of adolescent sexual activity, pregnancy and disease; limited adolescent knowledge about sexuality; and the unavailability and inaccessibility of health services—motivated people to participate in the initiative. Some residents who maintained their own values about the importance of abstinence were attracted to the effort and remained involved because of their surprise at the high levels of sexual activity among adolescents in their communities and their desire to help sexually active youth avoid pregnancy or STDs.

BUILDING AND MAINTAINING CONSENSUS

Consensus building and maintenance were, of necessity, ongoing and intensive. After formation of the resident core group, the next step was internal discussion and debate in an effort to formulate a shared vision of the Plain Talk mission. Other consensus-building activities were sex education and values clarification workshops sponsored by the Foundation.

As a result of these intensive activities, by the end of the planning year the core group in each of the five sites was able to agree that Plain Talk's fundamental objective would be to promote responsible sexual behavior and better contraceptive use among sexually active youth. Sites constantly had to attend to maintaining the consensus, since it was continually challenged by cultural and religious norms favoring abstinence for adolescents, by differing perceptions of what the Plain Talk agenda should include, and by turnover in the core groups themselves.

Each community's social structure influenced the possibility of mobilizing residents to change its mores. A community's capacity to develop and use strong community core groups depends to a great extent on the existence of both formal, institutional relationships among community members, and the strength and type of informal relationships as well. Plain Talk communities with strengths in one or the other used residents more effectively at relatively early stages of the initiative. Success in recruiting and sustaining the participation of residents was greatest when site staff targeted people with large networks in the community.

Communities that had neither strong institutional infrastructures nor strong informal networks took longer to implement the community change initiative. We speculate that, in some sites, preliminary community-building might be necessary before launching an effort such as Plain Talk. Also, while the ethnically diverse communities may have had fairly strong informal or institutional networks within ethnic groups, there tended to be relatively few networks or social ties across ethnic lines. It is likely, therefore, that the resources needed to implement an initiative with heavy resident involvement in a highly diverse community would likely be substantially greater than those required in more homogeneous communities. In the diverse communities, outreach staff needed to develop different outreach strategies for different ethnic groups, which required different preparation and implementation. Therefore, these sites needed more outreach staff or more staff time to accomplish their work.

Resident involvement in planning and implementing the sites' outreach and education efforts substantially affected the reach and shape of the initiative in the communities. Residents had access to people who were unknown to staff. In communities that were suspicious of outsiders, residents proved invaluable in creating and nurturing the links between the initiative and the community. Residents appeared to be more comfortable than were professionals in broaching discussion of teenage sex with other residents. They were also more likely to talk about Plain Talk as an initiative directed toward protecting sexually active youth. And, as residents, they felt they had the responsibility and the right to challenge other community members with that message. Professional health educators, who saw themselves as outsiders, felt less free to engage residents in discussion involving morals.

By acknowledging and respecting residents' personal values about adolescent sexuality, staff were able to keep residents involved in Plain Talk. Throughout planning and implementation, residents and staff periodically went through values clarification exercises in which they identified and acknowledged one another's personal values around adolescent sexuality. Site staff acknowledged that many residents valued abstinence, and then noted that, despite residents' personal values, the community mapping showed that many youth in their community were sexually active and therefore at risk.

COMMUNITY EDUCATION STRATEGIES

The sites' main education strategy was to train a cadre of residents to be Plain Talk's messengers in the community. Their mission was 1) to increase community awareness of the high rates of teenage sexual activity and its associated risks, and 2) to provide parents and other community adults with the information and skills they need to talk to their children about sex-related issues, including the need to use protection if and when they become sexually active. To carry out the mission, the sites had to develop a format and curriculum for delivering the message, prepare the residents to deliver it and assess their readiness to go out into the community. These activities consumed the first 18 months of implementation and, in three sites, continued throughout the period.

Workshops

All the sites used a similar format to disseminate the message: small-group interactive workshops in residents' homes or the Plain Talk office cofacilitated by trained core group members and staff of Plain Talk or agency partners. Only one site, Seattle, made an early decision to have a professional health educator design and deliver the workshops.

Using residents to deliver workshops was both labor intensive and productive. The Plain Talk design assumed that residents would perceive core group members, who were themselves residents, as more credible than professional agency staff. However, preparing core group members to cofacilitate the workshops proved to be a labor-intensive undertaking that took far longer than expected, given the enormous amount of information to be digested. Attrition was high and, after a year of intensive effort, none of the four sites was ready to send residents into the community as lay educators. As a result, Atlanta went the route of relying on a professional health educator; San Diego and New Orleans—heavily committed to developing resident leadership in gen-eral—delivered a new round of intensive training with good results; and Hartford eventually instituted a workshop series led by the assistant project director.

Training adult residents to facilitate workshops and other kinds of community education events enhanced the sites' capacity to give workshops to a large number of people in a relatively short amount of time. The New Orleans and San Diego sites, by relying on resident facilitators, were able to give workshops to over 1,000 adult residents in their communities in approximately one year. Observations of workshops indicated that both the quality of information provided and participant interest were high. Furthermore, even though the most intensive training produced only a small group of residents with the skills required for message dissemination in formal settings, most of the sites felt that they had succeeded in producing a larger cadre of "ask-able adults" who could present information informally in the community, function effectively as outreach workers and recruit other residents to the initiative.

By the end of the initiative, there was agreement among all sites that workshops needed to include factual information about adolescent sexuality and its consequences, as well as training in adult-youth communication. Depending on whether staff or residents drove the development of workshop curricula, they focused either on communication (staff) or knowledge (residents). As experienced health educators, staff knew that providing facts does not necessarily lead to changes in behavior; and they believed that the workshops would be less controversial in some communities if communication of parents' values rather than a focus on adolescent sexuality were emphasized. Core group members, on the other hand, knew how little many adults in the community knew about contraception, anatomy and physiology, and STD symptoms, transmission and prevention. For them, having accurate information was a prerequisite to communication.

All sites eventually decided that they needed to implement workshops that covered both communication and knowledge, but developing resident facilitators' capacity to integrate the two would require significantly more training. Therefore, sites would need either to spend more

resources on initial training or pair resident facilitators with professional staff. Both have down sides: training is already a significant use of resources; residents tend to take a back seat to professionals when both are leading workshops.

A variety of outreach strategies to bring residents into workshops proved effective. In the sites in which there was considerable resident involvement in implementing activities (San Diego, New Orleans and Atlanta), informal, word-of-mouth outreach was the most productive strategy for generating lists of people willing to attend community education sessions. Sponsoring community events (e.g., socials, fairs) and signing up people who were interested in workshops worked in sites that then made follow-up calls. In one site, outreach workers took the lead and recruited through schools.

Informal Outreach

Plain Talk staff encouraged core group members to carry the message to their neighbors and families, and it is clear that many did. Some recruited people to Plain Talk activities; others spoke of Plain Talk as they interacted with their friends, neighbors and relatives; a few spoke to youth in their capacity as paraprofessional youth workers. Data from interviews indicated that many core group members played critical roles as informed adult confidants—or "askable adults"—with youth who otherwise had no adults to confide in.

In talking with other adults, the most frequently reported topics were the symptoms and prevention of STDs, but the message about the need to encourage sexually active youth to use protection was communicated as well, if somewhat less frequently. Core group members also advised other adults about how to communicate more effectively with their children about sexual issues.

Trained residents talked to youth, too, in the course of their jobs or volunteer work, or as neighbors, aunts or uncles, and big brothers or sisters. They spoke with the friends of their own children and with community youth they encountered in their neighborhoods in the course of the day. Most of the reported conversations were between female core group members and female teens; some facilitated communication between a youth in crisis and her parents. The adults tailored their advice to the youth's age and whether or not he or she was sexually active. Reportedly, the youth seemed receptive to the messages and warnings.

"Askable parents" and "askable adults" played complementary roles in helping youth make responsible decisions about their sexual behavior. Targeting parents for community education increased parents' knowledge and suggested to them that it is necessary to speak with youth about sexuality. It also appears to increase the likelihood that they will speak. But it is not enough to engage only parents; there seems to be a limit to the role they can play. We found that parents had difficulty discussing sexuality with their children once they reached puberty. Their children, too, indicated a reluctance to approach their parents with questions and a preference for approaching another trusted adult with concerns about sexual relationships. Further, in some cases youth's relationships with their parents were so strained that constructive communication about sexuality

was highly unlikely.

For these reasons, it appears that training should include community adults who are parents as well as those who are not—in particular, adults who work with youth in a volunteer or professional capacity. Some communities, however, might find involving nonparental adults a violation of family primacy and privacy. One site, in particular, had difficulty in implementing activities that explicitly recognized the role that nonparents might play in talking with youth about sexuality. The site addressed the community's concern by focusing on teaching parents how to communicate with their own children.

CHANGING INSTITUTIONS

Persuading youth to be sexually responsible is more easily accomplished if health care institutions provide the services that youth need in order to behave responsibly. Without institutional change, the prospects of individual change decrease. Therefore, one of Plain Talk's goals was to increase the availability and quality of adolescent reproductive health services in the participating communities. At the project's outset, these services were either lacking or limited in all sites. Only one site had a neighborhood clinic that specifically addressed adolescent reproductive health, and available services were not particularly sensitive to the needs of local adolescents.

All the sites made significant gains in these areas as the result of pursuing three strategies: demonstrating the need through the use of local information (including the results of mapping); forming strategic relationships with providers; and encouraging residents to apply pressure on providers and funders for increases in services.

The sites' other efforts to achieve institutional change were much less successful, partly because they got under way late in the initiative and partly because collaboration with other institutions such as schools, businesses and churches was less well-defined and much more challenging.

In developing strategies for engaging institutions sites had to learn the importance of defining the reasons for approaching particular institutions, developing strategic relationships and understanding institutions' political and social contexts. Plain Talk and health care professionals, particularly those in the emerging field of adolescent medicine, have a shared agenda of safeguarding adolescents' health, so collaboration grew naturally. But working with other institutions was a far greater challenge.

It is not necessarily obvious to communities involved in a change process that they must determine from the outset what a collaborative relationship with another institution can accomplish, and what each partner would bring to the table. As a result, Plain Talk sites often invited such institutions as churches and businesses to participate in the effort and received no response. They did not know why they had been invited.

Collaboration with schools was also difficult, since schools must be responsive to public opinion

and, in recent years, traditionalists have been more active in public school politics than have liberals. To people with conservative values, the Plain Talk message was anathema. However, sites found other ways of collaborating with schools: they used school space for workshops, and core group members who volunteered or worked as aides in their local schools did outreach for Plain Talk events among parents whose children attended the schools.

Staffing patterns and inadequate planning time contributed to the sites' relatively small gains in the area of institutional change. Sites were able to turn their attention to institutional engagement only during the last year of the project and thus could only set the stage for future efforts, not achieve much more. But other factors were at play as well. Plain Talk staff were primarily trained for and engaged in community education and outreach, while executive staff time in the lead agencies was restricted by the Plain Talk budget to oversight of project work. In other community initiatives we have observed, institutional collaborations are facilitated by the commitment of senior administrative staff from lead agencies who have extensive contacts within institutional communities.

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The Plain Talk Initiative's findings are pertinent not only to the development of teen pregnancy prevention efforts but also to thinking about strategies that may be effective in other community initiatives, even those with different goals. Plain Talk was similar to other community initiatives in which resident involvement has persistently proved to be a time-consuming and difficult process. Program operators and evaluators are well acquainted with the myriad difficulties that face those who want residents to participate in what are, essentially, externally conceived attempts to change the values of communities, some of which may be as deeply held as the sexual norms addressed by Plain Talk. However, the results of the Plain Talk sites' efforts suggest that targeting both residents and institutions for change is a promising approach. Further, the Plain Talk initiative is rich in lessons about how to spark a community's interest in change and how to draw on a community's human and institutional strengths.

I. INTRODUCTION

In 1993, in a climate of growing concern over unintended adolescent pregnancy, increases in sexually transmitted diseases (STDs) among adolescents, and the negative consequences of teen pregnancy, The Annie E. Casey Foundation (AECF) undertook a teen pregnancy prevention program called Plain Talk, which was designed to create pervasive changes in families and communities. Unlike programs that focus on affecting the actions of individual youth, Plain Talk was a community initiative that sought to create community consensus about the importance of protecting sexually active teens at the individual, family, community and institutional levels. As at least one recent study has suggested, teen pregnancy programs that target individual behavior may never achieve their goals when the surrounding cultural environment does not support the behaviors and attitudes the program is intended to advance (S.S. Brown and L. Eisenberg, eds., 1995. Creating more pervasive changes in families and across communities might also help programs to sustain their benefits, even after the program itself has concluded. (See Appendix A for a review of the literature on teen pregnancy prevention programs.)

Comparing adolescent sexual activity, pregnancy, and birth rates in the United States and Europe, AECF noted that, while rates of sexual activity for adolescent women are similar, pregnancy and birth rates are significantly higher in the United States. A major reason for the lower rates in Europe appears to be that youth use contraception sooner and more consistently than do youth in the United States. This appears to be because there is wide consensus in European communities about the unacceptability of teen parenthood and the need to provide youth with accurate information about the risks of teen pregnancy and methods of protection. In addition, consistent and correct use of contraception is encouraged by providing youth with ready access to age-appropriate reproductive health services. AECF concluded that:

> The emphasis in these [European] countries is on the prevention of unintended pregnancies and births rather than the prevention of teenage sexual intercourse. Careful analysis suggests that the difference in rates of pregnancy among U.S. teens and those in other countries can be attributed to greater access to contraceptive services, [and] to unequivocal messages in support of contraceptive use among sexually active teens.[1]

Given the dearth of teen pregnancy prevention programs directed at sexually active teens and the comparisons of sexual activity and birth rates between the United States and other countries, AECF developed Plain Talk, an initiative that would attempt to create community consensus around the needs of sexually active youth.

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[1] *Plain Talk: A Community Strategy for Reaching Sexually Active Youth. A Strategic Planning Guide,* p.8.

THE PLAIN TALK STRATEGY

Plain Talk has three key elements:

- A community-based approach to creating a consensus among parents and adults about the need to protect sexually active youth through encouraging early and consistent use of contraceptives;

- Improving the way adults communicate with youth about responsible sexual decision-making; and

- Improving adolescent access to quality, age-appropriate and readily available reproductive health care, including contraceptive services.

Plain Talk's approach to preventing teen pregnancy and disease is unique in focusing on adults: it assumes that adults should play a key role in shaping messages concerning sexual activity among adolescents. Traditionally, parents have played limited roles in disseminating sexual and contraceptive information to youth. Parents often lack the information and confidence to engage their children in frank and open discussions about sexual behavior, or they fear giving the wrong messages to their children about the appropriateness of sexual involvement during adolescence. Professionals who work with youth may be uncertain that their messages to teens will be supported by their communities. At the same time, youth avoid approaching adults with questions about sex out of fear of adult disapproval. As a result, they often turn to their peers for information about sexuality and contraceptives, and that information is often inaccurate. Thus, a primary objective of Plain Talk is to provide parents and other community adults with the information and skills they need to communicate more effectively with teens about responsible sexual behavior.

A second unique aspect of Plain Talk is its community-based approach. AECF recognized the challenge involved in developing wide consensus on a topic as sensitive as adolescent sexuality, especially given this country's highly diverse population. Plain Talk planners believed that consensus could be achieved only if community stakeholders were allowed to shape and direct the course of the initiative. Thus, Plain Talk required high levels of community ownership and control. The involvement of parents and other community adults, as well as staff from community agencies, was critical at every stage of the development and implementation of the initiative. In particular, through their role as disseminators of the Plain Talk message to others in the community, residents were seen as key agents of community change. Working in partnership with local agencies, Plain Talk also hoped to create long-term changes in institutional policy and practices in support of better contraceptive services for youth.

In order to effect changes in individuals and institutions in the community, Plain Talk had to be tailored to local conditions. Thus, while AECF presented the Plain Talk communities with the initiative's basic objectives and possible strategies for engaging their residents, each community

was expected to develop its own plans about how to implement the initiative on the basis of a thorough assessment of community attitudes and current service needs and resources.

The overall goal was to create in each Plain Talk community a context in which adults acknowledge teen sexual activity and have the necessary information and degree of comfort in talking to teens about responsible sexual behavior so that sexually active teens will understand that use of protection is supported and encouraged. The hypothesis was that increasing the adult-youth dialogue and making contraceptive services physically and psychologically available to sexually active youth would result in earlier and more consistent use of contraceptives, which would, in turn, result in a decrease in the rates of pregnancy and STDS among youth in the community.

The Foundation recognized that its focus on protection for sexually active youth was controversial in national and local political and cultural climates. It strongly believed, however, that rates of unintended pregnancy and STDs would decline only if there was unambiguous discussion within communities about the needs of sexually active youth and the unacceptable consequences of unprotected adolescent sexual activity. Addressing challenges to this Plain Talk message was a major issue for the sites. As we show in the report, the message was modified in the sites over time, and we will explore which modifications might enable a community to provide greater protection for sexually active youth.

Plain Talk's design addresses a number of the limitations of previous pregnancy prevention efforts: it presents a clear, unambiguous message about the need to protect sexually active youth; it attempts to provide information in culturally sensitive ways; it attempts to provide greater access to improved reproductive health services; and it aims to be sustainable. At root, Plain Talk was about deliberately modifying communities' values. It was an externally conceived and directed effort—first by the Foundation, then by the lead agencies. As such, it was not very different from countless other attempts that have been made—particularly since the middle of the nineteenth century when the United States became the destination of immigrants from many different countries—to change the attitudes, norms and behaviors of poor Americans.

What makes Plain Talk and other recent community initiatives somewhat different from traditional reform efforts in poor communities is an intense effort to get community buy-in and acceptance. Plain Talk attempted to get that buy-in by directing that the agencies, working in concert with community residents, design plans sensitive to the communities' cultures and needs. Thus, on the one hand, it was a reform effort that was supposed to engage community residents as leaders. On the other hand, it was designed to change in specific ways the manner in which people in poor communities thought about pregnancy and STDs among adolescents. Predictably, therefore, Plain Talk's design created tensions in most of the sites at various times.

This report examines the process of implementation as it unfolded in five Plain Talk sites—Atlanta, Hartford, New Orleans, San Diego and Seattle. It examines why sites chose the strategies they did and explores the effectiveness of those strategies. It looks at whether and how

the lead agencies and site staff resolved the tension between Plain Talk's directive to protect sexually active youth and the sometimes strong community conviction that teens should not be sexually active outside marriage. Because it focuses on the implementation processes, the report does not look at whether Plain Talk was, in the end, successful in changing the sexual behaviors of adolescents in the five Plain Talk communities. Those questions will be examined later. It does ask, however, what lessons Plain Talk can teach us about teen pregnancy prevention, community change efforts and institutional collaborations.

OVERVIEW OF THE PLAIN TALK EVALUATION

To learn as much as possible about the process of implementing community initiatives in diverse settings, AECF selected Public/Private Ventures (P/PV) to conduct an independent evaluation. The evaluation design included a planning year study, an implementation study and an outcomes study. This report primarily covers the three-year implementation period, although we refer to the planning process as well (see Kotloff et al., 1994). The outcomes study, which consists of a baseline and follow-up survey in three sites, is currently under way.

Community initiatives, whether they attempt to address a broad range of issues within a community (e.g., the Dudley Street Neighborhood Initiative in Massachusetts)[2] or a narrow range of issues (e.g., Plain Talk), are difficult to evaluate for a number of reasons. First, they attempt to change the behavior of an entire community, not just a select group of people. Thus, random assignment, a method used by evaluators to examine the impacts of social programs, is impossible in such a context. Second, it is sometimes difficult to determine who actually receives the "treatment." For instance, Plain Talk's model assumed that community members would "spread the message." As time went on, it became clear that core group members who had been involved in Plain Talk from the beginning and were at some sites facilitating structured workshops were also "spreading the message" more informally—which was desirable from an implementation perspective but extremely difficult to study. Third, it is difficult to compare the effects of Plain Talk to the effects of doing nothing in comparable communities. Most important, how can one choose a truly comparable community? Even among the Plain Talk communities, which were similar in some ways, including the rates of poverty, the racial composition of the population and employment statistics—factors that are often used as defining variables—there were important differences, such as the history of the communities or the institutional resources available within them. Communities do not have twins.

Outcomes studies in community initiatives can be done by looking at conditions before the study begins and then doing a follow-up survey. The Plain Talk evaluation does, in fact, include such a study in its design. Outcomes studies, however, have several limitations, especially in the context of community initiatives. First, they provide only partial information and should be used in

[2]For a description of this community-generated initiative, see, for example, Peter Medoff and Holly Sklar. 1994. *Dudley Street Becomes a "Street of Hope."* Boston: South End Press.

conjunction with other methods and studies. Since people are not sure exactly how to implement community initiatives, process studies are an important component for understanding how and why changes occurred. Second, there is broad agreement in the community development field that community change takes several years to achieve. Funding practices, however, tend to be time limited, and thus, initiatives sometimes end before participants have agreed that the initiative has done its work. Under those circumstances, it is unlikely that observable change would have occurred.

Finally, community initiatives do not occur in a vacuum. Communities are subject not only to the efforts undertaken by the initiative but also to other efforts that may be undertaken by cities, states, the federal government, or even other community groups. Broad social changes may also occur that have unexpected outcomes. In any given outcomes study, how can one decide that the efforts of the subject initiative led to the observed changes? This was a particular issue in Plain Talk, which was undertaken during a period when broad efforts were made to lower rates of unintended pregnancy among adolescents. During the 1990s, teen pregnancy among unmarried women has also become increasingly stigmatized in many communities, and the rates of teen pregnancy are falling. In addition, public education efforts concerned with preventing the transmission of HIV have emphasized the danger of unprotected sexual activity. Thus, if an outcomes study determines that rates of teen pregnancy decrease in a community and use of contraception and protection from STDs increase, how do we know if we can credit Plain Talk?

To answer this question, studies that examine the way sites implement their initiatives and that explore the connections between strategies and community responses are fundamentally important.[3] However, implementation studies in community initiatives also present difficulties. The diversity of the sites, their lead agencies and, as we shall see throughout this report, their strategies for implementing Plain Talk presented several significant challenges as well as opportunities. On the one hand, the diversity across the sites provided the opportunity to learn how Plain Talk worked in different settings. On the other hand, there was so much variation across the sites that it was difficult to extract lessons about best practices that would work across a variety of communities. For many of the effective practices we observed in Plain Talk, one could ask whether

[3]In recent years, some have argued that a "theory of change" evaluation approach will solve many of the challenges confronting evaluators of community change initiatives (Schorr 1997; Connell, Kubisch, et al. 1995). In this approach, initiative stakeholders, including the evaluators, sit down together at the beginning of the initiative and determine what outcomes the initiative wishes to achieve. Working backward, the stakeholders then ask what actions will lead to the desired outcomes, eventually creating a multistranded chain of strategies leading from early outcomes, to the ability to implement other strategies that will lead to intermediate outcomes, to the ability to implement still other strategies that will ultimately lead to the final, or long-term, outcomes. The ordered chain of strategies and outcomes becomes the "theory of change." If the early, intermediate and long-term outcomes are achieved, the theory of change is deemed to have been supported, and the initiative itself is considered responsible for the change. If not, the theory of change is revised along the way as participants work to achieve their goals. This approach faces a number of challenges not least of which is the complexity of the social systems in which community initiatives are tried, which means that unexpected factors and events can influence outcomes in ways that cannot be controlled. Plain Talk was not evaluated using a theory of change approach.

they could be translated from that specific community to another. In some cases, we can only answer that the approaches seem promising, although we are not sure how they would play out in other settings. In other cases, however, similar dynamics were observed across several or all sites, and we can state with greater certainty that particular approaches are likely to be transferable.

Methods

Given the challenges, the Plain Talk evaluation was designed to be cross-site and multimethod, encompassing process studies of both the planning and implementation periods as well as an outcomes study. To target resources most effectively, the outcomes study was planned for three of the five communities on the assumption that surveying three communities would be sufficient to see if changes had occurred, while reserving resources for other parts of the evaluation. Planning studies were completed in the original six sites, and implementation studies were completed in all sites except for Indianapolis,[4] which dropped out of the initiative.

In our implementation research, we explored several major questions:

- Were the sites able to create structures or processes that seemed promising in creating a community consensus around STD and teen pregnancy prevention? If so, what facilitated their progress? If not, what challenges did they face?

- How effective were the community education strategies used by the sites in educating a large number of community adults?

- How did the sites link with institutional partners? Did their efforts result in extra goods and services for people in the community?

For the implementation study, sites received different levels of research effort depending on whether they were an outcomes study site. In Atlanta, New Orleans and San Diego, where the outcomes studies were to be completed, the original implementation study design called for an ethnographer to work in the site for a year to understand both the community and the process of implementation as completely as possible. Later, the Foundation requested that Seattle become an ethnographic site because AECF staff were interested in how Plain Talk was being implemented in a very diverse community. Thus, ethnographic work was completed in all sites except for Hartford. Ethnographic data considerably increased our understanding of how Plain Talk was unfolding in the sites, and this report tends to rely more heavily on data from the four ethnographic sites than on data from Hartford. (See Appendix C for a description of the ethnographic work completed in the Plain Talk sites.)

[4]The lead agency in Indianapolis was unable to accept the Plain Talk message of protecting sexually active youth and pulled out of the initiative. Unable to find a replacement lead agency, the site could not continue with the initiative. See the Plain Talk planning year report for a fuller discussion of the circumstances in Indianapolis.

In addition to having ethnographers in four of the sites, P/PV staff made regular visits to all five sites to collect data. P/PV staff and the ethnographers (in the four ethnographic sites) conducted semistructured, in-depth interviews with staff, core group members and Plain Talk institutional partners. Observations were made of the sites' community outreach and education efforts. Documentation (e.g., curricula, flyers, descriptions of programs) was collected. The work done by the ethnographers and P/PV staff was similar, but the ethnographers were able to gather far more data, to examine events in detail as they happened and to explore dynamics that, while not central to the overall Plain Talk effort, were illuminating.

We also relied on factual information supplied by the sites—in particular, the participation and pretest and posttest data that sites collected in their community education efforts. When we report data collected by the sites, we note it either in the body of the report or in a footnote. There were two major drawbacks to relying on data collected by the sites. First, some sites had better data-collection efforts in place than did others. Getting a community initiative off the ground is a time-consuming process, and data-collection efforts are often low on program managers' lists of priorities. While some sites consistently entered data in a database, other sites inconsistently tracked their efforts. The other major problem with using site-collected data was that sites counted participation in community education workshops somewhat differently. In some cases, we knew that people had taken workshops more than once, and they were then counted twice. The numbers we present in the report are, therefore, estimates. Because we had ethnographers in place in four of the five sites, we have a good awareness of the limitations of the data that the sites collected, and we have written footnotes where appropriate.

STRUCTURE OF THE REPORT

The Plain Talk initiative assumed that the urban communities in which it was implemented were made up of several components: residents, local agencies, and city- or state-based institutions. Thus, the general model for achieving change in Plain Talk was two-pronged. First, it assumed that developing consensus among a group of community residents would create a group that could then participate in efforts to create consensus among other residents. Second, it assumed that staff and residents could recruit other institutions to the effort. This report is structured around those efforts to develop consensus and get institutions to participate.

Plain Talk is a community-change initiative. To establish the context for understanding the implementation process in the five sites, Chapter II describes those communities in detail. Chapter III examines the initiative's rationale for emphasizing resident involvement, cultural barriers to Plain Talk, and the largely successful strategies the sites used to overcome those barriers and create and sustain consensus within the core groups. After the sites created the consensus, their next task was to develop a community education strategy that would carry the Plain Talk message to a larger group of residents. Sites varied in the degree to which they relied on the core group to carry out community education. Chapter IV examines how and the extent to which sites used and trained residents to disseminate the message within their communities.

While the message to protect sexually active youth was consistently conveyed by staff to the community core groups, the message tended to be modified as the initiative attempted to expand its reach. Chapter V describes the formal dissemination strategies the sites used and how and why the Plain Talk message was altered in these community education efforts. It looks at who influenced the content of the workshops, who the target audiences were, where the workshops were held, and who facilitated them—all factors that affected what message was delivered. Chapter VI then describes how many residents were reached through the workshops and examines the effectiveness of residents in the role of lay health educators.

Although formal adult education workshops were the focus of community dissemination strategies, it became clear, as the initiative progressed, that residents who had participated in the core group training were also beginning to speak informally to other adults and youth in their communities about Plain Talk and its message. In Chapter VII, we explore these informal education efforts. We look at the content of the discussions, the messages that core group members relayed, and how the content and messages were altered depending on who the audience was (for example, an adult, a sexually active youth, an early adolescent, their own child).

In Chapter VIII, we turn to an exploration of how the sites collaborated with institutions both within and outside their immediate target areas. Although community change efforts could conceivably take place with little institutional support, institutions can provide expertise, funds, services and other resources that might otherwise be difficult to obtain. Thus, the initiative included an effort to garner the support of institutions so they could participate in creating broad-based support for the Plain Talk message. To varying degrees, sites attempted to collaborate with health care providers, schools, businesses and churches. We explore the challenges the sites faced in these efforts as well as some of their successful strategies.

The Plain Talk evaluation has provided important insights and lessons about community change efforts in general (even those with significantly different goals) and about teen pregnancy prevention in particular. Thus, Chapter IX concludes the report with a discussion of our key findings—including promising approaches to resident involvement and mobilization and to institutional collaborations and community education—and the implications for policy and practice.

II. THE PLAIN TALK SITES, LEAD AGENCIES AND STAFF

In 1993, AECF began a yearlong planning process in six low-income communities across the United States—Atlanta, Hartford, Indianapolis, New Orleans, San Diego and Seattle. Each community had large numbers of sexually active youth, high rates of teen pregnancy and a demonstrated readiness to confront those problems. During that year, the Indianapolis site's lead agency concluded that it could not commit to the Plain Talk message of protecting sexually active youth and withdrew. The other five communities completed the four-year demonstration.

The lead agency for each site was charged with mobilizing the community for change by creating a community core group consisting of institutional partners and community residents.[5] The sites were given three overarching goals: to create consensus within the community that adults should take responsibility for guiding youth to be sexually responsible, including using contraception or protection if they were sexually active; to increase the quality and quantity of health services available to youth; and to find ways of sustaining the work of Plain Talk after the demonstration by building institutional collaborations.

Three years of implementation followed the planning year. Plain Talk staff generally spent most of the first year further developing the community core group and preparing for broader community education strategies. Although the sites' primary focus was community education, several sites were also working to increase or improve reproductive health services in the community. During the second year, the Foundation urged the sites to begin thinking about strengthening their collaborations with local institutions as a way of sustaining the work of Plain Talk after the end of the demonstration. Sites continued to work on their community education strategies, but some abandoned the idea of developing strong community core groups, while others continued to direct resources to resident leadership development. Progress in institutional collaborations varied across sites according to the nature of the institutions with which the sites were trying to work. By the end of the third year, the sites were refining their community education strategies. All the sites had either increased health services within their community or had resources committed to doing so and were in the final planning stages for new clinics. All had found ways of sustaining at least parts of Plain Talk's work within their communities.

Sites had great latitude in how they chose to achieve their goals and, as we show throughout this report, used very different strategies and had different priorities. Differences among the communities—in their histories, their demographic makeup, their cultures and their size—influenced how Plain Talk was implemented. We therefore begin with brief descriptions of key elements in each community.

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[5]See Kotloff et al., *The Plain Talk Planning Year*,for a detailed description of the development of the community core groups during the planning year.

THE COMMUNITIES AND LEAD AGENCIES

Since AECF wished to explore how Plain Talk would be implemented in diverse communities, it deliberately chose sites that were very different from each other. The communities shared very few qualities: they were all low-income (although 1990 poverty rates ranged from 25 percent to 86 percent across the communities—a huge range) and all urban. All had relatively high rates of adolescent sexual activity and pregnancy, and all had lead agencies that committed themselves to creating change. Target areas in the communities ranged in size from approximately 1,600 residents to more than 13,000. In two sites, Hartford and New Orleans, the target areas were entirely within the boundaries of public housing developments, and thus almost all community residents were poor. The other sites included some public and private housing, and poverty rates were somewhat lower. Some communities had a number of small businesses and institutions within them; others were almost completely residential. The sites were culturally and racially diverse as well, and the communities had different histories with and relationships to the cities containing them.

Like the target communities, the lead agencies were also very different. They ranged from traditional service agencies to a medical school to social reform organizations. Differences in lead agencies' missions, cultures and capacity influenced the way that Plain Talk was implemented in each community. Below we describe the communities and their lead agencies in more detail. Table 2.1 presents basic demographic data on the sites.

San Diego

The largest Plain Talk community was a predominantly Mexican and Mexican-American community called Barrio Logan, which is south of downtown San Diego. Many residents are monolingual Spanish speakers, and many have extended family living in the area. The population is mobile: in 1990, more than half the population had lived in their homes for five years or less. There are several reasons for the high mobility rate. First, many residents move back and forth across the Mexican border with some regularity, depending on jobs and family circumstances. Second, the community is often the first place people come to from Mexico; it is perceived as a temporary stop, and residents often move out of the community when they can afford to. According to the survey P/PV conducted in 1994, 48 percent of the youth had not been born in the United States.[6]

Poverty rates are high and employment rates low. In 1990, the employment rate was about 53 percent for people aged 16 or older. Residents lacking legal documentation from the Immigration and Naturalization Service to live and work in the United States commonly work for low wages,

[6]In 1994, P/PV conducted a baseline survey of youth ages 12 to 18 in three Plain Talk communities: San Diego, Atlanta and New Orleans. We therefore have data on households and youth behaviors in those communities that we do not have for Hartford and Seattle.

primarily in service occupations. The number of immigrants looking for work tends to depress local wages: one of the Plain Talk participants referred to the local economy as a plantation

Table 2.1
The Communities

	Atlanta (Mechanicsville)	Hartford (Stowe Village)	New Orleans (St. Thomas)	San Diego (Barrio Logan)	Seattle (White Center)
1990 Population*	3,300	1,600	3,000	13,500	6,570
Percent Living Below Poverty Line in 1990	70%	70%	86%	44%	50%
Ethnicity	African American	50% African American 50% Latino	African American	Mexican American Mexican	50% White** 25% Cambodian 25% Vietnamese
Name of Lead Agency	National Black Women's Health Project (1993-96) Morehouse School of Medicine (1996-97)	The Action Plan	St. Thomas/Irish Channel Consortium	Logan Heights Family Health Center	Neighborhood House
Type of Lead Agency	National Advocacy Group Public Health Program in Medical School	Citywide planning organization	Collaboration of local service providers under authority of Resident Council	Large compre-hen-sive health clinic	Settlement house

*Population figures for Hartford and Atlanta decreased over the course of the initiative. When the initiative began in 1994, the 1990 census figures were fairly representative of the actual population in the communities. By the end of 1997, however, there were indications that the populations had fallen. In Hartford, staff at the Action Plan estimated the population at 1,200 residents. In Atlanta, anecdotal accounts of the loss of housing stock leading up to the 1996 Summer Olympics as well as a preliminary screening done in preparation for a follow-up survey suggested that the area's population was shrinking.

**The figures for White Center's ethnic breakdown are estimates provided by the site's Plain Talk staff.

economy characterized by exploitation and lack of opportunity. Families often live in very crowd-ed housing conditions in order to share rent or help relatives who would otherwise have nowhere to live.

Like many immigrant communities, a number of small businesses, such as Mexican restaurants and groceries, serve the local population. There are also a number of churches, social service agencies that provide recreational and educational opportunities, two health clinics and four public

schools. Despite the poverty and problems facing the residents of Barrio Logan, the community appears to be relatively cohesive and vibrant. Residents report that the main streets are relatively safe during the day. The institutions (clinics and schools) and businesses within the community provide limited employment opportunities for local residents. In addition to relatively strong kinship ties among people in the community, resident women have relationships with women they call *comadres* and resident men have *compadres*. A *comadre* or *compadre* is a friend, but the notion and relationship include a strong element of obligation and reciprocity. The existence of these relationships obligates people to one another and strengthens the social ties among people in the community. As we shall see, the informal networks in the community were key to the site's dissemination strategies.

The lead agency, the Logan Heights Family Health Clinic (LHFHC), was founded in the 1970s as the Chicano Clinic to serve Barrio Logan. Over the years, it has been transformed from an activist health clinic on a shoestring budget to a well-funded, comprehensive health clinic that receives public as well as substantial private funding from local corporations. Dedicated and often innovative in its service provision to the local community, the clinic, over the course of Plain Talk, contributed greatly to both the growth and use of health services among Barrio Logan's adolescents. It serves a politically embattled population—not only poor but also immigrants from Mexico. As a result, the clinic's administration pays careful attention to public relations with funders and the broader San Diego community.

Hartford

Hartford's target community is Stowe Village, a low-income housing development located in north Hartford. It is the smallest of the Plain Talk sites, both geographically and in terms of the size of its population, and its population is composed of African Americans and Latinos of Puerto Rican descent.

Relations between these two distinct ethnic groups are fairly harmonious and, despite the challenges to designing an intervention that meets the needs of the entire community, Plain Talk successfully targeted both populations.

Stowe Village is characterized by high resident turnover and high poverty. In terms of health and social services, Stowe Village had been chronically underserved, and for many years gangs and drugs exerted a strong influence on youth in the community. However, conditions improved somewhat after Stowe Village was awarded a "Weed and Seed" grant from the federal government in 1995, which increased the police presence in the community and provided funding for a number of health and human service agencies to open branch offices in the housing development. Plain Talk also received additional funds through the Weed and Seed grant and is part of the new Family Investment Center that houses the branch offices. In addition, 1996 saw the opening of the Fred Adams Clinic in Stowe Village, a primary care satellite clinic of a local hospital, as well as the Plain Talk Teen Clinic. These changes have brought needed services to Stowe Village, and according to residents it has become a safer, quieter and more vibrant community.

The lead agency, the Hartford Action Plan, is an umbrella organization that coordinates efforts to reduce infant mortality and prevent teen pregnancy in Hartford. It receives its funding from corporations and foundations as well as from contracts and public grants. Well connected to both the corporate world and the service provider community in Hartford, its board members include representatives from city and state government, health department officials, school board members, corporate leaders and hospital administrators. The programs and projects that are either generated or taken on by the Action Plan are managed by The Parisky Group, a local private-public policy consulting firm. Since its establishment in 1985, the Action Plan has been a leader in teen pregnancy prevention in Hartford.

Atlanta

Atlanta Plain Talk was located in Mechanicsville, a small community of approximately 3,300 people living in single-family homes and several public housing developments south of downtown Atlanta. Originally a blue-collar community for families whose members worked in local industry, Mechanicsville has been on the wane for many years since local plants were closed. Crime rates in the community are high, and educational levels low. In addition to individual poverty, the area is poor in institutional resources: only a handful of local businesses operate within the community's borders, and the community is isolated from the rest of Atlanta by major highway arteries on two sides and old industrial sites on a third.

The liveliest part of the community is around the Dunbar Center, a city community center that houses the Senior Citizens' program, summer camps, day care, the Center for Black Women's Wellness (CBWW) and a branch of the public library. In addition, there is an elementary school and a small strip mall nearby. The community is otherwise bereft of institutions and businesses. As a community, Mechanicsville has a venerable history—one that brings people back to visit—but very little vitality. Its housing stock is shabby, and there are a number of vacant homes. During the day, its streets are deserted. It is at its most vital immediately after school when children walk home, but otherwise appears silent.

Atlanta Plain Talk was unusual in having two lead agencies over the course of the initiative. The first was the National Black Women's Health Project (NBWHP), whose CBWW, where Plain Talk was housed, is an advocacy group committed to promoting the physical, mental and emotional well-being of black women. CBWW's mission is to empower women through self-help groups and other kinds of educational programs. Although NBWHP was formally the lead agency for Plain Talk, CBWW staff took the lead in almost all aspects of administering the initiative.

In late 1995, the NBWHP relocated its national office from Atlanta to Washington, D.C., and AECF directed CBWW to find a local lead agency that could act as the fiscal manager for the grant as well as provide the site with other resources, such as access to funding sources and arenas in which to advocate for Plain Talk. In spring 1996, the site contracted with Morehouse School of Medicine to become the lead agency. The change in lead agency did not have a large impact on Atlanta Plain Talk, primarily because the director of CBWW, who had been directing Plain Talk at

the site, continued to lead the local effort. Morehouse was seen as a Plain Talk partner and a potential source of human resources; it played a support role to CBWW.

New Orleans

The New Orleans community, in contrast to Mechanicsville, is full of life and energy despite the poverty of the residents. Located in the St. Thomas Public Housing Development in the Irish Channel, several blocks from the Mississippi River, the community suffers from poor physical characteristics. The development, which was built in the 1930s, originally had 1,500 housing units, but about half are now vacant and in considerable disrepair. Burned-out buildings lend an ominous note; as one walks through the community, one passes entire courtyards of vacant buildings. A few of the occupied units were renovated in the early 1990s, but most are very shabby, and residents complain that even the renovated buildings are quickly falling apart because of poor construction practices.

There are no businesses within the housing development, but it is only a few blocks south of Magazine Street, a local shopping and entertainment district. A number of social service agencies have educational and health facilities that border the community. A local Roman Catholic church on the edge of the development has a large gym that is used for community events and recreation.

Despite the poor housing conditions and the residents' personal poverty, there is a strong feeling of community in St. Thomas. As they walk from one point in the community to another, residents greet and stop to speak with those who are sitting on porches. Community leaders take an interest in helping families in crisis. Celebrations sponsored by Plain Talk and other agencies draw large crowds of people. In contrast to the other communities, the overall population in St. Thomas was not very transient during Plain Talk because of the unique political and social conditions within the community. While a few people moved out when they found jobs and were able to afford better housing, no one moved in. There appeared to be two reasons for this. First, over the years the Housing Authority had allowed units to deteriorate until they were no longer habitable, and thus there were few places to move into. Second, in 1996, the community was awarded a HOPE VI grant.[7] At that point, a freeze was put on new residents. Current residents also became less likely to move out in the hope that they could be part of the community's rebuilding.

What makes St. Thomas Plain Talk so different from Atlanta's is the St. Thomas residents' degree of activism and their organized opposition to the New Orleans Housing Authority. In the late 1970s and early 1980s, the St. Thomas Resident Council (STRC) took an increasingly activist stance toward the housing authority, which culminated in several successful rent strikes. In addition, with the help of several community activists from the People's Institute for Survival and

[7]HOPE VI is the U.S. Department of Housing and Urban Development's primary vehicle for revitalizing severely distressed public housing. Grants awarded through local housing authorities are used to demolish unlivable units and replace them with more viable apartments and homes. Just as important, HOPE VI employs a larger community development strategy whose goal is to help residents become economically self-sufficient.

Beyond (a nonprofit training institute that works to overcome racism), the Resident Council has engaged in many other efforts to create community change. In 1989, STRC created a formal coalition of social service agencies that serve the local population. The coalition, the St. Thomas-Irish Channel Consortium (STICC), became the lead agency for Plain Talk.

STICC defines its mission as one of social reform—in particular, the transformation of institutions that oppress people of color. Although STICC works primarily for the improvement of the lives of people living within the St. Thomas-Irish Channel community, it also defines its role more broadly. Its goals are to integrate the services that are provided by other agencies, make service providers who are part of the consortium more sensitive to the needs and demands of the community, and work for institutional change in the broader community. STICC has been staffed by social activists who are not from the community as well as by community residents. It has a very small budget and relies primarily on grants from private foundations. It is also a relatively young agency, and it lacks a self-sustaining bureaucratic structure, relying instead on the energy and commitment of a few individuals. STICC thus has a very different mission and organizational structure from, for example, San Diego's lead agency. Its strengths lie in its ability to mobilize the community and bring attention to the community's problems. It is also very sensitive to the community's needs.

Seattle

The target area for Plain Talk in Seattle is a section of White Center, an unincorporated community in King County, just south of the city of Seattle. White Center has been described as a cohesive, close-knit community with a small-town atmosphere. Although it includes a busy avenue lined with businesses and offices, the area is largely residential and contains both public and private housing. White Center is a community of poor and working-class residents. A downward economic trend in the early 1990s brought increases in youth gangs, drug abuse and domestic violence. There are recent signs, however, that things are improving. A community police program and a no-tolerance policy implemented by the housing authority have resulted in a decrease in crime and gang activity, and there is a growing perception by residents and outsiders alike that White Center has become a safer, more desirable place to live.

White Center's most distinguishing characteristic is its cultural diversity. Historically a predominantly white community, it has experienced dramatic demographic shifts over the past 15 to 20 years. Attracted by the area's relatively affordable housing, several waves of immigrants have made White Center their home. The largest immigrant group is from Southeast Asia and includes refugees from Vietnam, Cambodia and Laos who came to the United States in the aftermath of the Vietnam War. The Latino population of White Center has also increased, as immigrants from many South and Central American countries joined the existing Mexican-American community. There are also small communities of recent immigrants from Eastern Europe and East Africa, as well as more well-established Korean and Samoan communities.

Plain Talk's original target area encompassed all of White Center, which has a population of over 25,000. Realizing that this was too large an area to manage effectively, the site selected a smaller neighborhood within White Center, an area that encompasses two 550-unit, low-income housing developments (Park Lake Homes I and II) and their surrounding neighborhood of privately owned single homes. This section of White Center has the highest rates of poverty in the community and also contains the highest concentration of Southeast Asians in White Center. Since the neighborhood surrounding the housing developments is predominantly white, Plain Talk staff estimated that approximately half of their target community was composed of Southeast Asian immigrants, half Cambodian and half Vietnamese. In order to reach more parents with their *Plain Talk for Parents* workshops, the site eventually expanded the target community to the boundaries of the entire Highline School District, an area that includes more middle-class and white families.

Given the demographic complexity of this area, the extent to which local agencies have been able to collaborate and share resources is striking. There are numerous coalitions of agencies, businesses and residents in the area. Over the course of the initiative, Plain Talk staff participated in several of these coalitions, and staff from local agencies joined Plain Talk's Resource Advisory Group. As a result, Plain Talk was able to mobilize agency support for a school-linked health clinic in the community.

The lead agency, Neighborhood House, is a Seattle-based settlement house that primarily serves the residents of five local public housing developments and their surrounding areas. Neighborhood House administers five social service offices called Neighborhood Centers, one in each of the developments. The Neighborhood Center in White Center serves Park Lake Homes I and II and has established a stable presence in the community. The center provides such services as advocacy, referral and emergency assistance, long-term case management, English as a Second Language (ESL) classes and translation. Neighborhood House provided office space for Plain Talk in its White Center office, which is located just outside of Park Lake Homes I.

PLAIN TALK STAFFING PATTERNS

While the lead agencies varied tremendously in size, mission, relationship to the local community and operating styles, early staffing patterns for Plain Talk were similar across the sites. Each lead agency hired staff to coordinate the local Plain Talk effort. Coordinators' experience ranged from being professional health educators to community activists to professional social service administrators. The one quality they tended to share was that each had a fairly extensive network among local health social service providers, which was perceived as important in getting Plain Talk started. In most sites, the coordinator quickly hired at least one outreach worker, since one of the first tasks with which the sites were charged was to convene a core group consisting of both residents and institutions. Most sites also hired a project assistant or administrative assistant, or both—someone who could help carry out the day-to-day work of Plain Talk while the director worked on advocacy, program development or fundraising.

As implementation progressed, sites added or changed staff as needed. The Seattle and San Diego sites added professional health educators to their staff. When staff in Seattle decided that they wanted to engage the Cambodian community, they hired a Cambodian outreach worker in addition to the outreach worker already staffing the project. In New Orleans, as residents developed leadership skills and health education knowledge, the professional health educator was replaced by a community resident in an attempt to increase community ownership of Plain Talk. New Orleans also added a male outreach worker, whose primary responsibility was to increase and sustain male involvement. San Diego, too, added a male outreach worker, though by the end of implementation the site had been unable to successfully integrate the position into the rest of Plain Talk's work, and the position was cut.

Thus, although staff fluctuated over the course of the initiative, there were several key roles that were consistently filled across the sites: a coordinator who could foster relationships with institutions beyond the lead agency; someone to run the day-to-day operations of Plain Talk (the role was variously filled by project assistants and outreach specialists); outreach workers who could recruit residents to activities or who could recruit others to do the recruitment; administrative support staff; and finally, health educators who could facilitate workshops and train residents to be facilitators.

THE YOUTH IN THE PLAIN TALK SURVEY COMMUNITIES

As part of the Plain Talk Evaluation, youth between 12 and 18 years were surveyed in three communities—San Diego, Atlanta, and New Orleans—to identify their attitudes, knowledge, and behavior around sexuality and contraception. The survey was different from the community mapping conducted by the Plain Talk communities. The table below briefly describes youth's family structure as well as providing some basic information about their sexual activity.

What is most obvious from the information presented in the table is that the two African American communities differed in important ways from the Latino community (San Diego). Household size was significantly larger in San Diego, which confirmed our ethnographic observations of very crowded housing conditions; households often included multiple families. Also, the percentage of youth living with both parents was much higher in San Diego than in New Orleans or Atlanta. Finally, the rates of sexual activity in all three communities were high, especially for older youth. Again, there appears to be a difference between the two African American communities and the Latino community; rates of sexual activity were somewhat lower for older youth in San Diego than in the other communities. Atlanta had the highest rates overall, and the rates of sexual activity among young adolescents in Atlanta is especially striking. In the Mechanicsville community, almost one in five youth aged 12 to 13, many of them boys, reported having had intercourse.

To summarize, the youth in the three communities were having sexual intercourse at relatively young ages, and many failed to use contraceptives consistently. The result for the girls was the large incidence of early pregnancy and childbirth. Although we did not survey the youth in Hartford or Seattle, we estimate that youth in Hartford's Stowe Village had rates of sexual activity

and pregnancy somewhere between Atlanta's and San Diego's rates. We are less sure about Seattle's White Center, primarily because the ethnic backgrounds of the community residents were so different from those of the other four communities. Nonetheless, the community was selected primarily because local data indicated high rates of early pregnancy.

Table 2.2
Youth Characteristics in the Three Survey Communities
1997

	Atlanta (Mechanicsville)	New Orleans (St. Thomas)	San Diego (Barrio Logan)
Average Household Size	4.3	4.4	5.6
Household Structure Reported by Youth			
% living w/mother	60%	75%	39%
% living w/2 parents	17%	10%	44%
Rates of Sexual Activity			
Age 12 -13	17%	9%	7%
Age 14-15	49%	37%	16%
Age 16-18	82%	75%	51%
Average Age at First Intercourse Among Sexually Active Youth			
Boys	12 yrs 6 mos	12 yrs 4 mos	14 yrs
Girls	14 yrs	14 yrs 8 mos	14 yrs 10 mos
Percent of All Sexually Active Girls Who Have Ever Been Pregnant	62%	43%	55%

III. RESIDENT INVOLVEMENT IN FRAMING THE PLAIN TALK MESSAGE

Adults in this country typically feel uncomfortable about acknowledging the emerging sexuality of adolescents, especially their own children. For moral or religious reasons, or to ensure that the youth will maximize their options in life unencumbered by too-early parenthood, adults want youth to delay sexual involvement for as long as possible. In some families, this clearly means remaining abstinent until marriage; in others, "delaying" often refers to some future time, when the child has finished school or seems mature enough to understand and handle the responsibilities that come with sexual intimacy. In many quarters, there is a strong aversion to encouraging youth to use contraceptives when and if they do become sexually active, for fear of appearing to condone or even promote sexual behavior during adolescence.

Continued high rates of teen pregnancy and the alarming increase of STDs among adolescents, however, convinced AECF that Plain Talk should address the needs of sexually active teens. Plain Talk communities would provide these youth with accurate information about condoms and other forms of birth control and improve their access to high-quality reproductive health care services.

To achieve this goal, each Plain Talk community had to create consensus about the legitimacy and value of the Plain Talk message among all segments of the community. The initiative called for each site to convene a core group composed of both community residents and staff from agencies that serve the Plain Talk communities. The core group would be maintained throughout the initiative and would play a key role in planning and implementation. The mission of the core group was twofold: to create and maintain a shared vision about the need to protect sexually active youth and then to convey this message to others in the community. This chapter examines how the sites created and sustained core group consensus about the goals of Plain Talk, while the next chapter discusses how the core group members were prepared to be Plain Talk's messengers in their community.

RECRUITING RESIDENTS FOR THE COMMUNITY CORE GROUPS

In keeping with the Plain Talk model, all sites convened a community core group in the early months of the initiative. The groups were initially composed of community residents and representatives from community agencies. In order to maximize resident input and build resident leadership, however, agency representatives in three sites regrouped into separate advisory committees so that the core groups could be composed entirely of community residents. Atlanta and San Diego differed from this configuration. In both sites, the core group included both residents and health and social service providers.

Community residents were recruited to the core group in a variety of ways. Many residents joined the group after participating in the site's community data collection effort (referred to as "community mapping" and described below). Plain Talk and lead agency staff recruited residents through their own network of contacts in the community. In Hartford and New Orleans, the

primary source of residents for the core group was the tenant association or resident council of the housing developments. Residents were also recruited by word of mouth and through recruitment drives at Plain Talk-sponsored events. Over the course of implementation, new core group members were brought in by current members or were recruited directly from other Plain Talk activities.

The size and composition of the core groups continued to change over the three implementation years, although the degree and patterns of change differed from site to site. Hartford and Seattle maintained relatively small, stable groups of between 10 and 15 members. In Seattle, membership remained fairly stable, but participation of individual members waxed and waned considerably over that time. In Hartford, there was more turnover in membership, although the size of the core group remained between 10 and 15. A small group of about five members was actively involved throughout implementation. Both communities are ethnically diverse, and after intensive recruitment efforts, both sites succeeded in building core groups reflecting that diversity. By the middle of the second year, Hartford's core group evolved from having an almost exclusively African American membership to being half Latino and half African American, reflecting the relative proportions of the two populations in Stowe Village. Similarly, Seattle's core group eventually included at least one member from each of the three major cultural groups (African American, Latino and Southeast Asian) in its target community of White Center. The ethnic composition of the core groups in the other three sites reflected the homogeneity of their target communities: Atlanta and New Orleans core group members were African American; the San Diego core group members were Latino of either Mexican birth or Mexican descent. Sites were encouraged to include men and women in the core groups. New Orleans and Atlanta managed to recruit a sizable number of adult and teenage males, Seattle and San Diego had one or two, and Hartford had none.[9]

In contrast to Hartford and Seattle, the core groups in San Diego, New Orleans and Atlanta continued to grow during the implementation years. San Diego's core group members continuously brought in new members and also invited workshop participants to attend core group meetings. By the third year of implementation, its core group had over 35 active members. In New Orleans, core group membership was loosely defined, but came to include members of the Resident Council, 10 to 12 Plain Talk Walkers and Talkers (residents who had received training as lay educators) and the 50-member Black Men United for Change (BMUC), a group that had been formed as part of the site's effort to involve men in Plain Talk. Atlanta's core group membership underwent the most fluctuation over the years. After a disruption midway through implementation, caused in part by the site's need to search for a new lead agency, core group membership dropped dramatically, and the site was forced to recruit an almost entirely new group. It succeeded in doing so through two intensive door-to-door recruitment drives and by channeling participants from workshops into core group meetings.

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[9]See Kotloff et al. *The Plain Talk Planning Year*, for more information about the recruitment efforts, including sites' attempts to recruit more men for the core groups.

BUILDING CONSENSUS

Given the core group members' role in carrying the Plain Talk message to others in the community, it was critical to forge a consensus within the group about the objectives of Plain Talk and build members' commitment to Plain Talk goals. Indeed, consolidating a single, community-based vision of the Plain Talk mission was a major objective for each site during the planning year.

Core group members participated in several activities that were designed to build consensus. The most successful of these was the community mapping carried out in the first months of the initiative. Community mapping was an intensive data collection effort in which each Plain Talk community worked with Philliber Research Associates to gather systematic information about the conditions that were the targets of change in their community. Residents were trained to conduct surveys of community adults and youth about their attitudes, knowledge and behavior related to adolescent sexuality and contraceptive use. Residents also assessed the contraceptive services available to youth in their communities.

Philliber Associates compiled the data and gave the findings back to the sites, where they were discussed at length by core group members and staff and served as a guide for developing implementation strategies. As outlined in the earlier report on the planning year, the mapping was highly effective, not only in helping sites understand community conditions but also in recruiting residents to the core groups and forging their deep and abiding commitment to Plain Talk. Participation in mapping increased core group members' sense of ownership of Plain Talk and commitment to their community. Many members who stayed with the initiative for the duration had participated in the mapping and spoke of the profound and continuing impact it had on them. Findings from the survey proved effective in breaking down residents' initial denial of the prevalence of sexual activity among teens in their community. Many residents became convinced that continued avoidance of the problem could place youth at greater risk of becoming teen parents or contracting an STD.

In addition to the community mapping, core group members in the sites were required to participate in discussions and debate to formulate a shared vision of the Plain Talk mission. Other activities also served to build consensus around Plain Talk goals. Foundation-sponsored sex education workshops for core group members were aimed at helping them feel more comfortable talking about a range of sexual issues, including homosexuality, sexual development and human reproduction. Values clarification workshops gave them the chance to explore their own views about sexuality, teen parenthood and other Plain Talk issues. As with community mapping, core group members spoke of these workshops as having a profound effect on their thinking about sex and the need to communicate frankly with teens about its risks.

As a result of these intensive activities, by the end of the planning year the core group in each of the five sites was able to agree that Plain Talk's fundamental objective would be to promote responsible sexual behavior and better contraceptive use among sexually active youth. Sustaining

this consensus over the course of implementation, however, was not always easy; it sometimes required revisiting the logic of the Plain Talk approach and its value to the community.

SUSTAINING CONSENSUS

During the Plain Talk initiative, three issues continued to pose a challenge to maintaining consensus within the community core groups: cultural and religious norms favoring abstinence for adolescents, differing perceptions of what the Plain Talk agenda should include, and turnover in the core groups themselves.

Cultural Norms Favoring Abstinence

Discussion of what Plain Talk's primary prevention message should be occurred in all the sites at some time over the course of the initiative. At issue was whether Plain Talk should focus exclusively on a message of protection for sexually active youth, whether it should advocate abstinence as the best choice for youth, and whether these two messages could be combined in some way. In four of the five sites, the community core groups endorsed Plain Talk's message of protection for sexually active youth with relative ease. Many individuals who joined the core groups, concerned about the increasing risk of HIV infection among teens in their community, were already sympathetic to Plain Talk's approach. The findings from the community mapping surveys, which showed that a large number of youth were engaging in unprotected sex, convinced others who may have been more skeptical that the best way to protect these youth was to promote effective use of condoms and other contraceptives.

In San Diego, however, core group members had considerably more difficulty accepting that message. Reflecting the population of the target community of Logan Heights, all the core group members were either Mexican born or of Mexican descent. The Latino culture in San Diego has strong cultural and religious norms that support abstinence until marriage. In addition, strong cultural taboos exist against discussing sexuality with teenagers, and sex is rarely discussed openly, even within the family. Moreover, cultural traditions of very early marriage and fertility patterns meant that the Plain Talk message to prevent teen pregnancy did not resonate with residents who were still rooted in these traditions—a sizable group in the community.

Because of their religious and cultural beliefs, it was initially very difficult for the San Diego core group members to accept the fact that many youth in their community were sexually active. Plain Talk staff and core group members reported that members reacted to the youth survey results with a profound sense of sorrow because they thought the results proved that their children were turning away from their culture and families. Staff reported, however, that the survey results also led the group members to accept the reality of teen sexuality and deepened their commitment to Plain Talk's protection message as a way to help the community's youth.

While this was a crucial turning point for the site, it did not mark the end of discussions about Plain Talk's goals. These discussions continued as the deep-rooted preference for abstinence

periodically resurfaced. Staff developed effective strategies that helped maintain the group's commitment to Plain Talk. They appealed to the members' sincere desire to help their youth and their community—and tried to show how Plain Talk goals could contribute to this. They frequently reinforced the need for Plain Talk by reviewing the findings of the community mapping youth survey. They also tried to frame Plain Talk's mission in terms that resonated with the Latino cultural values of strong family ties and the responsibility of parents to nurture and protect their young. It was with this goal in mind that the project director chose the site's logo: *Hablando Claro* (Plain Talk), *Con Carino y Respeto* (with love and respect). The logo, which appears on the site's numerous buttons, T-shirts and other promotional materials, is depicted graphically by two parental figures surrounding a youth. Framing Plain Talk in terms of Latino values helped core group members make a connection between their own values and those of the initiative. Furthermore, staff repeatedly told the core group that they did not have to endorse premarital sex personally but that for the sake of the youth they needed to set aside their personal preferences and convey accurate information. This is illustrated by the following presentation to core group members during a training workshop:

> The professional health educator asked the Plain Talk outreach worker to review the goal of *Hablando Claro*. The outreach worker said, "Protection of sexually active teens ..." and then asked the group, "How?" Then she said, "Learning how to talk with them ... so that we can answer them or know where to get the answer ... If they make the decision to become sexually active—not that that's good or bad—but having made this decision ... they need to know about the services available to them ... where to go ... It is not that we're promoting teen sex. The goal is also to prevent STDs (including HIV/AIDS) and unplanned pregnancies."

Similarly, when the issue arose of how to address birth control in their community outreach work, core group members became aware that some of their personal opinions and values were contrary to the goals of *Hablando Claro*. They took time to debate the issues and explore their values, and they ultimately agreed that it was important to impart information in a neutral way. When a core group member expressed doubt that she would be a good messenger for Plain Talk because of her negative views about oral and anal sex, staff reminded her, "But you're not going to be giving your opinion, only information." Thus, while most core group members remained ambivalent about the Plain Talk message, those who continued to participate ultimately learned to put aside their personal values and preferences and were able to convey accurate information to the community. However, as we discuss later in this report, it was not always as easy for group members to communicate the Plain Talk message unambivalently when talking to their own children—a dilemma faced by core group members in the other sites as well.

Male Involvement in Plain Talk

During the Plain Talk initiative, national attention focused on the roles that men could play in teen pregnancy prevention initiatives. Important lessons emerged from three of the Plain Talk Sites:

Identify men in the community who can act as outreach workers—either in a paid or a volunteer capacity. Atlanta had good success involving both adult and adolescent men in their activities by relying heavily on the involvement of two or three key male residents who recruited men to workshops. One young man, in particular, served as a role model for adolescent males in the community.

Allow community men to set a broader agenda.

New Orleans created a separate group called Black Males United for Change (BMUC). Most of the men in the group were in their 20s and 30s, and the group worked on leadership and job development and on improving the community's relationships with the criminal justice system. The "theory of change" behind the group's plans and work was that issues of sexuality could be addressed only in the context of holistic efforts to improve the lives of poor African American men. Although the group embraced the Plain Talk message and held occasional workshops on such topics as STDs and HIV/AIDS, they spent most of their time focusing on employment issues that they believed would more easily enable them to be responsible to their families and communities. Youth in the community—both boys and girls—looked up to the men, and the men sponsored a marching corps that provided positive opportunities for youth and adults to interact.

Link teen pregnancy prevention efforts with strong cultural mores and images.

Using funds from the State of California for a male involvement initiative in teen pregnancy prevention, San Diego implemented a formal peer education strategy among adolescent males. Under the guidance of two male health educators, a small group of adolescent males were trained to do outreach in their community and around their school. To anchor the Plain Talk message to the Latino culture, the site hired a consultant who explicitly linked the importance of *familia* with Plain Talk: "I didn't put sexuality in until later ... I first started with *familia* ... with what it means to be a man, a noble man ... About the culture of drinking and how that contradicts our family traditions ... It's important to talk about oppression, like at work, when they don't respect you, it's hard to know how to come home and talk with affection and respect to your kids." The idea of linking manhood to being a "noble man" was very appealing to the young men involved in the initiative.

San Diego was not the only Plain Talk community in which prevailing cultural norms oppose premarital sex. The Seattle and Hartford target communities included substantial populations whose cultural norms conflicted with Plain Talk goals. In White Center, approximately half the target population was from Southeast Asia, where cultural norms strongly support abstinence until marriage. Moreover, the prevailing community mores in White Center are very conservative, with a small but vocal group that staunchly opposes providing reproductive health services to youth and tightly controls sex education in the public schools. While these opposing viewpoints were not represented in the core group, the Plain Talk staff, as time went on, moved away from an exclusive focus on protection for sexually active youth. Their community education workshops emphasized the importance of parent-child communication about sexuality and encouraged parents to communicate their own values about sexual behavior and contraceptive use. Thus, by the time two

Southeast Asians joined the core group, the site's message had become less controversial and was readily endorsed by the new members.

Hartford, too, was a culturally diverse site—half African Americans and half Latinos who are either Puerto Rican born or of Puerto Rican descent. After doing intensive outreach within the Latino community, the site succeeded in recruiting several bilingual Latinos to the core group. These individuals endorsed the Plain Talk message with little debate. As an explanation of why the message was not a point of contention for them, we were told that a large segment of the Puerto Rican community in Stowe Village has become acculturated to American life and has come to accept the reality of sexual activity among teens. The lack of conflict over Plain Talk's message among the Latinos in Hartford's core group may also have resulted from the fact that the individuals who joined the group were bilingual and had spent many years in this country. Monolingual Spanish-speaking Puerto Rican immigrants, who are less acculturated to American life and thus may have had more trouble accepting Plain Talk, were not members of the core group.

Differing Views of the Scope of Plain Talk

An issue of importance concerned the scope and agenda of the Plain Talk initiative. Staff and core group members in all sites recognized how difficult it is to implement an initiative that solicits resident participation and commitment when residents are struggling with a host of economic, social and personal problems. How can residents be trained effectively as Plain Talk messengers when they are illiterate and cannot read informational materials? How consistently will people protect themselves from STDs when they have drug and alcohol problems? How can site staff and residents convince young men and women to be sexually responsible when their future opportunities are too limited to provide reinforcement of the positive consequences of sexual responsibility? While endorsing Plain Talk's message of protection for sexually active youth, core members and staff recognized that, if Plain Talk was to succeed in mobilizing community residents, it had to address a broad range of community needs and concerns.

The issue was particularly salient in New Orleans and Hartford. From the outset, the St. Thomas community in New Orleans held a broad view of what Plain Talk should be. Convinced that teen pregnancy could not be viewed outside the broader goals of individual and community empowerment, they saw Plain Talk as an integral part of a larger, ongoing community mobilization strategy. In addition to focusing on sexuality issues, their definition of the Plain Talk message encompassed many areas of concern to residents: inadequate housing, high levels of crime and drug dealing, a lack of positive activities for youth, and limited access to affordable, high-quality health care. The community wanted Plain Talk to address social and economic issues that were thought to be the root cause of teen pregnancy. They wanted Plain Talk to create a strong sense of community in the housing development. Their holistic approach can be seen in the name they chose for Plain Talk's community education curriculum: *Healing Our Sexual Collective*.

Hartford's decision to broaden its Plain Talk agenda was the result of lessons learned from early attempts to involve residents in Plain Talk activities. Through informal discussions with residents who attended the activities, the site realized that teen pregnancy was not as pressing a concern to many community adults as were other issues, such as substance abuse, domestic violence and unemployment (which became an issue of great concern to Stowe Village residents in 1996, when Connecticut became one of the first states to implement strict time limits on welfare benefits). Staff and core group members quickly saw that, if they hoped to engage the community in discussions about sexuality, they would also have to address these other issues.

Both sites attempted to find ways to address their community's concerns without losing Plain Talk's primary focus on preventing teen pregnancy and STDs. In core group meetings and other Plain Talk activities, they often moved gradually into discussions about sexuality, after trust was established. For example, the St. Thomas site initially had a great deal of difficulty (as did all the other sites) in getting men involved. Feedback from the men they did reach showed that teen pregnancy was not the issue that most concerned the males in the community. The site encouraged the men to form an all-male group to discuss and develop action plans around issues that were of concern to them. In their meetings, BMUC discussed men's roles in the lives of their families, job development and training, and improving relationships with the police. Over the course of the implementation period, however, Plain Talk gradually became part of the group's agenda. This started when some of the men became involved in the Walker and Talker training and began to bring up Plain Talk issues in their BMUC meetings and discussions. Plain Talk staff believe that allowing the men to define their own agenda and address the issues of most concern to them was a major factor in sustaining their involvement.

Hartford attempted a similar strategy. The site tried to insert the Plain Talk message into all community activities. Staff and core group members started all Plain Talk-sponsored community festivals by explaining the goals of the initiative and the need to practice safe sex. They also organized a series of educational sessions around issues of concern to the community and planned to emphasize the connections between Plain Talk and these other issues by showing, for example, how teen pregnancy and high-risk sexual behavior influence and are influenced by substance abuse, family violence, unemployment and the like. These sessions, which were led by staff from local agencies who were experts in their field, were well attended. Topics ranged from welfare reform to presentations on diabetes, breast cancer and domestic abuse. Because we did not have an on-site ethnographer in Hartford, however, we were unable to document the extent to which teen pregnancy prevention and adult-youth communication were addressed in these sessions.

Sites had to resist the time- and energy-consuming impulse to provide direct services to residents in need. Instead, they referred individuals to local agencies for needed services. Making appropriate referrals was a major responsibility of the Walkers and Talkers in New Orleans: in addition to their role as health educators and outreach workers, they became community resources for referrals about health services as well as for emergency needs of the St. Thomas families. In Hartford, too, the Plain Talk staff and core group leaders became a referral resource for the community.

Turnover in the Core Group

The third challenge to sustaining consensus within the core groups was the inevitable turnover in membership that occurs in any long-term initiative that relies on volunteers (as Plain Talk's core group members were). Individuals who joined the core groups later in the initiative did not have the benefit of the intensive orientation activities (described earlier) that were instrumental in convincing many of the early members about the value of Plain Talk. In order to maintain or expand the size of the core group without losing its focus or momentum, sites had to develop effective ways of orienting new members.

This issue was especially salient in San Diego, which continued to recruit new core group members until it grew to include over 35 residents. As was the case with the original members when they first joined the group, new members often felt that abstinence was the best way to prevent teenage pregnancy and disease. In a typical example, a group member who had been participating for only a few months at the time of her interview admitted that she would like to hear more about abstinence at the group's meetings, as well as more discussion about how adults could have "greater influence in encouraging [kids] to say no.' " In addition, the consensus that had been achieved during the planning year was somewhat tenuous, and many original core group members still had mixed feelings about Plain Talk's focus on sexually active youth. Not only did the site have to integrate new members but it also had to deal with the continuing ambivalence of many original members about the Plain Talk message.

To maintain consensus, staff in San Diego frequently reiterated Plain Talk's mission at core group meetings, especially when newcomers were introduced to the group. On such occasions, staff would refer to key findings from the community mapping to bolster the rationale for Plain Talk, while acknowledging the conflicting values that people might have about adolescent sexuality. Often, staff asked long-standing members to explain Plain Talk's mission to the newcomers. In fact, the continuing participation and commitment of a cadre of original core group members, who could be called on to bring new members into the fold, were key to sustaining consensus in other sites as well.

The value of intensive orientation for new members is highlighted by Atlanta's experiences. The original core group at that site had over 25 members and was clearly focused on Plain Talk's message of protection for sexually active youth. Early in the second year of implementation, however, the site experienced a series of delays after its original lead agency moved out of the city. During this time, core group meetings became irregular, and participation dropped dramatically. After several months, the site reconstituted the core group for the purpose of using resident members as outreach workers. About two-thirds of the residents were new, recruited through the *Askable Parents* workshops that had become the site's main community education activity. Unlike the orientation the original core group members had received in workshops that focused specifically on the needs of sexually active youth, the *Askable Parents* workshops focused more generally on parent-child communication. As a result, the new core group members were not

exposed to frequent and consistent statements of the message; and when describing Plain Talk's message, they were more likely to talk about the importance of adult-youth communication than about the needs of sexually active teens.

In contrast, new members of New Orleans' core group were recruited though the Walkers and Talkers training program, which focused on the risks of unprotected sex and the most effective methods of minimizing these risks. Those new members were thus much more likely to mention protection for sexually active youth in describing the main goal of Plain Talk.

Using this range of strategies over the course of the four-year initiative, most sites succeeded in sustaining consensus within the core groups about the central mission of Plain Talk. That consensus, developed through intensive orientation workshops and the community mapping process and its findings, was reinforced through repeated discussions and ongoing training. The result was that core group members remained deeply committed to helping teens in their community avoid early pregnancy and STDs. Recognizing that teens would continue to have sex despite adults' wishes to the contrary, the members endorsed Plain Talk's approach to prevention. However, their desire to encourage youth who were not yet sexually active to remain abstinent did not disappear. As we discuss in a later chapter of this report, when core group members (and staff) actually went out into the community to do outreach for Plain Talk, they modified their message somewhat in order to convey support for abstinence as well as to convey the message of protection. As one core group member explained, "Abstinence is our first choice, but if kids are sexually active, they need to protect themselves." Incorporating support for abstinence into the message they communicated to youth allowed core group members to affirm their values without compromising the basic Plain Talk message.

IV. TRAINING RESIDENTS TO DELIVER THE PLAIN TALK MESSAGE

The commitment of the community core group members to Plain Talk was the necessary first step in achieving the larger goal of community consensus. By the end of the planning year, sites had also developed a community education strategy to disseminate the Plain Talk message. Core group members were expected to play a key role in the dissemination effort, since the Plain Talk design assumed that residents would perceive core group members, who were themselves residents, as more credible messengers than professional agency staff. Thus, notwithstanding some cross-site variations, the main education strategy adopted by the sites was to train a cadre of residents to be Plain Talk's messengers in the community. Their mission was twofold: to increase community awareness about the rates of teenage sexual activity and its associated risks; and to provide parents and other community adults with the information and skills they needed to begin to talk to their children about issues related to sex, including the need to use protection if and when they became sexually active.

Preparing core group members to be Plain Talk messengers turned out to be a complex undertaking. Sites had to develop a program to train them and assess their readiness to go out into the community. They also needed to develop a format and curriculum for delivering the message. These activities were the major focus for sites during the first 18 months of implementation and, in three sites, continued to be a primary focus throughout the entire course of the pilot. They proved to be labor-intensive and time-consuming efforts that ultimately produced promising, although mixed, results. This chapter examines the challenges the sites encountered, how they were overcome, and the extent of the sites' success in preparing residents to do community outreach and education.

THE DISSEMINATION MODEL

All of the sites planned to use a similar format to disseminate the Plain Talk message in the community. The basic model originated in the New Orleans site, which had successfully used small group meetings held in residents' homes to disseminate the community mapping results. New Orleans had shared this approach with the other sites during Plain Talk conferences, and the sites adapted it to their individual communities.

Referred to by different names in each site—Home Health Parties in New Orleans, *Vecino-a-Vecino* (Neighbor-to-Neighbor) workshops in San Diego, and Living Room Chats in Seattle—small-group interactive sessions were planned as the format for community education in all sites. There were some site variations. In addition to small, intimate group settings, San Diego held larger educational sessions in public auditoriums as a way of repeating and reinforcing the Plain Talk message. The Hartford core group felt that residents in Stowe Village would not be comfortable hosting groups of people in their homes and held their workshops in the Plain Talk office instead. As the various names the sites chose for the workshops imply, their goal was to create an informal, nonthreatening, friendly atmosphere within which people could feel free to

open up and begin to explore the difficult, important Plain Talk issues. Staff in San Diego had another motivation for the home setting. Fear among undocumented residents led to social isolation among those who were unwilling to go far from their homes. It was easier to attract neighbors and friends to homes than to local schools.

Role of the Core Group Members

While details varied from site to site, the original plan was for core group members to lead these educational workshops. They would be trained to present factual information, facilitate small group discussions and explain the need for better adult-youth communication. The goal was not to try to produce "experts" but to give the residents enough knowledge to engage other residents in discussion and convey accurate information about Plain Talk issues. San Diego and New Orleans, the two sites that had clearly articulated community education strategies, intended to have Plain Talk staff or agency partners cofacilitate the workshops, providing support as well as expert information as the need arose. In addition to facilitating the workshops, the Walkers and Talkers in New Orleans would be responsible for recruiting hosts for and organizing the Home Health Parties and acting as resources to the community.

While not expected to become experts, residents were expected to present accurate information. Because human reproduction includes a wide range of topics—including reproductive anatomy and physiology; the symptoms, transmission and prevention of the various STDs, including HIV; birth control methods; sexual development; and sexual relationships—residents would need to gain at least a basic familiarity with several different technical vocabularies. Residents facilitating workshops also had to develop presentation and group facilitation skills; they had to present the information as dispassionately and nonjudgmentally as possible, even if their personal opinions were at odds with the information they were presenting. This was a challenging learning task for any nonprofessional; the task was made even more daunting because few core group members had any experience speaking in front of groups. There were language and literacy issues as well, especially in San Diego, where many of the core group members had only elementary school educations in Mexico: many were monolingual Spanish speakers, and a few were illiterate. Finally, because sexuality had not been discussed in their own homes when they were growing up and many had not had sex education in school, core group residents in all the sites had large gaps in their knowledge of basic facts and terminology.

Early in implementation, Seattle chose another route. Staff felt it was not cost effective or realistic to expect residents to gain the necessary competency in a reasonable amount of time. Instead, they hired a professional health educator to design and deliver the site's community education workshops, which became known as *Plain Talk for Parents*. While core group members were given some training to help them introduce Plain Talk to community groups, the site did not launch an intensive program to train the members as lay health educators. Early plans to have them cofacilitate the *Plain Talk for Parents* workshops with the health educator were dropped, and plans to have the core group members hold Living Room Chats did not materialize. A few of the members were occasionally asked to give short presentations or testimonials about Plain Talk to

community groups. But the site chose to rely on its professional staff to disseminate the Plain Talk message to the residents in the community.

TRAINING THE CORE GROUP MEMBERS

Given the ambitious goal and the challenges involved, it is not surprising that preparing core group members to cofacilitate community education workshops proved a labor-intensive undertaking that took far longer than expected. Training covered a wide range of topics and included knowledge acquisition, values clarification and presentation skills. It took several months to complete and required residents to participate in as many as 36 hours of workshops. In both San Diego and New Orleans, residents who completed training were expected to attend regular follow-up sessions to reinforce and expand their knowledge and skills, though these were not always held as regularly as planned, primarily because of lack of staff time. While the other sites used outside consultants for most core group training sessions, Plain Talk staff in San Diego and New Orleans developed and delivered those sites' training. In San Diego, for example, staff members had to develop the curriculum to train the *Promotoras*[10] (or lay peer health educators), which they did—in Spanish first and later in English. They also ran the training workshops, which consisted of seven or eight two-hour sessions. Once the *Promotoras* completed training and started in their role as Plain Talk educators, a staff member accompanied them to each *Vecino-a-Vecino* workshop or community education session and provided support and constructive feedback.

Among the sites, San Diego and New Orleans implemented the most well-conceived and comprehensive training efforts. By the beginning of the first year of implementation, both sites drew on the community mapping data to develop plans for the format and content of their community education workshops. They had also begun to think about the roles the residents would play in facilitating these workshops. While the effort to develop the community education workshops and the core group training program simultaneously was extremely time consuming, doing so enabled staff to organize the training program around the specific knowledge and skills the residents would need as workshop facilitators. These two sites also included practicums as part of the residents' training, which gave staff opportunities to give corrective feedback and determine the level of support that residents would need from staff in conducting the community education workshops. This practical training was particularly rigorous in San Diego. In addition to doing a practice presentation in front of staff, trainees had to give minipresentations in the community during workshops that were being led by Plain Talk staff. These practice sessions were carefully observed and critiqued by the staff and became an important tool for assessing the residents' readiness to go out into the community.

[10]The term *Promotoras* was used in at least two ways in San Diego. First, it was used to refer to the women who were trained to become peer health educators. Second, it referred more generally to core group members who promoted the Plain Talk message in their communities. In this report, we use the term to refer only to the peer health educators.

The training programs that Hartford and Atlanta held during the first 18 months of implementation were less focused. While both sites had a general notion that they wanted to train residents to do presentations about Plain Talk in the community, neither site had specific ideas about the shape these presentations would ultimately take. This made it more difficult to decide what needed to be included in the training sessions, what level of competency to aim for, and what to do with the residents once they completed training. As will be discussed below, this last point was a factor in the attrition that occurred among trained residents once their training was completed (see Table 4.1).

Training proceeded in fits and starts as sites tried various strategies. The first year of implementation was a period of trial and error. Through 1995, San Diego, Atlanta and New Orleans conducted training among residents which, as we shall see, did not lead to formal community education workshops, although it did result in the development of residents with greater knowledge of sexuality. Despite the challenges faced in 1995, the sites persevered, and their experiences tell us much about the practices and plans that lead to successful implementation.

Attendance and Attrition

Attrition was high among residents over the course of training, particularly during the start-up phase of implementation (mid-1994 to December 1995). Atlanta had the highest completion rates: of the 55 residents who attended the 18-session workshop, 40 completed at least 15 sessions, and 15 completed all sessions. Attrition was usually attributable to personal reasons, though staff in San Diego may have dissuaded residents who they felt would not make good *Promotoras* from continuing.

Some sites gave residents stipends as incentives for completing the training program. This strategy was only partially successful. Atlanta's relatively high attendance rate in 1995 may have been explained in part by the generous reward: $300 for completing all 18 sessions. A $200 completion award could not completely stem the rate of attrition in Hartford, but the five participants we interviewed acknowledged that it had been a motivating factor in their continued participation.

In light of the time and resources required, the initial results of the resident training programs were disappointing to the sites and to AECF. At the end of 1995, after a year of intensive effort, none of the four sites was ready to send residents into the community as lay educators. The training sessions produced few residents able to cofacilitate workshops; and sites experienced delays starting their in-home education workshops, which, in turn, resulted in more attrition among those residents who had completed training.

In San Diego, only four trainees were considered by staff to be ready to facilitate *Vecino-a-Vecino* workshops. Among the sites, San Diego developed the most rigorous standards to assess trainees' readiness.

Table 4.1
Core Group Training, 1995-1997

Site[a]	Training Goal	Number of Sessions	Topics Covered	Number Enrolled/ Completed	Number Who Gave Workshops
Atlanta	Prepare residents to present factual information on sexuality and prevention.	18 two-hour sessions	Human sexuality; STD/HIV prevention; sexual decision-making; community organizing.	55/55[b]	0
	Prepare residents to recruit others to Plain Talk workshops.	8-10[c] sessions (three rounds completed)	Plain Talk goals; sexuality; community survey findings; presentation skills.	25/23	19 (did outreach by hosting Plain Talk parties)
Hartford	Prepare residents to present factual information on sexuality and prevention.	12 three-hour sessions, with two-day follow-up session; refresher seminar practicums	STD/HIV prevention; human sexuality; reproduction; pregnancy prevention; birth control methods; presentation skills.	36/26 completed most sessions	7-10[d]
New Orleans	Prepare residents to cofacilitate workshops.	12 sessions (two series); practicum; follow-up sessions	Values clarification; STD/HIV prevention; reproductive anatomy; birth control methods; homosexuality; sexual abuse; adolescent development; presentation skills.	1st series 38/10 2nd series 10 completed	0 10
San Diego	Prepare residents to cofacilitate workshops.	7 two-hour sessions (two series); practicum; ongoing follow-up sessions (for second series)	Values clarification; reproductive anatomy; sexual development; birth control methods; STD/HIV prevention; adult-youth communication; presentation skills.	1st series 14/4 2nd series 8/5	1 5

[a] Core group members in Seattle attended a training workshop whose goal was to develop their ability to introduce Plain Talk to community groups. Approximately three core group members subsequently made presentations at two or three community events.

[b] In Atlanta, 15 people completed all 18 sessions, while 40 people completed at least 15 sessions.

[c] The first cycle of training workshops was 10 sessions. Later cycles were shortened to 8 sessions.

[d] In Hartford, between seven and ten trained adult and teenage residents periodically gave presentations on teen pregnancy and STD prevention at community events and small group sessions.

In the other sites readiness was determined by the number of workshops attended, but in San Diego it was judged on the basis of the trainee's demonstrated commitment to a variety of Plain Talk activities and skill in presenting the material. Residents in San Diego were required to exhibit a commitment to further learning. Also, as part of their training, *Promotoras* were expected to differentiate between opinion and knowledge and learn how to impart knowledge in nonjudgmental ways. Given the high standards, the four who graduated represented a real achievement. Thus, it was extremely disappointing when three of the four dropped away from Plain Talk shortly after training, and the year's effort produced only one *Promotora*, who was actually the site's full-time outreach worker. Reasons for the attrition were twofold. First, the women cited personal barriers to continued participation. Second, the site had not completed a curriculum for workshops, and the lag between completing training and the beginning of the workshops seemed to have been responsible for a drop in interest.

In New Orleans, the criterion for becoming a Walker and Talker was completion of the12 workshops and practice sessions. Ten residents were trained. However, the beginning of the Home Health Parties was delayed for several months, in part because the curriculum that would be the core of the parties was not yet completed. By the time the site was ready to begin scheduling the parties, most of the trained Walkers and Talkers had moved on to other things and were no longer available.

When training ended in December 1995, Hartford and Atlanta had not developed a plan for their community education strategy and did not yet have a clear idea about how to use the trained residents. Progress in both sites was delayed further by a series of interruptions, including Atlanta's search for a new lead agency, which put a halt to the site's Plain Talk activities for the next six months. Hartford ultimately held a refresher seminar in an attempt to revive interest among the 36 residents who had participated in the earlier training workshops, but only a handful attended. From that point on, the site held periodic training sessions for individuals interested in giving presentations about Plain Talk. Between seven and ten people received this training and periodically gave brief presentations about Plain Talk at community events and Plain Talk activities.

After considering the degree of effort expended to produce a few residents who were ready to go into the community—and feeling pressured by the fact that only two years of implementation remained—AECF advised sites not to continue devoting the best part of their resources to training residents as workshop facilitators but to find alternative community education strategies. In response to this advice, Hartford moved away from the idea of developing a systematic community dissemination and education strategy involving trained residents. Instead, they focused their efforts on three main activities. First, the assistant project director developed and ran a 12-session community education workshop series on teen sexuality and parent-child communication. Second, Plain Talk outreach workers organized educational sessions for community adults that focused on a variety of health-related topics, including teen pregnancy and STD prevention. Third, aided by a few core group members, Plain Talk staff conducted door-to-door outreach to introduce Plain Talk's goals and objectives and invite residents to participate in Plain Talk activities.

Atlanta changed its strategy as well. Having recently entered into an agreement with the Fulton County Health Department to implement a series of *Askable Parents*[11] workshops, the site decided to rely on a professional health educator to deliver the community education workshops and began to train the core group members to do community outreach. In this new plan, residents were trained to host Plain Talk Parties, whose primary purpose was to inform the community about the importance of Plain Talk, highlight the need for better adult-youth communication and encourage people to attend the *Askable Parents* sessions. Because Plain Talk Party hosts were not expected to give much factual information about sexuality, birth control or STDs, the role required much less proficiency with technical information and the scope of the training was much narrower. Further, one of the Plain Talk staff was expected to be present as support for the resident at each Plain Talk Party. This strategy proved much more successful than the earlier one had been: by the end of 1997, a total of 20 residents had been trained to be hosts, and the site completed two cycles of Plain Talk Parties. However, because the site's requirements to become a host relied solely on attendance at the training, the readiness and skills of the people who hosted the parties varied dramatically.

While Atlanta shifted to training residents to do community outreach after the staff decided their approach, San Diego and New Orleans continued with their original plan to train lay health educators to deliver Plain Talk workshops. Both the staff and core groups in these two sites had invested an enormous amount of time and effort in developing a curriculum for their community education workshops, and they were committed to seeing it implemented. More important, both sites remained deeply committed to developing resident leadership and saw building the core group's capacity to cofacilitate the workshops as a key part of this effort. Thus, in 1996, both sites launched a new round of intensive training, modifying their original training program in light of what they had learned from their first attempt. In both sites, staff concentrated the training into a shorter period, and newly trained *Promotoras* and Walkers and Talkers also had almost immediate opportunities to give workshops. Both strategies helped the sites sustain interest and commitment among the trainees. In San Diego, from the beginning of 1996 to mid-1997, five women became *Promotoras*. In New Orleans, 10 residents, including an adult male and a teen, completed the second round of training and began to facilitate Home Health Parties. If one individual left, another was trained, and the site was able to maintain a cadre of 10 Walkers and Talkers throughout 1997.

[11]In 1997, staff for Atlanta Plain Talk changed the name of the workshops to *Askable Parents/Adults* and then, later, they changed the name to *Askable Adults*. The name change, however, did not reflect a change in focus on the part of the facilitator who gave the workshops.

LESSONS LEARNED

The experiences of the sites demonstrate that it is indeed a major undertaking to train inexperienced community residents to present fact-based information on sexuality in a formal setting. At the very least, the training requires a long-term commitment of time and resources on the part of staff, a clear plan for the ultimate uses to which the training will be put and a system for quickly implementing the plan once training has been completed. Because of the technical proficiency required, it is likely that even intensive training will produce only a small group of residents with the required skills. Moreover, follow-up training and ongoing staff support will be needed to assure the continued quality of the presentations. Despite these reservations, we saw clear benefits to training residents as lay health educators. These benefits will be discussed later in this report.

In addition, while the number of residents completing training with the requisite skills was small relative to the effort involved, the project directors in San Diego, New Orleans and Hartford argued that the training workshops had at least succeeded in producing a larger cadre of "askable adults." That is, they felt that many participants who had not reached the point where they could present information in a formal setting had received enough training to disseminate the Plain Talk message informally in the community. As we will discuss in Chapter VII, there is ample evidence to suggest that this did occur. One limitation of informal communication as a dissemination strategy, however, is that it is difficult to monitor the accuracy of the information imparted through informal encounters.

The point made by the project directors highlights one lesson that can be learned from sites' efforts to train the resident core group members to disseminate Plain Talk: the usefulness of having a number of different roles available to residents who participate in training. Offering multiple roles that tap different skills and proficiency levels would broaden the goals of the training and eliminate the potentially divisive need to select a small group of "successes"—and thus eliminate the need to view all other participants as having failed in some sense. This, in turn, might sustain the participation of a larger group of residents. The project directors recognized the benefit of offering a variety of roles to residents but did not have the time to develop their ideas more fully.

Training residents to do community outreach might be one such alternative role. Atlanta's experience with Plain Talk Party hosts suggests that producing competent outreach workers requires less intensive training. Furthermore, it can use residents' strengths. Many of the residents who became involved in Plain Talk had extensive social networks within the community, and these networks could be tapped to recruit others to the initiative.

V. TAKING PLAIN TALK BEYOND THE COMMUNITY CORE GROUP

As we saw in the last chapter, sites showed that they could mobilize and train a core group of residents to conduct community outreach and education. By referring to the community mapping data about levels of adolescent sexual activity, site staff also persuaded core group members that it was important to protect sexually active teens and that adults needed to communicate openly with youth about sexuality and contraception and protection. Preparing the core group, however, was only one part of the work to be accomplished before the sites could begin taking Plain Talk to the community. Sites also had to decide how the group members and staff would carry the message; what information they would impart; and what skills, if any, they would provide to the community.

The work of deciding how to move Plain Talk beyond the community core group was primarily done during the first year or two of implementation. During the time that sites were preparing the core group, they were also developing curricula, hiring health education professionals, identifying the arenas in which they could present information as well as the population they wished to target, and devising specific strategies for recruiting community members to Plain Talk events. The sites' community education strategies varied along key dimensions, including who developed and facilitated the workshops, their content, and their target audience. The variations among sites, as well as some of the similarities, provide a rich source of information for addressing a number of key questions about implementation strategies:

- Why did the sites choose implementation strategies that emphasized either improving residents' knowledge about sexuality or improving their communication skills?

- What effect does a curriculum that emphasizes communication have on the delivery of the Plain Talk message?

- What effect does a curriculum that emphasizes providing information about sexuality have on the delivery of the Plain Talk message?

- What outreach strategies were most effective in bringing community residents to workshops?

- Can community residents be used successfully as community educators?

As the last chapter indicates, training community adults in the range of skills necessary to become Walkers and Talkers or *Promotoras* was labor intensive. The people who were trained, especially in the first implementation year, received knowledge-based instruction about sexuality as well as instruction on improving communication skills and making presentations. Although the goal of all the sites was to improve, across the community, adult-youth communication about responsible sexual decision making, site staff recognized that it would not be possible to train vast numbers of

community residents as intensively as they had trained core group members. They thus developed workshop strategies that would allow them to reach relatively large numbers of residents while still promoting the goal of improved communication about sexuality among adults and youth. This chapter describes the experiences of San Diego, New Orleans, Seattle and Atlanta[12] in planning education workshops for community residents; their decisions about how to focus the workshops; and their strategies for doing outreach to attract residents to those workshops. The next chapter will examine residents' effectiveness as workshop facilitators.

CURRICULUM DEVELOPMENT

During the planning period, all but one of the sites (Seattle) seriously considered using community residents as health educators who could spread the Plain Talk message and provide both factual information about adolescent sexual behavior in the community (using the mapping data) and information about how to prevent teen pregnancy and STDs. With this idea in mind, the sites developed curricula for their community education workshops. In general, these curricula tended to focus on either increasing adults' knowledge about sexuality, contraception, STDs (including HIV/AIDS) and adolescent development or improving parent-youth communication. While some sites attempted to include both communication skills and information about sexuality in their curriculum, every site had a strength in one or the other area. Table 5.1 shows the emphasis (in terms of time spent during the workshops) that sites put on providing information about sexuality or improving communication among adults and youth.[13]

In the two sites in which community residents were heavily involved in curriculum development and/or presenting workshops—San Diego and New Orleans—the curricula's primary focus was on providing information about sexuality. In contrast, in the two sites in which community residents did not sit on curriculum development committees and did not facilitate workshops, the curricula tended to focus on improving communication skills between parents and their youth. The

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[12]We have excluded Hartford from consideration in this discussion because, as described earlier, the site implemented a different approach to community education. In 1996, the site held two 12-session workshop series on teen pregnancy prevention and parent-child communication. One was for Spanish-speaking Latinos, and 18 women participated. The second series was for English speakers, but it was discontinued after six sessions because of declining attendance. While the site planned a second round of these workshops in 1997, they were not implemented because of problems with attendance. In 1996 and 1997, Hartford also ran biweekly "health concerns" group sessions on a range of health and welfare topics. These sessions were very well attended. Plain Talk staff planned to include teen pregnancy prevention throughout the sessions, but we were unable to document the extent to which they did so. We did not have an ethnographer in place in Hartford, and therefore we lack the detailed information that we have for the other sites. Because of the different approach to community education implemented by the site and the limited information we have available, it is difficult to compare Hartford to the other sites.

[13]We make a distinction between the workshops that sites gave and those they included in their curriculum. New Orleans, for example, had a curriculum that included a section on improving communication, but the choice of what to cover in the workshops was made by people who hosted Home Health Parties, and almost all of them were devoted to providing information about STDs.

connection between resident involvement and focusing on knowledge was far from accidental. On the following pages, we explore the factors that contributed to the kind of curriculum that was developed in each site.

Table 5.1
Emphasis of Adult Workshops Through 1997

Site	Information about sexuality, especially as it relates to STDs and pregnancy prevention	Improving parent/youth communication
Atlanta		✔
New Orleans	✔	
San Diego	✔	
Seattle		✔

Increasing Knowledge about Sexuality: San Diego and New Orleans

During the first implementation year, San Diego staff formed a subcommittee for curriculum development that consisted of four resident core group members, two staff members who were also residents, and two other staff members. The group drew on materials given to the site by technical assistance providers as well as on materials collected by staff members. Because of both staff turnover and the site's commitment to strong core group development, the residents played a large role in the end product.

For the core group members and staff involved in developing the curriculum, it was essential to break down the barriers to speaking comfortably about sexuality that existed in the Latino community. According to residents and staff, these barriers to communication were not only cultural; they also existed because residents lacked the knowledge necessary to open communication. Interviews with adult core group members illustrate the kinds of gaps, prior to

coming to Plain Talk, that residents had in their knowledge about their bodies, sexuality, reproduction and the physical symptoms of STD:[14]

> I didn't know a lot of things. I learned a lot ... Now I can talk more securely ... about the womb ... etc. ... I know where and what it is ... I don't confuse the womb with the vagina.
>
> *Female core group member*

> Before, I didn't really believe all that stuff about STDs ... but seeing it like on the slides at Memorial ... made a very big impact on me and my daughters ... We didn't realize how bad they were.
>
> *Female core group member*

> I didn't even know the names ... of the reproductive parts.
>
> *Female core group member*

> I'd never heard of STDs, like syphilis ... gonorrhea ... I'd never heard of, like, sperm ... They explained everything to us ...
> *How had you learned about sex*? ...
> A girlfriend told me what it was.
>
> *Female core group member*

The lack of knowledge about sexuality and reproduction among community members in San Diego is not surprising. Of the 15 core group members we were able to interview, about two-thirds were from Mexico—about half of them from rural communities—and had a primary school education or less. Given their educational and cultural backgrounds,

San Diego: *Vecino-a-Vecino* and Community Education Workshops

The same four-part curriculum was used for the *Vecino-a-Vecino* and Community Education workshops. The difference was that *Vecino-a-Vecino* workshops were delivered in homes to small groups of 6 to 10 residents, while the community education workshops were delivered to larger groups in schools or other community centers.

The curriculum was developed by residents to increase adults' knowledge of sexuality and related issues. It was organized around four topics: anatomy and physiology; adolescent development and puberty; STDs, including HIV/AIDS, contraception and prevention; and becoming an "askable adult." Each workshop series met for four two-hour sessions (8 hours total).

Residents and professional health educators facilitated the workshops. When residents were the facilitators, professionals were often present to help if necessary. People who hosted the workshops in their homes received a small stipend for refreshments. When the workshops took place in community settings, child care was provided.

Workshops were presented in lecture format, often in Spanish, with accompanying handouts. At the end of the sessions, the group played bingo with bingo cards that included the terms that had been learned over the course of the workshop.

[14]Adults responded to an open-ended question about Plain Talk's contribution. Nine of the 15 core group members who were interviewed indicated that Plain Talk had been important in increasing people's level of knowledge about sex or sexuality. The site's own internal examination of pretests and posttests administered by workshop facilitators and analyzed by faculty at San Diego State indicated that a large majority of workshop participants showed a significant increase in their factual knowledge about sexuality.

there were few opportunities for them to have gained general knowledge about sexuality, reproduction, contraception, and STD transmission and prevention.

Thus, the focus on knowledge development that the subcommittee gave to the curriculum reflected the core group members' concerns. The resulting curriculum, which was to be delivered in homes or in community centers (e.g., schools, Boys & Girls Clubs), was designed to increase other community members' knowledge of sexuality. (See the sidebar, "San Diego.")

As one staff member (and community resident) in San Diego said about the curriculum development:

> The decision to have anatomy and physiology was easy; [the curriculum subcommittee] thought people needed to have the basics first. Then puberty and development [to enable people] to explain sexuality to their kids. [Then] they included birth control, after people understood the other two sections. Finally, they included "how to become an accessible adult." The idea was, well, now that you have the information, now what?

The workshops were delivered in two-hour segments, with topics presented in the order listed in the sidebar on the previous page. In practice, the third topic—STDs, HIV/AIDS, and contraception and prevention—took longer than two hours to present. The final topic, "Becoming an Askable Adult," re-

New Orleans: *Healing Our Sexual Collective*

New Orleans Plain Talk developed an extensive workshop designed to take community members from being informed residents to being Walkers and Talkers. The curriculum included sections on common myths about sexuality within the community; anatomy and physiology; contraception; STD transmission, symptoms and prevention; homosexuality; and how to give a presentation.

Walkers and Talkers were required to complete the curriculum. Having done so, they gave Home Health Parties to small groups of residents, both adults and youth, in community homes. The hosts chose the topic of the workshop to be presented: the two subjects most often chosen were HIV/AIDS and STDs.

Workshops began with an icebreaker; then two Walkers and Talkers made a presentation on the topic, using large flip charts that illustrated their points and helped them remember the details. Questions and discussion were encouraged, particularly at the end of the workshop.

The site used several teaching techniques in the workshops to increase residents' knowledge. After one facilitator used a technical or medical term, the cofacilitator would follow up with the slang term, if there was one, so that people could connect the two terms and more easily remember the technical term. Also, Plain Talk staff or other Walkers and Talkers attending the workshops often asked clarifying questions of the facilitators. At times, someone would stop the session by calling for a "literacy moment," during which phrases or words would be defined.

At the end of each session, the Walkers and Talkers demonstrated the use of such protection measures as condoms and dental dams, and they encouraged the workshop participants to demonstrate the correct use of a condom (including such details as checking for holes in the foil wrapper and looking at the expiration date on the package) on a model of a penis. Refreshments were served at the end of the parties, and hosts or hostesses received a Plain Talk gift bag.

ceived short shrift until staff became aware that adult-youth communication was not being adequately addressed in the workshops.

Concerns about residents' lack of accurate knowledge about sexuality was also very important in the development of the New Orleans curriculum. (See the sidebar, "New Orleans.") Created primarily by staff who were residents of the community, the curriculum was designed to take community residents along a path from informed adult, to Plain Talk messenger, to Walker and Talker. Staff noted that many residents had inaccurate knowledge about sexuality, pregnancy and STDs, and it was important to correct common misperceptions by providing accurate information to both adults and youth. Because the curriculum was designed to be comprehensive, it included sections on how to make presentations and how to communicate clearly with others, as well as sections on sexuality.

When community residents went to workshops, however, they generally received information focused on sexuality, especially STDs or HIV/AIDS. In New Orleans, residents who agreed to host Home Health Parties were able to choose the subject of the workshop to be presented. In keeping with the concerns of the community expressed in public forums and in interviews, most of the people who hosted a party chose one of two related subjects: the transmission and prevention of STDs or HIV/AIDS. Although Walkers and Talkers were also trained to give presentations on anatomy and physiology, contraception, and communication, those subjects were rarely covered except in their practice sessions.

The lack of knowledge about sexuality that we observed among core group members in New Orleans and San Diego—and later among residents who went to the workshops— is probably fairly typical for residents in those communities. Previous research has suggested that American adults and youth have a great deal of misinformation about reproductive health issues. While the public school system provides some information, it is often shaped by the political contexts of cities and states and may be incomplete with respect to prevention or contraception (Brown and Eisenberg, 1995). Furthermore, the most complete information on contraception and prevention is

Atlanta: *Askable Parents*

The *Askable Parents* workshop was developed by a health educator to improve parent-youth communication about sexuality. Each workshop consisted of four topics (each topic was covered in two two-hour sessions, for a total of 16 hours). The four topics covered the importance of communicating with youth about sexuality, adolescent development, teen sexuality and how to speak with youth about sexuality. They were presented at CBWW in Mechanicsville.

One characteristic of the workshops was that the facilitator was responsive to participants' requests to discuss certain issues; thus, the workshops, although similar, were not all the same. They were also highly interactive. Role plays were used to examine participants' ideas about how and when to speak with youth, and the facilitator encouraged extensive discussion. The role plays and discussions were supplemented by videos.

provided in high school sex education programs, too late for youth who have already dropped out of school.

Given their low high school graduation rates and their cultural reticence to discuss sexuality, there are few places where poor Latinos, such as those living in Barrio Logan in San Diego, have the opportunity to receive formal, fact-based information about reproductive health. In New Orleans, conservative politics with respect to sex education curricula in the schools means that students do not receive complete information about contraception and STD prevention through their classes.

Improving Communication Skills: Seattle and Atlanta

In contrast to the curricula developed in San Diego and New Orleans, the Seattle and Atlanta curricula were developed to improve communication between parents and their children, particularly (although not exclusively) around issues of relationships and sexuality.

Both of these curricula were developed by professional health educators; in both sites, practical and philosophical concerns shaped their development. These concerns included an observed need for better communication between parents and youth; a desire to implement the workshops in schools and churches; and a belief that communication skills had to be improved before addressing needs for accurate information about sexuality, contraception and prevention.

In Atlanta, staff from the Teen Services Division of Fulton County Health Services, who developed the *Askable Parents* workshops, explained that the original impetus for the workshops came from concerns expressed by both adolescents who visited the clinics and their parents about their needs for better communication. (See the sidebar, "Atlanta.") The workshops were designed to be implemented in churches and schools in Fulton County and not exclusively in Mechanicsville. As a result, the developers were sensitive to the fact that providing information about contraception might prove too controversial:

Seattle: *Plain Talk for Parents*

Plain Talk for Parents was developed by a health educator to improve parent-youth communication, particularly on issues of social and sexual development. Each of the four workshops consisted of four separate one-hour sessions (for a total of 16 hours). They were facilitated by the site's professional health educator in three local elementary schools, beginning in May 1995. The four workshops covered topics on "personal boundaries," dating and relationships, HIV/AIDS and decision-making.

The facilitator used cartoons to spark discussion. Each week, as a way of exploring their attitudes and thoughts, participants completed cartoon exercises that consisted of two or more figures (often an adult and a youth) with blank speaking and thinking "bubbles" above their heads.

Participants in workshops filled in the bubbles. At the end of each session, they were given "homework"—blank cartoons they were supposed to fill out with their children. The theory behind the exercises was that the cartoons would provide youth and their parents an opportunity to have a serious discussion about sexuality or social development, thus opening the door for future communication. Parents presented the results of the discussions with their children at the subsequent session of *Plain Talk*.

> My focus is the communication. Now, when you get into issues of birth control, parents can be very [moved her hands in an agitated way]; my focus is nonthreatening. That other stuff might have to be written in later—but if you put in something about birth control, parents are going to be very uptight.
>
> *Developer of the Askable Parents curriculum*

In Seattle, Plain Talk staff explained that parents need to be able to teach children about healthy relationships in general. (See the sidebar, "Seattle.") Thus, the primary goal of the *Plain Talk for Parents* workshops was:

> To help parents improve communication about healthy relationships and sexuality. Friendship education comes before sex education. If we can't teach youth to be responsible in a platonic relationship, they can't learn this in a sex relationship. We have to make sure the foundations about how to be a good friend are in place before we expect them to use a condom in a sexual relationship. [Youth] have to know ethics of relationship (not just condom use)—without it, you can't go far in sex education.
>
> *Plain Talk staff member in Seattle*

As in Atlanta, the Seattle Plain Talk staff wanted to field the workshops in local schools:

> What we're trying to do is establish a communication link between parents and kids ... Our philosophy is that once that has been established, down the road prevention is something that you want to make sure parents understand ... There is a public health department which can offer all kinds of information about prevention.
>
> *Plain Talk staff member in Seattle*

> Well, in the class I demonstrate the condom and say how it can prevent AIDS and STDs and pregnancy if used correctly ... They have that awareness. But because we want to respect the cultural values of all the different parents, we've not specifically created a cartoon, for instance, of a character holding a condom.
>
> *Developer of the Plain Talk for Parents Curriculum in Seattle*

Thus, in two sites, residents took the lead in shaping the focus and content of the community education workshops, whereas in the other two, professionals developed the workshops and no residents were involved. Table 5.2 shows that the similarities between San Diego and New Orleans and those between Atlanta and Seattle were not limited only to the focus of the workshops and who developed them. In Atlanta and Seattle, the workshops were designed for parents; in San Diego and New Orleans, in contrast, the workshops were targeted more generally toward community adults and youth. The role of residents in focusing the workshops and determining the target audience is discussed below.

Other Community Education Strategies

In addition to the community education workshops, most of the sites also developed other forums for educating residents. For two summers in Atlanta, the CBWW ran a youth leadership program that addressed, among other issues, responsible sexual decision-making. Youth worked on projects together, heard speakers and received stipends for their summer's participation. The program was partially funded by Plain Talk, and two Plain Talk core group members who had extensive experience working with youth became counselors in the program. In addition, the summer program was an incentive for parents to get involved in Plain Talk, since they could sponsor their own or other people's children for the program.

Seattle developed a *Plain Talk for Parents and Kids* workshop alongside *Plain Talk for Parents*. The curriculum emphasized "setting personal boundaries" and learning how to communicate boundaries to others. The site held eight workshops in 1996.

In Hartford, a Health Concerns Group met every two weeks over the course of the initiative to discuss a range of issues, including substance abuse and AIDS, that concerned residents. Outside speakers were invited to give presentations, and the entire community was invited. According to the site's records, 223 adults attended at least one session from 1995 to 1997. In addition, the site held two workshop series in 1996 that focused on parent-youth communication and teen sexuality.

San Diego developed an extensive teen pregnancy prevention program that complemented the work of Plain Talk. In 1996, the site received a "male involvement" grant from the California Office of Family Planning, with which they implemented a male peer education program and a public relations campaign. Smart Teens Educating Peers (STEP), the peer education program, was closely tied to Plain Talk; it was seen as the youth complement to the adult component and was based on similar theories of community change. Adolescent males who participated in the program were trained in ways similar to those used for the *Promotoras*. In 1997 the site received a grant to expand its peer education program to girls.

POLITICAL CONCERNS AND MORAL AUTHORITY IN THE DEVELOPMENT AND DELIVERY OF THE PLAIN TALK MESSAGE

Observers of community initiatives frequently remark on the "insider-outsider tension" that exists between funders and site participants (The Aspen Institute, 1997). The term refers to conflict or tensions over who has decision-making authority. In some Plain Talk sites at particular points in the initiative, this kind of insider-outsider tension existed with respect to decision-making.

Table 5.2
Resident Participation and Target Audience in Workshops

Site	Focus of community education workshops	Residents involved in curriculum development?	Workshop facilitators	Target audience
San Diego	Information about sexuality and reproductive health	Yes	Mix of residents and professional staff	Community adults
New Orleans	Information about sexuality and reproductive health	Yes	Residents	Community adults and youth
Atlanta	Improving communication skills	No	Professional staff	Community adults, including parents*
Seattle	Improving communication skills	Minimal (feedback on early drafts)	Professional staff	Parents of fourth to sixth graders

*The curriculum was designed for parents, but site staff invited all community adults to attend. Many participants were not parents.

But more relevant here, we observed in Plain Talk another kind of insider-outsider dynamic: insiders felt authorized to take a moral stance on the need to protect sexually active youth and to challenge other residents to learn more about sexuality, whereas outsiders were hesitant to do either. Thus, the tension did not center on who could make decisions about the community's needs and the services to be provided; instead, it centered on who could speak to the community and what could be said. For the purposes of Plain Talk, insiders were residents and staff members (some with professional experience) who lived in the community. They always shared the ethnic or racial background of the target population and tended to be working class or poor. Outsiders were professionals who lived outside the immediate community. They were often middle-class and sometimes of a different ethnic or racial background than people in the target community.

Resident insiders generally exhibited great concern about the level of ignorance about sexuality in their community. When they developed or facilitated workshops, they were very sensitive about the need to define terms and provide knowledge for other residents. For example, resident leaders

in the New Orleans Plain Talk community perceived language to be a powerful tool that could be used to intimidate, and thus they felt responsible for ensuring that words were used to explain, not intimidate. They developed the notion of "literacy moments," in which workshop participants were encouraged to stand up and note that they did not know what a particular word meant and would like a definition. The person who had used the word was then responsible for giving a clear and easy-to-understand definition. Also in New Orleans, workshop facilitators used slang forms of words and cofacilitators followed up with the "correct" terminology, thus explicitly connecting different levels of language. In San Diego, great attention was paid to leaving plenty of time in workshops to identify and define parts of the body. At the end of the sessions, participants played a version of bingo in which the cards contained words that had been defined during the workshop. The definitions were read, and players put stones on the matching words.

Both sites thus saw providing information about the body, anatomy and physiology, and other reproductive concerns as an important endeavor, and they devised learning opportunities in these areas for community residents. In contrast, although staff who developed the *Askable Parents* workshops in Atlanta were also concerned that the sessions be geared toward people with limited literacy, the solution proposed for dealing with this issue was to reduce the language level required by the workshops instead of identifying what people did not know and raising their level of knowledge.

Not only did residents believe that they had the right—in fact, the responsibility—to challenge others to learn, but they also thought that they had the moral authority to tell others how important it was to protect sexually active youth. *Promotoras* and Walkers and Talkers defined the problem of teen pregnancy and STD transmission as their problem and their community's problem. As residents, they felt authorized to take a particular moral stance in the local debate over teen pregnancy prevention. Also, perhaps because they defined the problem as their community's problem, the residents in San Diego and New Orleans had far fewer qualms about noting that there was a collective duty to create a new community consensus around protecting sexually active youth. Their workshops were thus broadly targeted at community residents. In New Orleans, the phrase "It takes a village to raise a child" became a mantra for the Plain Talk Walkers and Talkers, and we heard it repeatedly during our visits.

In contrast, the professionals took a more "outsider" perspective and were sensitive to possible political problems in delivering a morally controversial message. When professionals led the development of the community education workshops, they tended to downplay the controversial message of protecting sexually active youth, since they were concerned that the community would not otherwise accept the workshops. For them, it was enough to supply parents with information about communicating with their children.

Thus, the Seattle developer of *Plain Talk for Parents* did not include in the curriculum a cartoon that involved the use of a condom, for fear of offending the Cambodians. Likewise, the developer of the *Askable Parents* curriculum emphasized that parents have very different parenting styles that must be respected. Given the current national discourse on the need to respect individuals'

cultural diversity and the sovereignty of the family, it is easy to understand how sites that rely on outside professionals may hesitate to deliver messages that could be perceived as insensitive to cultural norms.

The professionals' approaches toward cultures other than their own appeared appropriate. American social history, particularly up until the 1960s, is full of reformers who focused their energies on changing the behaviors of poor individuals to ameliorate their social conditions. Reform movements of the early twentieth century tended to demand that the working class or poor— often immigrants or people of color—give up social behaviors perceived as maladaptive to middle-class American culture. In the 1960s, the civil rights movement focused attention on analyses of social life that argued that social structures and social institutions oppress individuals; the cultures of minority groups and individuals are to be respected and preserved, not changed. Since the 1960s, the pendulum has swung back the other way to some degree as people focus their attention again on how individual behavior can be changed. The result is an ongoing debate about how much responsibility for change is the individual's and how the social service provider can effect change in individuals while respecting cultural values—especially values that center around an issue perceived as a private one. It is in this context of social reform that the relatively values-free approach taken by the professional health educators can be understood.

The insider-outsider dynamic existed across all sites and was not exclusive to Seattle or Atlanta. The difference was not in whether the dynamic existed but in who developed and implemented the workshops. The participation of community residents in San Diego and New Orleans appeared to significantly reduce the unwillingness of those sites to be explicit with adults and youth about pregnancy, disease and prevention, although professionals in the two sites were sensitive to possible political repercussions.

An unusual event that occurred in San Diego highlights the differences between resident insiders and professional outsiders in delivering controversial messages. The site received a series of educational slides about STDs that had been developed by the Centers for Disease Control. The slides included a series of graphic photographs of genitalia that showed symptoms of advanced cases of syphilis, genital warts, herpes and other STDs. During the second implementation year, *Promotoras* began to use the slides in community and in-home workshops at which both adults and youth were present. The slides were a big draw to the workshops, and both youth and adults were fascinated by them. One afternoon, two health educators, a *promotora* and an outreach worker gave a community workshop to a group of youth. The outreach worker and *promotora*, both community residents, wanted to show the slides, but the health educators explicitly instructed the outreach worker not to do so. However, when key staff left while the workshop was still in progress, the outreach worker showed the slides. When administrative staff became aware that the slides had been used, the staff member was terminated and further use of the slides was halted. When asked why he showed the slides, the staff person said

> Well, I wasn't going to, but then I decided to ... This is reality ... These kids need to see reality ... I like to tell it like it is.

The outreach worker felt empowered to show the slides because he was a community resident. From the perspective of the *Promotoras* and other community residents, the loss of the slides as a workshop tool was unfortunate. One *Promotora* reported that the mothers in a workshop group had really wanted to see them, "since they'd heard about them from their kids who'd gone to the previous workshop," and she couldn't understand why the staff was opposed to showing them. From the professional staff's perspective, however, showing the slides was extremely dangerous; one staff member reported she was "horrified" to learn that the slides had been shown to a group of youth and "kept expecting to hear from outraged parents."

The episode also highlighted the tensions inherent in hiring residents and expecting them to follow the norms and culture of the professional environment while simultaneously expecting them to draw on their insider status to do their work. Because New Orleans and San Diego were the sites with the strongest commitment to training residents to do professional and semiprofessional work, they were the sites that grappled most often with the potential contradictions between doing the work of Plain Talk both in a professional way and in a way that was sensitive to the norms of the community.

Just as professional outsiders across sites were hesitant to deliver controversial messages, resident insiders who were core group members in Atlanta and Seattle (along with staff who were residents) were more willing to be controversial than those sites' approaches suggested. Their ability to do so, however, was restricted by their limited involvement in implementing community education strategies. For instance, in Atlanta, a long-time core group member who attended the first *Askable Parents* workshop series in Fall 1996 had a lively debate with the facilitator over whether it was "all right to tell kids not to have sex." The core group member, a resident insider, took the position that it was not acceptable, since the important thing was to protect sexually active youth. The facilitator, a professional who lived outside the neighborhood, emphasized that parents had different values, and she was reluctant to impose her values on someone else.

Similar insider-outsider dynamics occurred in Seattle. There, the outreach worker for Plain Talk, who was Cambodian and identified herself as a community member, was able to form relationships with Cambodian elders in the community who could provide Plain Talk with some legitimacy. Although Caucasian staff members had approached the elders the previous year, their reception was largely negative, and the staff backed off. Initially, the outreach worker also received a negative reception when she made overtures to the group. If anything, the elders treated her far more harshly than they had treated the white staff members. They ridiculed her for having taken the position as outreach worker—a job, they said, that no one else in the community would have—thus suggesting that she was an outsider since she was different from all others in the community. The outreach worker was quiet and let the elders have their say. Then she explained to them, "If you love your kids, you need to teach them about safe sex." She continued to make overtures to the elders until she persuaded them of the importance of Plain Talk. Ultimately, they became involved by helping her translate the community mapping survey into Cambodian and helping her reach other adults in the community.

CONDUCTING OUTREACH TO BRING RESIDENTS TO THE WORKSHOPS

Once sites had trained or hired health educators, developed their workshops, and scheduled them, their next step was to attract residents' attendance. Sites used a variety of methods to bring participants to the workshops, and the effectiveness of the strategies varied. In the sites in which there was considerable resident involvement in activity implementation (San Diego, New Orleans and Atlanta), informal, word-of-mouth outreach was the most productive strategy for generating lists of people who were willing to attend community education sessions. In all three sites, there were several core group members who had been trained to give workshops who also had large networks they could tap effectively. In San Diego, for example, one *Promotora* worked as a community aide in a local school, and she came into contact with many parents whom she recruited for the workshops. Similar people existed in New Orleans and Atlanta.

Door-to-door canvassing—which was tried in Atlanta, San Diego and New Orleans—was not very effective,[15] but other methods were more productive. In Seattle, the outreach worker built relationships with Cambodians in the community when she addressed some of their basic needs and acted as an advocate. In exchange, she was able to get the residents to attend *Plain Talk for Parents* workshops. In San Diego, staff and core group members sat at tables during community events, signed up people for workshops, and then followed up by mailing calendars of events and making telephone calls. In New Orleans, Plain Talk staff initiated a series of "community walks" one summer, during which they canvassed the community and gave out flyers at different times of day. Their walks sparked curiosity among some residents and resulted in several Home Health Parties. In both San Diego and Seattle, staff inserted information about Plain Talk workshops that were going to be held in the schools in flyers that those schools were sending to parents.

In 1997, Atlanta implemented an unusual outreach method. By mid-1996, Atlanta site staff had deemed the task of training resident facilitators too difficult, given the slowness with which San Diego and New Orleans had completed this task. (Atlanta Plain Talk started implementation six months after those sites and thus was able to observe their progress.) The staff decided to use professional facilitators for the workshops and to train residents to do formal outreach in the community—both door-to-door outreach and a more personal outreach through Plain Talk Parties. The idea behind the parties was that core group members would make a presentation, using a communication strategy of their choice (e.g., role plays, discussions or skits) that illustrated the extent of the teen pregnancy problem in Mechanicsville and emphasized the need for greater

[15]In Atlanta, before the beginning of the *Askable Parents* workshop series, staff trained community residents specifically to go door-to-door and give a short explanation of what Plain Talk was and the activities it sponsored. The site had identified 140 families with adolescent children in the community; and during one outreach blitz the 10 residents who were trained as outreach workers reported that they were able to recruit almost all of them for at least one of the Plain Talk activities. While adults from some of those families did attend the activities, they reported that they were recruited by informal word of mouth from relatives, friends, and parents whose children attended the local elementary school—not through the door-to-door outreach. In fact, they may have been recruited through both methods but reported the one that was most meaningful to them.

parent-youth communication. While the strategy never really resulted in much recruitment to *Askable Parents* workshops, it kept enthusiasm for Plain Talk high among the core group members, and they were key in the site's recruitment successes. In fact, among the new participants to the *Askable Parents* workshop series that began in fall 1997, almost all reported that they had heard about Plain Talk through core group members.

Seattle differed significantly from the other sites in the way it conducted outreach. After the first year of implementation, staff primarily relied on two outreach workers who actively recruited parents by calling them and by placing ads in the school newsletters that were distributed to parents. They also used lists from the schools' PTAs to contact parents.

Despite the variations in strategies, bringing residents into workshops was not a significant challenge to any of the sites. While, as we discuss in the following chapter, there was variation in the number of workshops that sites were able to hold, as well as in the overall number of residents they were able to attract, the differences resulted primarily from the fact that using Walkers and Talkers and *Promotoras* vastly increased sites' capacity to offer workshops, not from differences in outreach methods.

VI. THE EFFECTS OF RESIDENTS AS WORKSHOP FACILITATORS

By the end of implementation, Atlanta, New Orleans, San Diego and Seattle were all able to offer community education workshops that were often well attended by community members.[16] Table 6.1 describes the approximate number of workshops that each site was able to implement and the total number of participants. The results are striking. Sites that used professional facilitators (Atlanta and Seattle) were able to begin workshops soon after deciding who would facilitate the workshops and thus spent less time and fewer resources training core group members. However, the advantage of starting sooner was quickly overcome by the advantage of having multiple facilitators. Both San Diego and New Orleans spent the first one-and-a-half to two years of implementation in training community residents to give educational workshops on sexuality, STDs and contraception. Soon after they began giving community education workshops using resident facilitators, however, they surpassed—in both the number of workshops they held and the number of people they reached—the sites that relied on professional facilitators.

For instance, Seattle began to implement community education workshops in May 1995 and scheduled them regularly through April 1997. In that period, the site implemented approximately 30 workshop series and served approximately 300 people. In contrast, San Diego implemented its first workshop series in November 1995. By the end of April 1997, the site had implemented close to 60 workshop series and served over 700 people. Part of the difference was that San Diego had two paid staff who could give community education workshops, whereas Seattle had only one, but the contribution of the *Promotoras* was significant. They facilitated all the *Vecino-a-Vecino* workshops during that period and some of the community education workshops. Although the site was late in getting started (and even though, until spring 1996, the site was not using *Promotoras* to give workshops), once it did get started, the advantages of having multiple facilitators became clear. Thus, in one very tangible way, the time devoted to training residents to give workshops produced positive results.

Although a formal cost study was not part of the evaluation, the cost of providing community education workshops using San Diego's approach appeared to be roughly equivalent to Seattle's. In San Diego, *Promotoras* received a stipend in the form of a gift certificate for $250 to a local merchant for each *Vecino-a-Vecino* or community education workshop series they facilitated. (It took each Promotora approximately 20 hours to prepare and give each workshop series.) In addition, the site gave each hostess a small stipend to provide refreshments and a gift certificate for hosting the workshops in her home. During the demonstration period, the site held more than 110 four-part workshop series, with over 1,000 participants. The cost per person of the workshops facilitated by *Promotoras* (about 80 total, with approximately 800 participants) was

[16]Because it employed a different community education strategy, Hartford, again, is not included in this discussion.

Table 6.1
Number of Workshops and Total Participation

Site	Emphasis of workshops	Number of sessions in each workshop series	Hours per session	Number of series given by site 1996-1997	Approximate number of adult participants in all workshops[a]
Atlanta	Communication	8	2	3, facilitated by staff	~125
New Orleans	Knowledge	1	1	> 100, facilitated by community residents	~800
San Diego	Knowledge ----------	4 ----------	2 ------	~110 ; 80+ were facilitated by residents ----------	> 1,000 ----------
	Communication[b]	1	2	23, facilitated by staff	350
Seattle	Communication	4	1	~30 ; facilitated by staff	~300

[a] In some sites, the numbers of participants include duplicate counts of residents who attended workshops more than once. For instance, we know that in Atlanta, most of the people who received Plain Talk Party Host training after going through the first *Askable Parents* workshop also participated in the second workshop series.

[b]During 1996 and 1997, the health educators who worked for San Diego's *Hablando Claro* recognized the absence of a communications piece in the workshops, despite having a section titled "Becoming an Askable Adult." They put energy into developing and piloting a separate communications workshop, which was given by the health educators themselves. (They explained that it was very difficult to teach the *Promotoras* how to give the communications workshops.)

about $30, including the stipends paid to the *Promotoras* and the workshop hostesses. The cost per person of the community education workshops was considerably lower, since refreshments were provided but there were no stipends (unless the workshop was facilitated by a *Promotora*).

In Seattle, by contrast, the nonstaff expense for each workshop was the $25 stipend that each participant received at the end of the four-part series. Although San Diego paid more in stipends, staff at that site spent less time organizing and facilitating workshops than did staff in Seattle. Staff salaries were also higher in Seattle. Overall, San Diego probably spent less money implementing its workshops and reached more residents than Seattle did. In addition, San Diego created a core of lay health educators and was thus less vulnerable to disruption in its community education schedule should trained facilitators or professional staff leave Plain Talk. The Seattle health educator did ultimately leave the lead agency, which disrupted the site's community education efforts for several months.

ARE RESIDENT LAY HEALTH EDUCATORS EFFECTIVE WORKSHOP FACILITATORS?

The extent of community participation is only one way of examining the effect that resident facilitators had on the workshops. One concern that site and AECF staff had about training residents to give education sessions was whether they could deliver high-quality workshops. If they could not, it would not matter how extensive their reach into the community was. Thus, in examining the workshops that residents delivered, we ask a number of questions:

- Did facilitators effectively convey the importance of communicating with youth about issues of sexuality?
- Did facilitators present accurate information about STDs, contraception, STD prevention, pregnancy, and anatomy and physiology?
- Did facilitators present information in ways that were easily understood by the participants?
- Were participants given opportunities to ask questions?
- How did facilitators respond to questions to which they did not know the answers?
- How did the participants respond to the workshops?

To answer these questions, we rely on information from observations of workshops, interviews by P/PV staff and ethnographers, and information provided by the sites themselves. Because our interest is in the quality and effectiveness of resident-facilitated workshops, the discussion focuses on the experiences in the San Diego and New Orleans Plain Talk sites.

Did facilitators effectively convey the importance of communicating with youth about issues of sexuality? Perhaps because the workshops in both San Diego and New Orleans focused on providing knowledge about sexuality and STDs to people in the community, the facilitators did not always emphasize the importance of communicating with youth about these issues. San Diego *Promotoras* were more likely to discuss the importance of communicating with youth about

sexuality than were New Orleans Walkers and Talkers. In San Diego, facilitators usually began the first workshop by explaining that the community mapping had shown that many youth were sexually active and did not often communicate with adults about sexuality. Throughout the four-part series, the facilitator (or the staff who provided support in the workshops) occasionally mentioned the importance of remembering that, even though the adults in the workshops might not like the idea of talking about contraception for sexually active youth, the reality was that if youth were sexually active, they should protect themselves.

In their workshops, Walkers and Talkers in New Orleans always noted that Plain Talk was an initiative designed to protect sexually active youth, but they did not always emphasize the importance of communicating information to youth. Although community mapping was also done in New Orleans, the site did not use the information in its community education strategies. Walkers and Talkers would occasionally comment, however, on some of the health problems facing the community and the need to address the problems.

Did the facilitators present accurate information about STDs, contraception, STD prevention, pregnancy, and anatomy and physiology? The information presented in the workshops was generally accurate in both sites. San Diego used professional health education staff to monitor the workshops given by the *Promotoras*, and this proved very effective in ensuring the accuracy of the information that was presented. Staff in both sites encouraged the resident facilitators to read materials that were available in the Plain Talk offices and held ongoing training sessions to increase the facilitators' knowledge.

Did the facilitators present information in ways easily understood by the participants? Both sites developed techniques for communicating sometimes complex medical and scientific knowledge to groups of lay people. In San Diego, the fact that residents developed the curriculum and accompanying materials meant that there was great sensitivity to what information needed to be carefully explained. *Promotoras* explained information clearly, using both medical-anatomical terminology and slang terms to help participants make the connection between terms. At the end of sessions, participants played *Hablando Claro* Bingo, an activity that helped reinforce their memories about the terms and concepts that had been introduced in the session.

Although New Orleans worked very hard to present information clearly to community residents, certain workshop materials were written in ways that made the information difficult for the Walkers and Talkers to present. While the flip charts used by the site were helpful visual aids, facilitators tended to rely heavily on the explanatory blurbs on the back of the flip chart instead of using their own words to present the information. It helped to have cofacilitators who asked questions and helped the facilitator to slow down, but this strategy did not completely solve the problem of the material's inaccessiblity. In addition, the site did not have the staff capacity to train the Walkers and Talkers beyond a certain level of knowledge. There were discussions with the local health clinic about the need to provide more training, but advanced training sessions had not been implemented by the end of the funding period.

Were participants given opportunities to ask questions? In both sites, participants were encouraged to ask questions. In New Orleans, participants and Walkers and Talkers often engaged in an extended question-and-answer period or an extended discussion after the formal workshop had been presented and during the time when the group was relaxing and eating the food that was always served. In San Diego, the people who developed the workshops were initially concerned that participants would hesitate to ask questions given the cultural silence around sexuality. Thus, people were encouraged to write questions on paper at the end of every session, and the questions were answered in the succeeding session by the *Promotoras*. This practice was extremely effective in eliciting a broad range of questions, and after a couple of sessions people became much more comfortable asking questions during the workshops. The following are examples of the written and verbal questions:

- Are X-rays harmful during pregnancy?
- Could one get pregnant during a menstrual period?
- How does one talk with young kids about their bodies and sex?
- What does it mean when there is a bad odor during sex?
- If someone in the family has AIDS, can other family members get it?

In general, the range of questions asked during workshops—from questions about diseases and infections to questions about development and anatomy—illustrated both how little the residents knew about sexuality and how comfortable they were in asking.

How did facilitators respond to questions to which they did not know the answers? People in both San Diego and New Orleans inevitably asked questions to which *Promotoras* or Walkers and Talkers did not know the answers. This was a concern that Plain Talk staff who trained the facilitators had voiced early on: training residents to provide information was a high-risk, expensive undertaking that would be made worse if the *Promotoras* or Walkers and Talkers spread misinformation when they gave workshops. In both San Diego and New Orleans, staff emphasized that if facilitators did not know an answer, they should not feel they had to make a guess. Instead, facilitators were told to say they would find out the answer. In San Diego, when *Promotoras* were unsure of the answer to a question, they turned to the health educator who was present at the workshop to provide support. By encouraging written questions, San Diego also provided an opportunity for *Promotoras* to find the answers to questions they did not know before going into the next workshop. In general, the sites' approaches to ensuring that facilitators gave accurate answers, or no immediate answers, were successful. Facilitators rarely guessed at answers during workshops.

How did the participants respond to the workshops? Participants in San Diego and New Orleans responded positively to the workshops. They reported that they thought the quality was good and that they felt more comfortable speaking with youth about sexuality than they had before. It is difficult to know whether their comfort levels translated into actual changes in behaviors in their discussions with youth, and, if so, whether those discussions were helpful to the

youth in encouraging them to become sexually responsible. (This second question can be addressed only through analysis of the follow-up survey.)

In San Diego, in addition to participants' reports that they felt more comfortable talking about sex, their responses to pretests and posttests also indicated that their factual knowledge about sexuality had increased significantly. For instance, the sites' analysis of pretests and posttests of Plain Talk workshops concluded that 30 percent of adult workshop participants responded correctly on the pretest to the question, "Gonorrhea can cause permanent sterility (not being able to have children)." The number rose to 70 percent on the posttest. While not all of the knowledge-based questions showed increases quite that large, almost all showed substantial increases of 20 to 30 percent.

The Effectiveness of Resident Facilitators

Resident-led workshops were very effective in providing other community residents with basic knowledge on a number of subjects. Although some facilitators were more comfortable and skilled in giving workshops than others, there was no doubt that the sites could train residents to give accurate and clear information on a number of topics. We have shown that several strategies were effective in helping the sites overcome some of the challenges they faced in using residents as facilitators, as well as in dealing with the challenges involved in helping workshop participants understand as much of the material as possible. These were among the strategies:

- Carefully assessing whether the residents who had gone through training were ready to become facilitators was key to ensuring the quality of the workshops. San Diego, which graduated only five *Promotoras* over 18 months, was particularly concerned about choosing people deemed ready to facilitate workshops. The presentation skills of all five were very good. (One of the *Promotoras* was illiterate; staff had initially doubted that she would be able to succeed but soon discovered that she compensated for her illiteracy by having excellent verbal recall.) As we have noted, New Orleans relied more on whether Walkers and Talkers had completed the training sessions than on individual assessment of each one's readiness to give workshops. As a result, while some of the Walkers and Talkers were very good at facilitating workshops, others were less skilled.

- Ongoing and increasingly advanced training was important for the resident facilitators. In San Diego, the site took two approaches to providing ongoing training. First, having workshop participants write down their questions, which the *Promotoras* researched before the next session, meant that the resident facilitators were continually increasing their knowledge. San Diego also held weekly meetings, where the *Promotoras* discussed the workshops and prepared for upcoming sessions.

- Having workshop participants write down their questions increased participants' comfort as well as their knowledge—since it allowed time for resident facilitators to research questions to which they did not know the answers.

- Having staff attend resident-facilitated workshops ensured that workshops were of high quality and provided the facilitators with support, if necessary. Staff were also able to identify challenges facing the facilitators that needed to be addressed. One risk of having staff present, however, was that they occasionally took over the workshop from the facilitator. Some facilitators were better at avoiding this than others.

DELIVERING THE PLAIN TALK MESSAGE

As we have described in this report, staff across all sites consistently communicated to community core group members that it was important to protect sexually active youth; and in order to do so, it was key that adults—both parents and others—communicate clearly with youth about sexuality, including providing information about contraception and STD prevention. This message was delivered with great intensity, and over several years, to core group members during the planning and early implementation period. As a result, a consensus was achieved among the people in the core groups that it was important to protect sexually active youth, even if community adults did not personally approve of sexual activity among youth.

The Plain Talk model posited that creating broader community consensus could be achieved by communicating to a larger group of residents that a significant portion of the community's adolescents were sexually active, were therefore at risk for pregnancy and contracting disease, and needed to know what to do to protect themselves. This message was to be disseminated primarily through the education workshops. Thus, looking at what was said to participants in those workshops is key to understanding what was communicated by the sites as they moved beyond the core group.

In all four sites that gave Plain Talk workshops, staff believed that adult residents needed both information about sexuality and reproductive health and training in communication skills to convey that information to youth effectively. However, they differed in their beliefs about what the first steps toward achieving change should be and that, in turn, affected the focus of workshops in the sites and the way the Plain Talk message was delivered. The two sites that stressed communication skills as a prerequisite for improving communication between adults and youth around issues of sexuality tended to focus much less on the idea that community youth who were sexually active needed to be protected. In contrast, in the two sites where workshops were developed and delivered by residents, facilitators were more likely to emphasize the need to protect sexually active youth. There, resident facilitators felt authorized to stress this point to other community residents, but they were less likely to emphasize adult-youth communication and discuss how youth needed to receive clear and consistent messages from adults.

The full Plain Talk message was thus fragmented in all the sites when it was delivered in workshops. It is difficult, however, to know how much the fragmentation of the message matters to the desired goals of the Plain Talk initiative. In knowledge-based workshops, the tendency to ignore the importance of communication was usually an oversight. When it was brought to their attention, staff in San Diego developed a separate communication workshop (about which we

know relatively little, since the workshops were implemented after most of the research was completed and after the Spanish-speaking ethnographer's work was done).

In the communication-centered workshops, the tendency to downplay the protection message was accompanied by a hesitancy to make controversial statements within potentially conservative institutions or to impose values on residents who might find the values abhorrent. Professional health educators' reluctance to tell community residents that it is important to protect sexually active youth suggests that, for Plain Talk to be effective in creating community consensus, residents must be willing to speak with others—adults and youth—about youth development, adolescent sexuality, contraception and disease prevention. In the next chapter, we look at how community members who had been involved in Plain Talk spoke informally with other adult and youth residents about sexuality.

VII. INFORMAL OUTREACH IN THE COMMUNITY

Core group members were given the mandate to go into the community and spread the Plain Talk message, and they took this responsibility very seriously. In the original Plain Talk model, the primary objective of the core group training (described earlier in this report) was to prepare the members to give formal presentations. Both Plain Talk project directors and core group members, however, saw that the trained members could also play a more informal, but no less important, role: talking to other adults and youth in an effort to mobilize the community, change attitudes and build consensus around Plain Talk goals.

Although Plain Talk staff encouraged core group members to carry the Plain Talk message to their neighbors and families, records of this kind of activity were not kept, and thus it is difficult to assess the precise frequency of these interactions. But we can point to a number of key issues regarding informal outreach as a dissemination strategy. It is clear that some core group members in each site did at least some informal outreach. Some members recruited people to Plain Talk activities; others spoke of Plain Talk as they interacted with their friends, neighbors and relatives during the course of their daily lives; a few spoke to youth in their capacity as paraprofessional youth workers. Many took their role as Plain Talk messengers very seriously and reported that they talked about Plain Talk "all the time."

The trained residents' one-on-one dialogues with other community members proved a powerful way of disseminating the Plain Talk message. Data from interviews with core group members who were asked to describe these conversations reveal that they conveyed the importance of Plain Talk's objectives to others accurately and with sincere conviction, and the conversations often had the effect of influencing the person to whom they were speaking. These data also show that many core group members were playing a critical role as informed adult confidants—or "askable adults"—with youth who otherwise had no adults to confide in. In fact, comparing the way core group members spoke with their own children to the way they spoke with other youth reveals that teens prefer not to discuss some areas of sexuality with their parents, even if their parents have become more knowledgeable and accepting of teen sexuality.

This chapter examines the informal outreach activity of Plain Talk core group members and describes conversations they had with other community adults, teenage relatives, other teens and their own children. Most of our examples come from Atlanta, New Orleans, Hartford and San Diego. Core group members in Seattle also reported talking to other adults in their communities and to their own teenage relatives. However, reports of those group members talking to other community youth were rare. As we explain at the end of the chapter, the Seattle Plain Talk site had a very different community ethos than that of the four other sites, one that considered discussions with children about sex as the exclusive responsibility of the family.

TALKING TO OTHER ADULTS IN THE COMMUNITY

While core group members reported giving information to community adults about many aspects of Plain Talk, the most frequently reported topics of conversations were the symptoms and prevention of STDs, including HIV. The spread of STDs is a major concern in the Plain Talk communities, and the training that core group members received made them important sources of information. As two Walkers and Talkers in New Orleans reported:

> [Before becoming involved in Plain Talk], I didn't know what to tell people about STDs because it wasn't stuff I knew about. [Even] if I knew about it, I didn't know about how to tell people the information. Now I know, and I can just walk up and be talking.

> Oh, [my friends] basically knew a lot, but I'm able to share more information with them, especially around diseases and using protection.

In talking to other adults, core group members reported that they often corrected misinformation about the symptoms and transmission of STDs and stressed the importance of using protection at all times. For example, when the brother of one Walker and Talker proudly announced that he had decided to limit the number of his sex partners in an effort to reduce his risks of contracting an STD, his sister, fresh from facilitating a Home Health Party, quickly responded, "Well, you better be using that condom, even with one [partner]. You don't know who all she's been with before you." A male core group member in Atlanta reported that he frequently talks to his friends about the need to practice safe sex: "Our last conversation we talked about protection. A person was sleeping with someone without protection. I was going to persuade them I was not going to sleep with anyone without protection."

Because getting male involvement in Plain Talk was especially difficult, having male core group members talk to their male peers in the community was vital. One male Walker and Talker in New Orleans said that other men in his community told him, "We need more men like you. We need more men to be stressing this stuff because these STDs is a big problem." Emphasizing the importance of males acting as Plain Talk messengers, this Walker and Talker told us, "And I think that, far as the males, they need someone. Where a female couldn't [talk] to a male, a male could [talk] to him to make him understand certain things that's going on."

As these quotations illustrate, the focus on teens often got lost in these conversations, perhaps because many of the adults quoted above were young themselves and many had no children or only very young children—and they were talking to their peers about a critical health concern. But the message about the need to encourage sexually active youth to use protection was communicated as well, if somewhat less frequently. For example, in Atlanta and Hartford, core group members spread the word to other community adults about the new teen reproductive health clinics that opened in their communities. They also explained the importance of recognizing that teens will have sex regardless of adult wishes to the contrary, and that giving teens correct information about safe sex and contraceptives is a way to protect them.

One core group member in San Diego explained how she handles parents who resist this information:

> I've gotten some to change. I tell them that we don't tell people, "Here are the condoms." Basically, we teach them how their organs function and that you can control the desire to have sexual relations ... but if your kids decide to have sex, they will do it with or without information. But if they have the information, there won't be pregnancy or an infection. So I ask them, "What do you prefer? ... That a kid comes home and tells you she's pregnant and has AIDS, or that she's having sex but is using protection?"

Perhaps to reassure her neighbor, or perhaps because of her own deep ambivalence about Plain Talk's message, she added:

> This is only to let [the youth] know they can protect themselves ... Some people think that we're going to teach them sex positions or tell them to have sex! The most effective method we teach is abstinence ... That's the only 100 percent sure way not to get pregnant or a disease ... no other method is 100 percent effective.

Core group members also advised other adults about how to communicate more effectively with their children about sexual issues. Two young adult core group members in different sites described advising their own mothers about better ways of discussing sex with their younger siblings. Explaining how Plain Talk has affected the way she talks to her mother, one core group member in New Orleans reported:

> The focus is really my sister, the one right under me [sixteen years old]. I try to tell [my mom] that you have to trust her and talk to her the way I talk to her. Talk to her like you're her girlfriend, even though she won't see you as that. Let her know to not have sex with all kinds of boys, but don't scream and holler at her about it.

A core group member in San Diego corrected her neighbors if she felt they were making their children feel ashamed about their body's normal functioning or giving them misinformation about their sexuality:

> [A lady I knew] screamed at her little daughter for scratching her crotch, saying she was *cochina* [pig, disgusting]. I told her, "No, she's not *cochina* ..." I heard at school a lady tell her daughter, who had just started her period, that she could no longer get together with boys. I talked with her about a different way to talk with her daughter. *Hablando Claro* helped a lot.

Finally, a core group member in Hartford reported that she tried to tell parents who are "still in denial" about their teen's sexual activity to come to her if they find out their child is sexually active, and she will tell them how to handle it.

The experience of another Hartford core group member illustrates how one well-placed "messenger" can spread the word to many others. This woman, who had been a core group member since the beginning of implementation, went through the many months of training that the Hartford site offered. While she gave only one formal presentation in her home, she continues to talk about Plain Talk to her clients in her current job referring addicts for services. She said:

> I let folks know about the Plain Talk males group. I send kids from here over to the Plain Talk office so they can know about the [adolescent reproductive health] clinic—girls and boys. Sometimes I've sent parents; they come to me with questions, and I refer them to the Plain Talk office. For example, questions about sex, condoms—I pass them out—about the clinic, birth control, how to talk to kids about sex ... I send them to Plain Talk—I want them to learn. I give out Plain Talk brochures to people who come into my office. I post all of the Plain Talk flyers. I talk to them about STD prevention and teen pregnancy prevention. Some of the kids and parents think that birth control will prevent disease. I tell them it will protect against pregnancy, but not disease. I tell them the best way to prevent is abstinence. But we know kids won't go for this.

CONVERSATIONS BETWEEN CORE GROUP MEMBERS AND YOUTH

Fostering better adult-youth communication about sexuality is a key Plain Talk goal. Thus, the sites strove to create a community environment in which the adults with whom youth speak—both at home and in other contexts—communicate the importance of preventing teen pregnancy and STDs. Plain Talk core group members were well positioned to serve as these "askable adults," and many did so. They talked to youth in their capacity as Plain Talk representatives, in the course of their jobs or volunteer work (e.g., as paraprofessionals in schools), or as neighbors, aunts or uncles, and big brothers or sisters. They talked to the friends of their own children or to community youth they encountered in their neighborhoods in the course of their day. Many were adults to whom youth seem to gravitate or in whose homes neighborhood youth tend to congregate. Others were taking on this role for the first time. Plain Talk support staff and outreach workers, who were themselves community residents, also talked to youth. In addition, the Atlanta, San Diego, New Orleans and Hartford sites had activities for youth, and youth often hung out in Plain Talk offices at these sites.

Most of the reported conversations were between female core group members and female teens. It is clear that adolescent boys are less likely to confide in adult women about their sexual concerns, and the female core group members seemed less inclined to approach them. However, the male core group members we interviewed reported talking to male teens, and leaders of the Black Men United for Change (BMUC) in New Orleans made it a point to mentor young males.

There were differences among sites in both the youth whom the core group members talked to and the messages they gave. As stated previously, group members in Seattle were less likely to report conversations with community youth, although they did talk about sex and protection to their nieces, nephews and grandchildren. In San Diego, core group members' continued ambivalence

about Plain Talk's emphasis on protection rather than abstinence can be seen in the responses of many of the adults, whose advice often contained encouragement to remain abstinent. San Diego's core group was not alone in this regard. To a lesser extent, similar ambivalence and mixed messages were reported by core group members in Hartford, New Orleans and Atlanta.

Adults tailored the advice they gave depending on the youth's age and whether he or she was sexually active. Youth seemed to be receptive to their messages and their warnings. On the whole, if the youth was under the age of 15 or was not yet sexually active, the adult tried to convince the youth to postpone sexual involvement until he or she was older. However, adults understood that it would be useless to try to talk sexually active youth out of continuing to have sex; instead, they advised the youth to use protection. As a core group member in San Diego explained:

> My message is not to tell them to stop being sexually active if they already are, but to encourage them to protect themselves. And if they're not yet sexually active, to try to help them to put it off.

When trying to convince young teens to delay sexual involvement, most core group members would explain the risks of sex, especially the risks of contracting an STD. A core group member would occasionally be more forceful and use the risk of disease to try to scare the young teen away from sexual involvement, as in the following example:

> Me and my son were walking up the street. [A young girl] called me over, and I say, "What's going on?" She says, "Don't tell nobody." I says I won't. She says, "You know I'm going with such and such. He asked me to do it with him. I told him I'm going to think about it." She's only 14! I say, "You're too young to think about sex, you go to school. This is what can come out of what you thinking about doing—diseases." She said she didn't know that. [I told her], "Even if you use condoms, you could get diseases. Condoms pop. He could have anything. Only way is abstinence. You think about what I said!" A few days later, I saw her and she called me over. She said she changed her mind—she's scared. I hugged her, told her she could come to me.

Core group members also warned youth who were already sexually active about the risks of STDs and pregnancy. But rather than trying to dissuade youth from having sex by warning about the unreliability of condoms, they usually provided sexually active teens with accurate information about condoms and birth control methods or referred them to a clinic. As one core group member explained, they could help youth better if they were not judgmental:

> I've been working with teens all my life, and I've learned that kids will do what they want regardless of what you say, so why make it worse by condemning them? It's better to try to get them help. Sit down and talk to them, and if you can't get through to them, hopefully, someone else will.

The information provided was sometimes quite explicit:

> *Interviewer*: If you know they are already sexually active, how do you handle that?
> *Walker and Talker*: I get them protected. I get them some kind of contraceptives and the condoms that they have. I tell them to show this to the guys and let them put this on their penis. We also have the female condoms. I tell them to use them to be protected because they do not need all this disease and they do not need all these babies.

Core group members in Hartford, New Orleans and Atlanta also referred sexually active youth to adolescent health clinics. Some offered to escort youth to the clinic if the youth were reluctant to go themselves—if the core group member was sure that the youth's parents wouldn't mind. In New Orleans, one core group member told us, "We tell our youth, don't be afraid to go to St. Thomas Health Services. We'll go with them, as long as it's okay with the parents." In Atlanta, a male core group member who is personally opposed to birth control for religious reasons is nonetheless committed to Plain Talk to the extent that he refers sexually active youth to the site's Center for Black Women's Wellness (CBWW). In Hartford, a core group member who works with youth reported:

> I talk to the kids [in my youth group] all the time; they're my "daughters." One of them broke her virginity the other day and I found out and I talked to her about protection. I told her to go to the clinic right away. I have been talking to youth this way, but Plain Talk taught me how to do it more professional.

In San Diego, some core group members gave similar information to their teenage nieces or nephews but, on the whole, seemed more reluctant to give community youth detailed information about contraception. Only one San Diego core group member, a paraprofessional in a local middle school, said she referred community youth to a clinic. While she estimated that she had referred 50 to 60 youth to the Logan Heights Center's adolescent clinic, it is not clear how many of these youth were referred specifically for reproductive health services, as Logan Heights is a general health clinic.

Perhaps the most common situation about which young girls sought advice from core group members was how to handle their boyfriends' requests for sex. In cases where the boyfriend was several years older than the girl, or the girl was not yet sexually active, the adult usually tried to steer the girl away from sexual involvement. Whatever the situation, the adult's message was clear: "Don't let guys coerce you into having sex with them if you do not want to." The adult would try to make the girl think about whether she was simply caving in to pressure or whether she really wanted this for herself. The two quotes below show that, although the adults may have put different spins on it, their underlying message to the young girls was not to give in to sexual pressure.

In the first quote, a core group member from San Diego seems to convey the notion that boys who really respect girls do not ask for sex (suggesting that "good" girls don't cave in to such pressure):

> Every day [girls on the playground] come up to me. I am very affectionate [with them] because I never had affection ... For example, the other day a girl said to me, "I've been with my boyfriend for a year, and he said I have to show him I love him. What should I do?" I asked her if she thought that if he really loved her he'd ask for sex. This makes the girls think ... to react. This particular girl disappeared for two or three weeks, but then she showed up again and said, "I feel so clean, and I feel better."

In the second quote, a core group member counsels a young teen being pressured by her girlfriends to date someone much older than herself:

> One girl came in and said that a guy 23 wanted to talk to her [i.e., was interested in her]. But she was interested in a 13-year-old boy. She was 14. Her friends wanted her to go with the older guy because he could give her things. She asked me what I thought. I told her not to go out with the 23-year-old. "If you want to be friends with the 13-year-old guy, okay. Don't let no one persuade you to do things you don't want to do."

While most of the examples that were reported were encounters between female core group members and female adolescents, the male core group members we spoke with also told about giving advice to male teens. The group member from Atlanta who referred the young males he worked with to the adolescent clinic is one example. A second male core group member from Atlanta also reported giving teenage males advice about sex and protection. This young man, who tried to be a role model for young men and women in the community, was aware of the potentially powerful influence he could have on youth because of his age. He was just out of his teens and knew that youth would be more likely to listen to him because he was close to their age and experience:

> I talk with teenagers all the time. I guess ... when teenagers see you in the community, and they see that you're a role model, they can come and talk to you about everything. So teens feel comfortable, and a lot of guys and females feel like I'm their older brother, and they know that I won't jump down their throat as an adult would, that I'm more on their level. I talk Plain Talk all the time. I got a teenage cousin and his friend—he's 16. I know he's at the stage he's thinking about sex ... I make him be aware of how deadly AIDS is, and I strongly believe that you cannot bring a child into this world that you cannot care for, and I drill this into him, and I also tell him, "Until you ready, don't make nobody make you do nothing that you don't want to do, and if you feel that you are ready, know your responsibilities and what you're getting into. Protect yourself at all times."

Finally, core group members sometimes served another vital function—facilitating communication between a youth in crisis and his or her parents. In San Diego, for example, a core group member offered to talk to the mother of one distraught girl who confessed that she was pregnant. In New Orleans, a core group member reported:

> I had a little girl come to me and she was crying. She had got scared. I said, "What's the matter, baby?" She said, "I had sex, and my momma didn't want me to do it." I said, "Did you sit down and talk to her about it?" She said, "But my momma won't listen ..." I asked if she had gone to the doctor and she said she wanted her momma to go with her. So I found out who her momma was, and she took the child to the clinic and everything ended up being fine. She got the little girl onto some kind of birth control. So [the girl] comes to me and hugged me and said, "Thank you because it helped me." And I said, "Next time you get ready, talk with your parents. And if you need any kind of counseling or help with birth control, I'm here for you because I have teenage daughters."

One older teen in Hartford, who had been involved in Plain Talk for over two years, said that talking to the Plain Talk outreach worker helped her communicate better with her own mother. She described how she would use the outreach worker to gauge adult reaction to her revelations, questions and concerns, which helped her frame how she broached these topics with her own mother:

> At first me and my mom, I never spoke to her about sex. I would rather talk to [the Plain Talk outreach worker]. Now it's easier to talk to my mom about it. Before it was embarrassing, now it's more of an adult thing to do. I think this change is because of my experience in Plain Talk.
> *Interviewer*: What about Plain Talk helped?
> *Teen*: Knowing that I could talk to someone else first before I talked to my mom. So I could see their reaction, see what to say and not to say [to my mom].

PARENTS AND OTHER ADULTS: WHO IS MOST "ASKABLE"?

Two basic approaches ultimately emerged in the Plain Talk sites as they developed their education strategies for changing adult-youth communication in their communities. Seattle and Atlanta adopted an "askable parents" model and concentrated on developing workshops that were targeted exclusively to parents. San Diego and New Orleans, on the other hand, targeted all community adults and youth in their education workshops.

We were interested in exploring the potential of the two approaches and the relative merits of each. Thus, in addition to gathering information on how core group members talked to community youth, we also asked the group members and Plain Talk outreach workers whether and how they talked to their own teenage children about sex. As this chapter has discussed, core group members could be effective "askable adults," disseminating the Plain Talk message to other community adults and acting as confidant and adviser to community youth and to their teenage relatives. But did their involvement in Plain Talk help them become askable parents to their own children? We hypothesized that if their intensive involvement and training in Plain Talk did not change the way core group members talked to their own children, it would be unlikely that less intensive parent education strategies (which, at most, involved four hours of training) would produce real and lasting changes in parent-child communication.

Most core group members told us that their involvement in Plain Talk did help them talk to their children about sex. At the same time, however, despite their extensive training and immersion in Plain Talk, even the most deeply committed members acknowledged that they found it easier to talk to other youth about sex, especially if the topic was the teen's own sexual behavior.

The comments of one core group member in Hartford were particularly striking because of the length of time she had been involved with Plain Talk and because of her openness with her own children. She has been committed to teen pregnancy and HIV prevention initiatives for the past 12 years and has worked extensively with teenagers in her community, helping them get birth control if she knows they are sexually active. She urges parents in her community to come to her when their kids become sexually active, so she can help them understand what to do and what to say. She explained that, although she has frequently spoken to her two children about sex and protection, it is still difficult to deal with her own teenage daughter's sexuality. When asked if her involvement in Plain Talk has changed the way she talks to her daughter, she said:

> No, it's different when it's your own child. I have a friendship with her friends, and they tell me their deep-down details, but my daughter doesn't tell me these things. And if she did, I don't know how I would respond to her, because she's my child. So I have [the Plain Talk outreach worker, who is her longtime friend and neighbor] talk to her. It's hard. I thought I would be ready for her, but I guess I'm not.

A Walker and Talker in New Orleans also acknowledged the limits of parent-child communication and echoed what the Hartford core group member said about the value to her children of having another adult to confide in:

> There's a lot of kids in the neighborhood that I know. And my kids will bring their friends home. They'll share with me things that they can't share with their parents ... I have all kinds of kids coming to me. And, like I have a friend that my boys are more comfortable going to. Maybe she can give them some information that I don't. And her son comes to me ... [My] boys might feel awkward coming to their momma. And I know she's going to give my boys good information, too, 'cause she knows about Plain Talk. And she knows that if I don't know something, I'll find out or I'll send her boy to Plain Talk to find out. So we help each other out like that.

This suggests that there may be limits to what parents and their teenaged children can comfortably discuss together—limits that exist despite the openness of their relationship and the parents' level of factual information. There are undoubtedly many reasons for these limits, some specific to the particular parent-child relationship and others rooted in the nature of the parent-child bond. In part, it may be that the parent's responsibility for the child's upbringing and well-being takes priority over the desire to be open and accepting. Part of the parent's role is to establish behavioral expectations for the child and to communicate the parent's own values and definitions of right and

wrong. If a parent is being parental, it is difficult for that parent to be a friend and confidant. The "askable adult," on the other hand, is freer to do so.

For example, both as parents and as adult confidants, core group members urged youth to delay sexual involvement until they were "ready." But there was a subtle difference in the way parents and nonparental adults spoke about the youth's "readiness" to become sexually active. Many parents advised their children not to have sex until they were ready but then went on to say that they hoped the child would not be "ready" for quite some time. "Askable adults," on the other hand, were more inclined to inquire whether the youth really wanted to have sex or were simply being pressured by their boyfriends or girlfriends. They communicated that it was ultimately up to the youth to decide what to do; but if they decided to have sex, the adults would help them get protection. Parents' responsibility to set behavioral limits for their children—to convey the hope that their children will delay sexual involvement until later—may, in turn, make sexually active youth reluctant to confide in their parents out of fear of disappointing or angering them. On the other hand, youth may be more willing to confide in nonparental adults whom they trust but who would not have a similar reaction.

In a series of astute observations, the project director in Hartford noted these and other differences in the way her staff (who are former core group members) talk to their own children compared with the way they talk to the teens who come to the Plain Talk office:

> I started seeing it with staff. They feel that they could talk to other teens in the community, but their own kids . . . I think it's not that they don't want to talk to their kids, it's more that they want to impose their knowledge on their kid instead of being flexible to their teens, because they love their kids so much they want to help them escape from danger. Like they want them to avoid danger and say, "I know what's best for you, listen to me," but they are more flexible with other teens in the community. They will listen to them, give them options. Since they don't have the responsibility for these kids that comes with these choices, it's easier for them to let the other teens make their own choices. But with their own kids, the choices their own kid makes will affect them directly.

This project manager remarked that the children of these staff members often prefer to talk to adults other than their own parents:

> [Staff members] will talk to their own kids, but their kids will talk to other adults as well as their parents. In this community, teens feel comfortable talking to other adults ... They prefer talking to adults not their parents—even the kids of staff here feel this way. And they will talk about anything with these other adults. Like the teen rap group that I do, the teens talk to me about anything ... They tell me, "No one else knows about this." Some of these teens who tell me this are related to staff here.

This points to the most striking difference that our data revealed about adult-youth and parent-child communication. In the adult-youth interactions described earlier, it was the teen who approached the adult to seek advice or help—usually, at least for girls, about whether to initiate sexual activity. Because the youth approached the adult for advice, the adult could offer guidance or refer the youth to services in response to a situation that the youth was dealing with at the moment. The fact that the youth approached the adult for help with an immediate and pressing concern may also have made it more likely that she or he would follow the adult's advice. But while community youth often approached core group members for advice about sexual behavior, the children of these group members did not approach their own parents. Only one core group member reported that her child came to her and told her that she was sexually active (excluding situations where daughters had to tell their mothers that they were pregnant). This suggests that parents do not often know for sure if their child is or is not yet sexually active. Thus, they often have to offer their children advice about the need for protection in conversations that are more like abstract lessons (and that could easily sound like a lecture to a child) rather than in conversations that arise out of an immediate situation.

The core group members we spoke with typically reported telling their teenagers they hoped that they would postpone sexual involvement, but if they did become sexually active, they should use protection. Some asked their children to come to them when they became sexually active so that they could get them birth control or give them condoms. Other parents told us that they would wait to give their child detailed information about birth control until they were sure the child was sexually active. The point is, given children's understanding of their parents' wish for them to wait, youth may be reluctant to reveal precocious sexual activity to their parents. Thus, parents will not have the opportunity to respond at the time when pregnancy is most likely to occur—in the first six months of sexual activity. Our data suggest that youth who confide in a trusted nonparental adult might be more likely to get help during this critical time. Furthermore, because they are more likely to confide in a nonparental adult when they are unsure about whether to initiate sexual involvement, the nonparental adult will be able to address the issue of sexual coercion as it is occurring rather than as an abstract principle.

In sum, despite their training and presumed openness, many of these core group members still found it difficult to talk to their own teens about the teens' sexual concerns and behavior. This finding is supported by two recent studies that looked at parent-teen communication about sexuality. In order to provide a more nuanced look at what parents and teens talk about, these studies divided sexuality into several different domains or topics. One study (Raymond and Silverberg, 1998) examined conversations between mothers and daughters, and the second (Rosenthal and Feldman, 1998) looked at both genders of parents and teens. Both studies found that although teens felt comfortable talking to their parents about topics that were removed from their own experiences—e.g., premarital sex, STDs and their prevention, contraception and safe sexual practices—they did not feel that it was appropriate to discuss the details of their own sexual experiences. In the study by Rosenthal and Feldman, the subjects that teens felt were inappropriate to discuss with their parents included details of their dating relationships and peer pressures about sex. Raymond and Silverberg found that these topical boundaries existed regardless of the quality

of the mother-daughter relationship: daughters who were close to their mothers did not want to discuss their sexual experiences out of fear of disappointing or worrying their mothers, and daughters who were more distant wanted to avoid their mothers' anger or judgmental reactions. The researchers concluded that, although parents play a vital role in the sex education of their children, there seems to be an explicit, and perhaps developmentally necessary, boundary—or need for privacy—that renders sexual disclosures by teens to their parents inappropriate.

These findings do not suggest that efforts aimed at helping parents communicate more effectively and comfortably with their teens about sexuality are without value. On the contrary, most core group members felt that their training did help them understand and accept their children's sexuality, made them more sensitive to their children's point of view, and helped them broach what, in the past, had been a very uncomfortable, if not taboo, topic. However, these data do argue against an *exclusive* focus on parent education and point to the vital role that nonparental adults can play in the lives of youth. There may be limits to what teens are willing to discuss with their parents, and these limits may impede the parent's ability to assure that the sexually active youth is using protection as soon as he or she becomes sexually active. Providing training aimed at developing a core of "askable adults" may lead to adult guidance for youth in areas that their parents—even those who are open and honest with their children—may not be able to give.

This approach, however, would work only in communities or neighborhoods in which there is a great deal of consensus about teen sexuality and where there is a sense of communal responsibility for child rearing, so that the "askable adult" would be seen by parents as supporting their own values. We found these sentiments to be strong in Hartford, New Orleans and Atlanta, and, to a lesser degree, in San Diego. As the project director of the Seattle site pointed out, it would not work in such communities as White Center, where many parents strongly believe that sex education is the exclusive responsibility of the family. Even there, however, service providers who work with youth could benefit from training to help them feel more comfortable talking to youth about sexuality.

VIII. CHANGING INSTITUTIONS

Deliberate efforts to address social problems by changing social behaviors face many challenges. Social scientists and social service practitioners have long recognized that changing individual behavior is only one step that must be taken. Institutions must also change in ways that encourage or enable individual behavioral change. Persuading youth that they must be sexually responsible is more easily accomplished if health care institutions provide the services that youth need in order to become sexually responsible individuals. Without broad institutional change, the possibilities of individual change decrease significantly. While there are always a few individuals who, by force of will, luck or even random chance, may change their behavior in ways that are desirable under current social conditions, there are many more who cannot make changes unless there is institutional and social support that enables them to do so.

One of Plain Talk's goals was, thus, to create change within institutions. Explicitly, Plain Talk aimed to increase the availability and quality of adolescent reproductive health services in the communities. At the beginning of Plain Talk, reproductive health services for youth were either lacking or limited in four of the five sites. Youth often had to travel outside their communities to find services. When clinics did exist, their hours of operation sometimes conflicted with youth's school schedules.

Plain Talk, however, did not aim only to make reproductive health services more accessible to adolescents; it also aimed to change such institutions as schools, churches and government. During the second and third implementation years, as part of the overall effort to create a community consensus around the need to protect sexually active youth, the sites were increasingly directed to identify and make changes in institutions that could make a difference in Plain Talk. The specific goals of these collaborations were left up to the sites, and collaborating institutions could enhance Plain Talk in several ways. They could agree to include the Plain Talk message in broader citywide or statewide efforts to prevent teen pregnancy and STDs. Thus, the funding practices of government agencies could encourage teen pregnancy prevention in wider arenas, or local school districts could include the Plain Talk message in their sex education curricula. Institutions could also provide Plain Talk with resources that would otherwise be unavailable. Schools, for example, were identified as good locales for holding workshops and informing community members of the problems of adolescent pregnancy and STD transmission. Government and businesses were seen as potential supporters of funding and supplies. Finally, collaborating institutions could help build acceptance for Plain Talk's work. Churches in particular, with their strong moral leadership within communities, were seen as a possible vehicle for legitimizing the Plain Talk message. Thus, the sites' mission to change institutions was broadly defined, and a variety of efforts were undertaken to create collaborations.

This chapter examines the collaborations that sites created in their efforts to change institutions. We explore key questions about those collaborations as well as the strategies the sites used:

- Why was it generally easier for the sites to improve reproductive health services than to change other institutions?
- What strategies were effective and why?
- What were some of the contextual factors that affected sites' attempts to change institutions?
- What specific benefits accrued to the Plain Talk sites as a result of their efforts to change institutions?

Because increasing adolescent health care was a major priority for the initiative, we examine it separately from other efforts. We then turn to the diverse efforts the sites undertook to create effective institutional collaborations that could further the goals of Plain Talk. Despite a number of challenges, it was much easier for the sites to collaborate with health care providers and make strides in accomplishing their health care goals than it was for them to collaborate with other kinds of institutions. We explore what the sites tried to do and why collaborations were so difficult. Systems reform and institutional collaborations are efforts that many community initiatives undertake in order to engage and change institutions: designers and implementers of community initiatives understand that having institutional support enhances the process of change in individuals. However, efforts to engage institutions are often very difficult. The Plain Talk experience was not unique and offers several lessons.

WORKING WITH HEALTH CARE PROVIDERS TO INCREASE AND IMPROVE REPRODUCTIVE HEALTH SERVICES FOR COMMUNITY ADOLESCENTS

To understand how the sites were able to increase and improve reproductive health services and the challenges they faced in doing so, it is first necessary to understand something about the health care contexts in which the Plain Talk sites were operating. Those contexts were affected by national as well as local social and political factors. The implementation period for Plain Talk coincided with increasing nationwide public concern about teen pregnancy and STD prevention. In the latter half of the 1980s, birth rates rose substantially among all adolescents, both married and unmarried.[17] Concern over children born to poor teen mothers was, in part, concern over whether the government would have to support teens and their children. In addition, STDs, including HIV/AIDS, increased in the adolescent population, especially among poor adolescents.

[17]See "U.S. Teenage Pregnancy Statistics." August 15, 1997. New York: Alan Guttmacher Institute; and Brown and Eisenberg, *The Best Intentions*.

In the public health sector, the concern over births to teens and STD transmission resulted in a variety of prevention strategies: in some urban areas, needle exchange and condom distribution programs were initiated to prevent the spread of HIV. School clinics experimented with providing reproductive health services and contraception to avoid pregnancy. The American Medical Association (AMA) developed adolescent health guidelines that explicitly recognized and addressed the reproductive health care needs of adolescents.

One of the reasons the AMA developed guidelines for adolescent health care was to encourage the development of medical practices that recognized that adolescents had different health care needs from children. Adolescent health care has traditionally been subsumed under pediatrics, and adolescent medical needs that arise out of their social and physical development have been treated unevenly. There has been increasing recognition, however, that adolescents should receive care that is sensitive to their physical, social and emotional development; thus, a field of adolescent medicine has emerged. Practitioners in this field have come to believe that reproductive health care, including contraception, is necessary for adolescents who are sexually active. With respect to Plain Talk, the developing field of adolescent health care meant that there was a fairly close fit between the sites' agenda to protect sexually active youth and the agenda of adolescent health care practitioners. The shared agenda positively affected the sites' abilities to increase adolescent reproductive health services.

At the same time, however, managed care was becoming an increasingly popular way of funding public health care in several of the Plain Talk communities. While the interest in managed health care and the surrounding debate were particularly intense in San Diego, where the county had made a large commitment to managed care, the issue arose in other sites as well. In some instances, managed care was seen as an opportunity for the sites, which hoped they could negotiate for needed reproductive health care services with managed care organizations interested in providing services in their communities. In other instances, managed care acted as an impediment to the work of Plain Talk. In San Diego, the community debate over managed care's efficacy in serving poor residents took precedence on the local health care agenda.

Other contextual factors that influenced the development of more or better adolescent reproductive health care services existed locally. In San Diego, for example, while funding for adolescent pregnancy prevention in general was increasing, overall health care funding for immigrants was decreasing. Over the course of Plain Talk, the public outcry grew against providing social services to immigrants. Although this was happening on a national political level, it had particular implications in the San Diego site, which served both a large Mexican American and a large immigrant Mexican population—and where, as a border community, the public discourse about immigrants was particularly strident. In Seattle's White Center, a relatively well-organized group of conservative white residents who supported abstinence for adolescents mobilized to try to prevent a school-linked health clinic from providing reproductive health care services to adolescents—although they were ultimately unsuccessful. In New Orleans, the fact that Louisiana has traditionally been a state with low levels of public

funding for social services presented an ongoing challenge for the site. Just retaining existing resources there represented success—and took considerable effort.

While there were a number of influences, both positive and negative, on the sites' abilities to increase or improve reproductive health services, the overall climate was open to strengthening those services. A number of the assumptions that sites made about adolescent reproductive health care needs in their communities were based on previous research and supported by medical guidelines, such as the AMA's "Guidelines for Adolescent Preventive Services" (GAPS), which aim to improve the health and well-being of adolescents. The following GAPS recommendations refer to reproductive health services:

> **Recommendation 2:** Preventive services should be age and developmentally appropriate and should be sensitive to individual and sociocultural differences.
>
> **Recommendation 9:** All adolescents should receive health guidance annually regarding responsible sexual behaviors, including abstinence. Latex condoms to prevent STDs, including HIV infection, and appropriate methods of birth control should be made available, as should instructions on how to use them effectively.
>
> **Recommendation 16:** All adolescents should be asked annually about involvement in sexual behaviors that may result in unintended pregnancy and STDs, including HIV infection.
>
> **Recommendation 17:** Sexually active adolescents should be screened for STDs.
>
> **Recommendation 18:** Adolescents at risk for HIV infection should be offered confidential HIV screening with an enzyme-linked immunosorbent assay (or ELISA) and a confirmatory test.
>
> **Recommendation 19:** Female adolescents who are sexually active or any female 18 or older should be screened annually for cervical cancer by use of a Pap test.

Sites' definitions of adolescent health care needs in their community were also based on their own experiences and beliefs about how care should be provided. Over the course of the initiative, site participants identified key elements necessary for providing high-quality, comprehensive reproductive health services for youth:

- Clinics should be accessible to area youth.
- Clinic hours should be convenient to youth.
- Service providers should be sensitive to the cultural contexts and developmental stages of youth.

- # Clinics should serve both male and female youth.

- # All youth should have risk assessments completed, and follow-up STD or pregnancy tests should be performed if necessary.

- # Counseling about contraception and STD prevention is necessary.

- # Contraceptives need to be available through the clinics.

The obvious overlap between the mainstream medical association's recommendations and the goals of Plain Talk suggests that, from the beginning of the effort to increase medical services, the issue of "mission-fit" would not pose a challenge for the sites. The medical community considered the activities that the sites wished to pursue crucial in safeguarding adolescents' health.

Reproductive Health Services Before Plain Talk

The sites' levels of reproductive health services available to adolescents in their communities varied before Plain Talk was implemented. San Diego, whose lead agency was a comprehensive neighborhood health clinic, had an adolescent clinic that was held one afternoon a week. From the beginning, the fact that the clinic and *Hablando Claro* were housed in the same agency meant that the *Hablando Claro* staff were able to have some influence over clinic services. In Seattle, the health department ran a teen clinic in the target community that offered reproductive health services to local adolescents.

None of the other sites, however, had a neighborhood clinic that specifically addressed adolescent reproductive health needs. Atlanta was arguably the site with the most pressing need, since the Mechanicsville community is separated from other communities on three sides by major highways or other geographic barriers. Although CBWW (where Plain Talk was housed) had a women's clinic that provided pregnancy tests and exams, it could not fill prescriptions for contraceptives and did not serve adolescents.

In addition to a general lack of services, sites noted that even available services were not always sensitive to the needs of the local adolescents. For instance, early in the initiative San Diego *Hablando Claro* conducted an evaluation of local adolescents' satisfaction with community health clinics and found a number of complaints with respect to both the adolescent clinic of the Logan Heights Family Health Clinic (LHFHC) and five other clinics that served community youth. Among the complaints were long waiting times for appointments, being put on hold on the telephone for long periods while trying to make appointments, and receiving inconsistent information about HIV/AIDS.

Overview of the Sites' Accomplishments

Sites proceeded to increase and improve reproductive health services in several ways. In four sites, staff worked closely with other agencies to bring clinics to the community. Plain Talk staff in Hartford and Atlanta teamed up with the local health departments to bring clinics to their sites. In New Orleans, staff collaborated closely with the community health clinic in order to serve St. Thomas youth within the context of more comprehensive services. To better serve youth, the clinic ultimately received funding from the State Department of Family Planning to open an adolescent clinic in the evening. In Seattle, staff worked closely with a local coalition to get funding for a school-linked health clinic. In the fifth site, San Diego, the lead agency had its own capacity to improve reproductive health services for adolescents, and over the course of Plain Talk it substantially increased the number of hours the clinic was open as well as the number of adolescents served.

Sites also worked to strengthen reproductive health services for youth more broadly. Plain Talk staff in San Diego teamed up with a physician whose specialty was serving adolescents to hold a two-day workshop for health care providers about serving youth. The lead agency in Hartford, working in concert with other institutions, created the Health Finances Project (HFP), which focused on teen pregnancy prevention and ways that health care providers could do more to prevent teen pregnancy. A report issued by the HFP incorporated important elements of Plain Talk.

The sites' specific accomplishments in improving health care and increasing reproductive health services are provided in Table 8.1. All sites made significant gains in these areas. Below, we discuss the strategies they used to increase health care services and the challenges they faced as they attempted to implement their plans.

Strategies for Increasing and Improving Services within the Target Communities

Sites generally used three strategies for increasing or improving services. They demonstrated the community's need for more or better services through the use of information, such as the community mapping or other local service and needs assessments. They formed strategic relationships with providers—doing so allowed sites with relatively little in-house capacity to gain access to the resources of much larger institutions. Finally, sites also encouraged residents to apply pressure on providers and funders for increases in services.

Using Local Information

Sites successfully used several kinds of information to generate support for increased reproductive health services. First, they used the information gathered in community mapping, conducted early in the initiative, to talk about rates of sexual activity and contraceptive and clinic use in the communities. Staff used these data when they made presentations to providers about the need for services and when they made presentations to community residents to garner support for services.

Table 8.1

Adolescent Reproductive Health Services Available in Sites Before and After Plain Talk*

Site	Clinic in target area provides adolescent reproductive health services?		Screenings completed to determine risks?		Contraceptives available for adolescents at clinic?		Behavioral counseling for adolescents available at clinic?		Weekly average number of youth served	
	Before	After	Before	After	Before	After	Before	After	Before	After
Atlanta	No	No	—	Yes	—	Yes	—	Yes	—	5-10[b]
Hartford	No	Yes	—	Yes	—	Yes	—	Yes	—	3-6[c]
New Orleans	Yes	Yes	Yes	Yes	Yes	Yes	Limited	Yes	N/A	N/A
San Diego	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	6-8	20+
Seattle[a]	Yes	Yes	N/A	N/A	Yes	Yes	Yes	Yes	8-15	40-50[d]

*"Before Plain Talk" refers to the period prior to the beginning of implementation in mid-1994. "After Plain Talk" refers to December 1997.

[a]The Seattle reproductive health services described here are those provided through a clinic operated by the county's Department of Health. Seattle Plain Talk worked with other local agencies and residents to get a school-linked clinic that would be located in the school district. The group was successful in receiving a grant from the county, and the clinic opened in early 1998, after the period when these data were collected.

[b]Because patterns of clinic use fluctuated seasonally, it is difficult to provide an accurate estimate of weekly use. Between July and December 1997, the clinic served between 20 and 40 youth a month.

[c]Hartford's teen clinic was open one afternoon per week for two hours.

[d]Although adolescent use of the Health Department clinic rose significantly over the course of Plain Talk, it is difficult to ascribe the changes to the initiative. Health Department staff reported that the increases came as a result of opening the clinic an additional evening each week. While clinic staff sat on Plain Talk's Resource Committee, the two groups did not directly collaborate to increase services at the teen clinic.

In addition to the mapping data, four sites conducted evaluations of reproductive health services that were currently provided to youth in their communities. In the early implementation period, San Diego conducted an evaluation of how comfortable youth were in using reproductive health services at both the lead agency's adolescent clinic and other clinics that served adolescents in the area. Plain Talk youth called and visited the clinics and reported on their experiences there. In Hartford, staff from the Hartford Action Plan conducted informal evaluations of the Plain Talk clinic in order to understand why so few adolescents were using its services; and in Atlanta a community assessment examined residents' use of, and satisfaction with, the clinics available to youth in the target area. To report on how clinic services needed to be improved in the New Orleans community, Plain Talk staff relied on largely anecdotal information they heard about the local clinic from youth and adults. They formed a close working relationship with the clinic, and when site staff received complaints about the service, they discussed them with clinic staff.

Forming Relationships with Providers and Funders

Another successful strategy used by the sites was to invite and nurture relationships with service providers and funders who could provide resources.[18] In Hartford, Atlanta and New Orleans, staff and residents were particularly successful in forming relationships with public health providers who eventually opened clinics or provided funds to open clinics in the community. The development of the relationships was interesting since, in New Orleans and Atlanta, the participants involved did not necessarily define the goals of the relationships early in the initiative. Instead, there was an extended period during which the providers observed Plain Talk and offered occasional advice to the sites. Only after the sites did fairly extensive community education and mobilization did the providers step in with funds and other resources.

For government agencies in the Plain Talk cities and states, the idea of nontraditional clinics in the sites was promising, and they used the Plain Talk clinics as test models for potential further

[18]One question that could be asked about sites' efforts is: Where was Planned Parenthood? Although Planned Parenthood is a key institution in the delivery of reproductive health care services and education in the United States, it was a minor player in Plain Talk, and this fact deserves some exploration. Early in the planning process, staff from local Planned Parenthood agencies sat on several of the advisory groups for Plain Talk. As implementation got under way, Planned Parenthood staff also conducted some of the resident training. However, the early implementation period was characterized by intense community mobilization efforts, and Plain Talk staff's relationships with other institutional partners attenuated. When staff once again turned their efforts to institutional collaboration, they never brought Planned Parenthood back into the picture to a large degree. We did not explore the absence of Planned Parenthood in Plain Talk, but several reasons suggest themselves. First, with one exception—New Orleans—Planned Parenthood did not have clinics near the sites and so was not a ready source of reproductive health care for adolescents in the communities. Second, Planned Parenthood provides sex education and offers programs that address parent-adolescent communication about sexuality. Plain Talk was, in some sense, a competitor, and, in the midst of all their other work, Plain Talk staff did not concentrate on how they could link with the agency. Third, in one site in which Planned Parenthood staff conducted some training, the residents who received the training were dissatisfied—a reflection, most likely, of a mismatch between the residents' needs and the workshops offered. The residents were core group members who had already received training, and they found Planned Parenthood's curriculum too basic.

expansion of reproductive health clinics into other communities. In Atlanta and Hartford, the sites were able to open clinics where none existed. In New Orleans, the site opened an adolescent clinic that had evening hours and provided counseling by community Walkers and Talkers.

Encouraging Residents to Demand Increased Services

Sites took two approaches to involving residents in the efforts to improve adolescent health care. They encouraged youth to increase their use of existing services to the point where current providers would find it necessary to expand their hours. Sites also mobilized community residents to apply political pressure in support of funding for additional adolescent reproductive health services.

The first strategy was most apparent in San Diego, which had a new adolescent clinic that, at the beginning of the initiative, was open one afternoon a week. The Plain Talk health educator helped increase clinic use because she was both an effective outreach worker (she gave presentations to adolescents in schools) and a well-regarded counselor in the clinic, where she also worked. Other Plain Talk staff and the *Promotoras* also encouraged youth to go to the clinic. In addition, the site received a grant from the State of California that allowed the clinic to create a "male involvement" initiative that used adolescent peer counselors and also had a marketing component. That grant, in turn, put the site in a good position to apply for funding to expand the peer counseling to girls, which the site received in 1997 from the Kaiser Foundation. Youth in both initiatives passed out wallet-sized cards that listed all local adolescent clinics, their addresses, phone numbers and hours. They also helped educate area youth about STDs and pregnancy. The interconnections in the efforts led to increased clinic use and thus allowed the LHFHC to expand its adolescent clinic's hours. By the end of the implementation period, the clinic was open four afternoons a week and on Saturday mornings, and clinic use had quadrupled. In addition to committing resources for grant writing to support the expansion of activities and services, LHFHC purchased a building in fall 1997 to house its expanded teen services.

Seattle and New Orleans employed the second strategy: they increased—or at least prevented a decrease in—health services by mobilizing residents for political action. In Seattle, in 1996, the King County Health Department announced competitive grants to establish school-linked health clinics. The site's Plain Talk project coordinator, who was also president of the local district's school board, worked to build support within the board—which had to give its approval before the district could apply for a grant. Other Plain Talk staff mobilized members of the Plain Talk Resource Committee and of the resident core group to demonstrate support. Members wrote letters to the newspaper, spoke out in community forums, and wrote letters of endorsement that were included in the grant application. The Highline School District ultimately won one of two grants.

In New Orleans in 1996, residents were mobilized to attend a city council meeting to protest funding cuts to the local health clinic. Over 100 community residents marched into the meeting, and several spoke in support of rescinding the budget cuts, which had threatened STD counseling

and HIV testing. Their action resulted in the restoration of $86,000 of the $90,000 cut from the clinic's budget.

The success of two very different sites in using a similar strategy indicates the flexibility of community mobilization when used for well-defined purposes. The strategy provided residents with an opportunity to do something concrete for Plain Talk, and their actions resulted in increasing or preserving health services. Together with the strategy of encouraging greater use of existing services, community mobilization showed that residents in poor communities can effectively influence institutions in important ways.

Improving Reproductive Health Services for Adolescents in Plain Talk Cities and States

As the national concern and discourse over teen pregnancy grew, sites were encouraged to engage in state and local efforts to address the problem. The Foundation hoped, for example, that San Diego Plain Talk would draw on the lead agency's strong standing in the community to influence health care services in other clinics as well as to affect local health care policy. The efforts in the sites were diverse and, in some cases, relatively diffuse. While the sites made some strides in achieving their goals, the efforts got under way late in the initiative, and the results were ambiguous.

Plain Talk in the States

Staff and residents from New Orleans were invited to sit on a state task force that was devising a comprehensive plan to prevent teen pregnancy. In Georgia, a Plain Talk partner who strongly supported the work of Atlanta Plain Talk (in a sense, she could be seen as a professional Plain Talk messenger) sat on a similar task force in Georgia. The creation of the task forces had been sparked by changes in federal funding for teen pregnancy prevention—specifically, by the creation of abstinence-only funding—as well as by the national debate over teen pregnancy. Both met over a period of months in 1996 and 1997 to discuss appropriate strategies and identify ways to use the abstinence-only funding in the context of comprehensive teen pregnancy prevention.

In both states, the reports published by the task forces included elements of Plain Talk, such as explicit plans to protect sexually active youth, improve communication between adults and youth around sexuality, and develop community-based efforts to prevent teen pregnancy and STDs. Since the reports were published in the last year of the demonstration, it is too soon to tell whether the recommendations that concurred with Plain Talk's goals will be implemented.

Sitting on task forces created by state health departments proved far more effective in conveying Plain Talk's ideas than attempting to create a statewide coalition, which was Seattle's strategy for spreading Plain Talk in Washington State. In December 1996, the site sponsored a forum for health care providers and policymakers to discuss adolescent pregnancy prevention. A second forum was held in Fall 1997. Although there was great enthusiasm for the forums among health care providers, concrete reports or strategies were not produced. The challenge facing the site was

one of capacity. During Spring 1997, two key Plain Talk staff members had resigned, and remaining staff concentrated on the community education effort and the development of the *Plain Talk for Parents* curriculum. The site lacked the staff time to focus on coalition building, which, at the state level, takes a lot of administrative support. The Georgia and Louisiana health departments had the capacity to support their task forces, but Plain Talk in Seattle did not. It may generally be more effective for small neighborhood organizations running community initiatives such as Plain Talk to create awareness about and interest in their efforts rather than attempt to lead efforts to change institutions statewide.

Local Coalition Building

Among all the sites, Hartford Plain Talk was the most well positioned to influence adolescent reproductive health services at the city level. In partnership with the City of Hartford and the Hartford School District, its lead agency, the Hartford Action Plan, had developed the Breaking the Cycle Campaign (BTCC)—a five-year, seven-million-dollar initiative designed to lower teen pregnancy rates in Hartford, where the rate was twice the national average. BTCC has several elements. Among them are a school-based educational component for fifth graders and a community component that includes a parent-youth communications project and a public awareness media campaign. The community component draws heavily on the Plain Talk philosophy, although the parent-youth communication piece has not been fully implemented.

There is also a component that aims to improve and expand adolescent health services, and the Action Plan, through its Health Finances Project (HFP), had a key role in making the recommendations for how this would be accomplished. The HFP had originally been established to develop funding, within the new managed care system, for maternal and child health and for teen pregnancy prevention programs. Its focus soon narrowed exclusively to teen pregnancy prevention programs. Although it was concerned at first with convincing managed care providers to fund existing programs, it soon broadened its approach to address how health care providers could do more to prevent teen pregnancy. To develop its recommendations, the HFP convened a committee that included the Action Plan staff, representatives from major hospitals, family planning clinics, health insurers and the school district's school-based clinics. The Plain Talk project manager also served on the committee.

The result was an extensive plan for changing adolescent reproductive health services at the city level. The plan supported the use of the AMA's GAPS guidelines for serving adolescents. HFP's own cost-benefit analysis had shown that the cost of providing preventive health services that followed those guidelines was less than the cost of the pregnancies and STDs resulting from unprotected sexual activity. HFP also recommended that BTCC "adopt explicit strategies for identification of, and outreach to, sexually active youth, and for improvements in access and provision of the reproductive health services they need." While not driven by Plain Talk, the recommendations were heavily influenced by the initiative's philosophy, including ideas about improving adolescents' access to reproductive services (including contraception) within their own communities and providing culturally appropriate services.

As with the plans developed by the States of Georgia and Louisiana to prevent teen pregnancy and the spread of STDs, the HFP report was published too late in the Plain Talk evaluation for us to know whether and how the recommendations will be implemented. Staff at the Action Plan continue to work on implementing the plan, however, and there appears to be broad community support for Breaking the Cycle in general. HFP staff have been able to get this far with a citywide plan to improve reproductive health services for at least two reasons. First, the Breaking the Cycle Campaign (BTCC) was composed of key citywide political and service institutions, and HFP had a mandate to create a citywide plan. Second, the city of Hartford was acutely aware of its high rate of teen pregnancy, and the Action Plan kept attention focused on the problem through its media campaign—and, in several publications, presented data showing that Hartford had one of the highest birth rates among adolescents in the country.

It is useful to compare the organizational structure and political climates in which the Hartford and San Diego site staff worked to create comprehensive local plans for teen pregnancy and STD prevention. Comparing the two sites' experiences provides interesting insights into contextual factors that can facilitate or impede institutional reform.

Early in the initiative, it was hoped that the lead agency's strength in San Diego's health care arena would enable the site to make a difference in the county as a whole. To that end, staff were encouraged to contact local policymakers and sit on committees and boards that worked on health care issues. The site's efforts, however, were limited by political realities that constrained the options of the Logan Heights Family Health Center (LHFHC) for engaging in some efforts, as well as by the realities of the health care arena. As noted above, the national discourse over providing social services to immigrant populations was becoming increasingly conservative. In California, particularly in the communities bordering Mexico, conservative calls to limit services to immigrant populations were particularly strong. The political mood was a potential threat to LHFHC, a clinic that had been founded in the early 1970s to serve the poor Mexican and Mexican American population of the barrio. Through the years of its existence, LHFHC had grown from a small activist clinic to a major provider of comprehensive health services in several low-income areas. As it grew, it depended more and more on both state health care funds and donations from corporate sponsors.

Given its strong multiple funding sources, the clinic was able to provide a wide range of services. Since it served a politically unpopular immigrant population, however, the clinic's administration was very conscious about how it expended its political capital. While it provided strong support for the work of Plain Talk within the community, the administration was not prepared to advocate for Plain Talk in the broader health care arena without substantial evidence that it was an effective strategy for preventing teen pregnancy and STDs. Since the initiative was in a demonstration period, the agency's administration thought it unwise to promote such a controversial message strongly in an environment that was already hostile to the population served by the clinic. As a consequence, the lead agency's efforts to support the work of Plain Talk widely were more limited than expected.

The site did make some efforts to support Plain Talk's goals in the larger San Diego community, and staff faced challenges that suggested that, even had the clinic supported the initiative more strongly, the results may not have been very different. The Plain Talk coordinator sat on several boards to improve health services in San Diego County. She sat on the San Diego Board of Supervisor's Health Services Advisory Board. By the end of the research, she reported that her work had not produced obvious results. In a later conversation, however, she noted that teen pregnancy prevention and adolescent health issues were being given more attention. One board, the Society for Adolescent Medicine, did concern itself with teen pregnancy prevention; with no compelling evidence supporting the Plain Talk community-based approach, the coordinator was unable to convince the society to try Plain Talk.

Although specific individuals on other boards supported Plain Talk's approach to preventing teen pregnancy and STD transmission, the boards themselves were concerned with other health care issues. While Hartford had defined teen pregnancy as a key social problem facing the city, San Diego's attention was focused elsewhere. For instance, public health care services were being privatized through managed care companies. Figuring out what the implications of the emerging system were, as well as working out some of its details, took precedence over teen pregnancy prevention strategies.

The nature and missions of the lead agencies in Hartford and San Diego also appear to be fundamental determinants in the sites' efforts to create citywide plans for teen pregnancy prevention. As an umbrella organization representing an alliance of corporations, government officials, health care providers, community organizations and schools, the Action Plan has at least two priorities that LHFHC does not: to serve the entire City of Hartford and to find ways for service institutions to collaborate in improving the health status of mothers and children and in preventing adolescent pregnancy. In contrast, LHFHC's priority is to provide direct health services to the residents of Logan Heights. While LHFHC worked hard to increase and improve reproductive health services to youth in the Plain Talk site—by the end of the initiative, the agency had an extensive teen health program—it did not engage in the same kind of effort to create citywide plans. In the following section, when we discuss efforts that the sites made to collaborate with other institutions, we talk about "mission fit"and note that when institutions can define complementary goals, the possibilities of collaboration are greatly enhanced. The expectations of the Plain Talk initiative were not realistic given LHFHC's mission to serve local residents' health needs.

The comparison between San Diego and Hartford suggests that politics and institutional missions profoundly influence the extent to which organizations are able to lead broad local efforts at institutional reform. Certain kinds of lead agencies may be more able than others to initiate and lead such efforts, and a city will be more willing to undertake efforts to address a problem that it has identified as a priority.

COLLABORATIONS WITH OTHER INSTITUTIONS

As we have seen, Plain Talk sites succeeded in increasing reproductive health services within their communities. Health departments saw the creation of adolescent clinics in the target neighborhoods as an innovative way of successfully meeting their goals to reduce teen pregnancy rates. During 1996 and 1997, as the initiative approached its conclusion and sites considered how to sustain their work after Foundation funding ended, they were pushed to think more deeply about how to collaborate with other institutions. Their efforts to work with institutions other than health care providers, however, were not very successful. While the sites often generated interest among other institutions, they were less able to generate commitments from institutions that would allow them to sustain some part of Plain Talk after the Foundation funding came to an end. Nor were they very successful in getting the grassroots work of Plain Talk onto the agendas of institutions. The following section explores how the sites worked to establish these relationships and the major challenges they faced.

Collaborating with Schools

From the beginning of the initiative, it was assumed that local schools were a natural institutional partner for Plain Talk for a number of reasons. First, their missions overlapped: just as Plain Talk hoped to prevent teen pregnancy and the negative consequences that accompany it, including dropping out of school, schools hope to graduate youth. Second, one of the tasks that schools have taken on in this country is sex education, and Plain Talk hoped to modify the focus on abstinence in many sex education curricula. Third, schools were seen as a community resource that could provide space for community education workshops. Fourth, school PTAs could provide Plain Talk with participants for its community education programs. And finally, school staff were seen as potential partners in the Plain Talk effort; they could bring the Plain Talk message into the schools.

Despite the hope that schools would prove useful partners, the sites had limited success in engaging them. Three Plain Talk sites attempted to implement activities within the local schools. One site, New Orleans, was just beginning its efforts as the initiative was drawing to a close, and there is little to report. In 1997, New Orleans staff, Walkers and Talkers and members of Black Males United for Change (BMUC) held several meetings with the principals of two local schools to introduce them to Plain Talk and request it be allowed to use the schools for Protection Pizza Parties. Establishing a relationship with school staff was a difficult task because there was distrust on both sides. By the end of the year, however, Plain Talk members were feeling optimistic that they would be able to implement activities in these schools and hopeful that they would be able to expand their activities to other schools in the district.

Two sites, San Diego and Seattle, had considerable success in using the local schools as a setting for workshops and announcing their education sessions in PTA and school newsletters. In addition, in San Diego the Plain Talk health educator regularly gave workshops to youth who were involved in the Latino Advocacy program, a school-based program designed to give Latino youth

support and encouragement to stay in school. Plain Talk staff also arranged for a Latino health educator, who had been doing work with male involvement, to give a talk about manhood and sexual responsibility to more than 300 male high school students. Finally, in both sites, staff (and in San Diego, *Promotoras*) were active throughout the initiative in bringing Plain Talk workshops and Plain Talk concerns to the attention of teachers and principals.

In addition to their successful efforts in taking *Plain Talk for Parents* to groups recruited through the PTAs, staff in Seattle tried to engage the schools in one other way. In September 1997, the site held a "Plain Talk for Parents Training of Trainers Institute" designed to teach other people to carry on the Plain Talk workshops. Many participants were recruited through the schools. In particular, a Plain Talk staff member who had years of experience working with local PTAs contacted the principals or PTA officers and tried to get a commitment from them to send people to the institute. Since it was held in September 1997, only a few months from the end of the initiative, we do not know whether it resulted in *Plain Talk for Parents* workshops being held in other schools. However, because of its efforts throughout the implementation period, the site did draw considerable attention to the *Plain Talk for Parents* curriculum, and by the end of the initiative both the National Educational Association and the Washington Educational Association had expressed interest in it. The other two sites, Hartford and Atlanta, had relationships with administrators at the school and district level, but those relationships had not translated into Plain Talk activities at the schools.

The limited success that sites had in collaborating with schools is the result of two major factors. First, schools are highly politicized institutions, and American public schools are at the center of several intense political debates: Should public schools confine themselves to teaching academic subjects, or should they attempt to instill certain values in children? If the latter, what values? Who gets to decide? Plain Talk's core message, that it was important to protect sexually active youth, was too controversial to be included in formal public school curricula.

Second, even if local school principals or teachers agreed with Plain Talk's approach (as some did), the high degree of curriculum centralization in urban school districts would have prevented local schools from including Plain Talk in the school sex education curriculum. The Plain Talk staff and core group residents were generally working at the local school level, where access to school staff was through the personal networks of the core group residents or site staff. Plain Talk would have needed relatively high-level contacts in the local school districts to make the case for changes in curriculum, and neither the staff nor the residents had those contacts. The one exception was in Seattle, where the project director was also the school board president, but he recognized that the conservatism of the local community precluded a curriculum that disseminated the Plain Talk message.

Despite their limited reach into the schools, Plain Talk's successes in recruiting residents through PTAs or in garnering philosophical (if not concrete) support from local school personnel were significant. In other words, as an attempt to change school institutions, Plain Talk was unsuccessful, but it was able to secure school resources for community education.

Plain Talk's Efforts with Businesses and Churches

Several sites attempted to work with local businesses in attempts to advertise the work of Plain Talk and garner resources for the initiative. For instance, Plain Talk youth in New Orleans developed a plan to approach area businesses to see if they would allow Plain Talk to place brochures and condoms in stores. Also in New Orleans, staff approached area businesses for contributions to such community events as the Back to School Jam Fest that the site held in conjunction with the Kuji Center, an abstinence-based pregnancy prevention and youth development program. Hartford also made similar plans to place condoms in stores and to get contributions of services and supplies.

Although the sites had some success in getting contributions for specific events and were able to get commitments to place condoms in some stores (in Atlanta, a local video game parlor that was centrally located had long had a large jar of free condoms available), working with local businesses was difficult because the fit between the businesses' agendas—to sell goods and services—and Plain Talk's agenda was not good. Site staff and volunteers were never clear on how they could access the resources of local businesses; and since there was so much work to be done in other areas, there was a tendency to make working with businesses a low priority. Sites' efforts to work with local churches were even more limited and met with even less success.

THE CHALLENGES AND POTENTIAL OF COLLABORATION

While the sites were able to work productively with health care providers to increase or improve the quality of reproductive health care services for area youth, their efforts to engage other institutions that can influence the lives of young people were much less successful. We suspect that, even if the sites had been able to resolve the specific challenges of getting people to the table, finding a common agenda on which to work, or coming up with doable plans in the context of all their other work, the undertaking would have been too ambitious for Plain Talk, which was conceived as a grassroots, community-based initiative.

National and local political and philosophical contexts were significant barriers to getting schools and churches to collaborate with Plain Talk. Working with PTAs to recruit parents to take Plain Talk workshops held in the schools after school hours is one thing; getting Plain Talk into the sex education curricula of the schools is another. By the end of the demonstration period, none of the Plain Talk sites had the political strength to engage in sustained campaigns to get their message into those curricula.

"Mission fit" was another significant challenge to institutional collaboration. When sites attempted to collaborate with institutions that had similar or complementary goals, the chances of success were fairly high. Thus, collaborations between local health departments and Plain Talk sites were promising because their goals—to increase the provision and use of health services—were similar and their resources complementary. Where the health departments brought resources to the communities, the sites had the potential (in some cases realized, in other cases not)

to bring people. School PTAs and Plain Talk sites formed another kind of promising collaboration. The PTAs have access to space as well as to parents; Plain Talk provided information resources to parents about sexuality and communicating with youth. The "mission fit" between Plain Talk and businesses was more problematic. While some businesses were willing to donate goods and services to some Plain Talk activities (e.g., back-to-school festivals or community events), there did not otherwise seem to be much collaboration.

Finally, competition among agencies or providers was a factor in limiting institutional collaborations. This has been observed in a number of service integration initiatives (e.g., New Futures),[19] and there were indications that turf issues played a role in Plain Talk. For instance, Atlanta Plain Talk attempted to partner with the Georgia Campaign for Adolescent Pregnancy Prevention (GCAPP), an initiative designed to provide youth development opportunities to adolescents in two low-income communities in Georgia—one was Mechanicsville, where Plain Talk was located—and to undertake a statewide campaign to publicize the problems of adolescent pregnancy and garner support to address it. The collaboration between Plain Talk and GCAPP brought up turf issues on both sides. At one point, Plain Talk and GCAPP each had separate steering committees that included many of the same stakeholders. Although the two initiatives' missions and goals were similar, it appeared to stakeholders as well as to staff that the organizations were competing instead of collaborating for local residents' time and participation. GCAPP eventually ceased its efforts in Mechanicsville. A different kind of competition—competition for financial resources—may have played a role in San Diego, where community clinics often found themselves competing for the same grants. Staff in several clinics acknowledged that the competition, which is inevitable given granting practices, limited collaboration.

Modern social institutions operate in a complex environment, especially in urban areas. Although we can and do conceive of a "community" as a bounded area with a specific number of people living and working within it and with particular institutions serving it, the distinction is artificial in many respects. Almost every person within a community has ties to people outside it—among them are kin, as well as occupational, religious and social associates. Likewise, local institutions are often part of larger, more centralized bodies. Community schools' curricula are often defined by a central school district. Churches may belong to a larger body. Clinics may be supported by hospitals outside the community. Businesses may be members of franchised chains.

The often complex and varied obligations that local institutions have to larger institutions at a city, state, national or even global level (e.g., the Roman Catholic Church) mean that attempts to change institutions at a local level may not produce results. What appears to staff and residents working at a community level as a need for a local institution to be more responsive to relatively

[19]New Futures was an initiative of AECF designed to improve social and educational services for at-risk youth in five mid-sized cities. The initiative was designed to change youth-serving institutions through the creation of citywide collaboratives that could address policy issues, increase accountability, and develop consensus about the nature of the problems serving youth as well as the solutions needed to address the problems.

simple requests may entail changes in a larger institution that are difficult to make and may require resources (either in terms of staff time or more senior staff involvement) that are unavailable.

IX. CONCLUSIONS

Although the implementation and evaluation phases of the initiative ended in December 1997, the sites have continued to grow and develop. Unlike demonstration program models where a set theory of change and a set range of tasks are provided at the outset, the Plain Talk sites were charged with developing approaches that would help them achieve the Plain Talk goals under unique community configurations. The task, as we have noted throughout this report, was daunting, and every site found it necessary to evaluate and modify its plans at different points in the initiative. The time allotted for the demonstration ultimately proved too short for the sites to accomplish all their goals and objectives. Every site, however, accomplished important tasks, and some of the work begun in the Plain Talk sites continues in every community.

The Plain Talk evaluation has provided important lessons and insights about community change efforts in general and teen pregnancy prevention in particular. Through the evaluation, we have learned much about the uses and effectiveness of resident involvement, the ways in which social networks contributed to Plain Talk's work in communities and with institutions, the political and institutional contexts that facilitated or constrained Plain Talk's efforts, and how community education was conceived and delivered in the sites. What has been learned can be useful for two audiences.

First, Plain Talk has much to say about effective strategies that can be used in other community initiatives, even those with significantly different goals. Community initiatives are complex and difficult undertakings. No single community can replicate the strategies used by any other community because fundamental differences between the communities inevitably affect implementation. So despite the existence of general information about the inherent difficulties in involving residents in initiatives or attempting to create institutional change, there has been little specific information that explores the effectiveness of using particular strategies in different contexts. The Plain Talk evaluation, with its cross-site comparison, has allowed us to do this.

Second, the findings from the Plain Talk evaluation may be useful in the development of teen pregnancy prevention efforts—especially those that attempt to create a communitywide consensus through adult education. Considerable emphasis has been placed on the importance that adults, especially parents, can play in ensuring that youth have the information and moral guidance they need to make responsible decisions about sexuality. The Plain Talk sites undertook a range of educational strategies. As a result, the evaluation was able to explore key issues involved in the development of educational curricula and in targeting specific audiences.

Below, we summarize key findings from the report and explore the potential for using specific strategies in a variety of circumstances for community change initiatives and teen pregnancy prevention programs.

WHAT CAN PLAIN TALK TELL US ABOUT COMMUNITY CHANGE?

The designers of Plain Talk understood that strategies and programs attempted in the 1980s that targeted youth in isolation from their communities did not succeed in stemming the teen pregnancy rate. They hoped that creating communitywide consensus about the importance of protecting sexually active youth would result in fewer teen pregnancies and lower STD rates.

Creating consensus is an ambitious undertaking: it requires working with the people living in the communities as well as the institutions that serve them. Communities consist not only of individuals and families, friends and neighbors, but also of schools, churches, businesses, health care providers and other institutions. Therefore, Plain Talk sites primarily used two approaches to changing communities' beliefs and behaviors. First, they attempted to use community residents to "spread the Plain Talk message" and persuade other residents, both adults and adolescents, that it is important to protect sexually active youth. Second, they attempted to change the way key institutions educate and serve adolescents. Both approaches, as this report has documented, are time consuming and arduous. The sites struggled to find strategies that would work in their communities and repeatedly had to rethink their approaches. Nonetheless, the results of their efforts suggest that targeting both residents and institutions for change is a promising approach and that certain strategies appear to be more successful than others.

Using Residents as Plain Talk Messengers

From the outset of the initiative, people involved in Plain Talk knew how controversial its message was. Health care providers and social scientists understand how devastating early parenthood and STDs can be for adolescents. Although many do not approve of early sexual activity among adolescents, they are more concerned with the consequences of the activity (pregnancy and disease) than the activity itself. Thus, encouraging sexually active youth to use contraception and protection from STDs becomes more important than attempting to stop adolescents from having sex. Not everyone, however, subscribes to that pragmatic philosophy. In many communities and among many groups of people, including some of the Plain Talk communities and the residents living in them, teen sexuality, and not some of the negative consequences of that sexuality, is perceived to be the greater problem.

Ideas about sexuality, reproduction and disease are fundamental to people's cultural definitions and morality. Attempting to alter people's attitudes about sexuality, therefore, involves more than simply giving them information and asking them to assess risk in the same way that medical professionals do. To the degree that the ideas behind Plain Talk ran counter to the prevailing norms concerning sexuality, getting residents to accept the ideas often entailed moral persuasion.

It is important, however, to avoid thinking that the mores of urban communities in the United States are a coherent and cohesive whole. As we have emphasized throughout this report, communities are complex entities, and Plain Talk's philosophy met with a broad range of

responses within the communities. While the prevailing culture of the target populations in some of the communities valued premarital abstinence, it is also true that the residents with whom we spoke held a wide range of beliefs about sexuality. Some residents, by virtue of tragic life circumstances (such as having young relatives who had contracted AIDS) or hopes that their children's lives would be better than theirs, accepted the Plain Talk message relatively easily. Others did not. This diversity in people's opinions about adolescent sexuality and the fact that some core group members came into the group supporting the Plain Talk philosophy meant that Plain Talk was able to grow in the communities. If the ideas behind Plain Talk were unacceptable to everyone in the community, we doubt that we would have observed growing core group membership or workshop participation throughout the implementation period.

Plain Talk was similar to other community initiatives in which obtaining resident involvement has persistently proved time consuming and difficult. Program operators and evaluators are well acquainted with the myriad of difficulties that face those who want residents to participate in what are essentially externally conceived attempts to change the values of communities. In addition, there has been relatively little data available to show what benefits have been produced by the efforts to involve residents. The remainder of this section discusses our major findings in connection with these issues.

1. **Using local data collected through the community mapping was an effective strategy for awakening residents' interest in the initiative.**

Staff discussed at length how the Plain Talk message could be integrated into the local culture and individuals' value systems to get people to accept the message. While this proved a difficult undertaking, especially in some of the Plain Talk communities, several strategies were useful as the sites moved from one stage of development to the next. As we noted in the report on the planning year and observed throughout implementation, using local data effectively sparked interest in the initiative. Demonstrating the problems facing the communities—such as high rates of adolescent sexual activity, pregnancy and disease; low rates of adolescent knowledge about sexuality; and the limited availability and accessibility of health services—motivated some people to participate in the initiative.

While early Plain Talk core group members were often people who supported the Plain Talk philosophy, occasionally people who did not agree with the ideas behind Plain Talk were drawn into the core groups. Sometimes they dropped out after participating for a relatively short time. But sometimes they stayed and engaged in extended discussions about Plain Talk with staff and other residents. Using the community mapping data as well as persuasion, staff and residents occasionally convinced people of Plain Talk's approach. At other times, people stayed in Plain Talk because they supported some of the work that was being done, such as providing health services to youth with STDs or improving the lives of youth in general, even as they maintained their own values about the importance of abstinence.

2. **Sites tended to be more successful in sustaining the interest and involvement of residents when they recruited people who had previous involvement in other community volunteer activities or who had large informal networks within their communities.**

In addition to sparking people's interest, it was also important to sustain their involvement for ongoing work. Core group members were more likely to remain interested and involved in Plain Talk if they had been engaged in other volunteer activities or had extensive informal networks in the communities. For example, people who were involved in their local PTA were more likely to come into contact with other parents and recruit for Plain Talk activities. People who had large informal networks—either kinship or friendship networks—had more opportunities to speak with people than those who had smaller active networks. Identifying the appropriate people takes familiarity with the community, and, over time, the sites that relied heavily on residents generally became better at identifying people who would sustain their interest in and contribute to Plain Talk.

3. **Resident involvement in planning and implementing the sites' education efforts substantially affected the shape the initiative took in the communities.**

The fact that resident core group members integrated the Plain Talk philosophy into their own value system and felt comfortable communicating it to others in their community made Plain Talk a community-based, and not simply an externally imposed, initiative. In fact, in the Plain Talk sites we observed a particular kind of "insider-outsider" dynamic that centered around what the Plain Talk message would be and how it would be delivered. The insiders were community residents and staff members (some of whom had professional experience) who lived in the community. The outsiders were professionals who did not live in the immediate community.

Residents appeared to be more comfortable than professionals in broaching the discussion to other residents. They did not have the reluctance to engage other residents in discussions about morals that the professional health educators, who saw themselves as outsiders, did. The residents were also more likely to talk about Plain Talk as an initiative directed toward protecting sexually active youth. They connected the work of Plain Talk to local cultural mores, such as those stressing the importance of knowledge and the importance of caring for youth. Core group members in the Plain Talk communities felt that, as residents, they had the responsibility and the right to challenge other community members with the message that they should be protecting sexually active youth.

4. **Resident involvement in the sites' outreach and education efforts substantially affected the sites' capacities to reach into the communities.**

The real benefits of resident involvement emerged in the last 18 months of the initiative when core group members demonstrated their value as outreach workers and workshop facilitators. Residents enhanced the sites' capacity to conduct outreach and generate interest in Plain Talk

workshops and community events. Given the sensitive topic of Plain Talk, word-of-mouth outreach was fundamental to every site's efforts, and residents had access to people who were unknown to staff. In addition, because some of the communities were so leery of outsiders (in San Diego, the Mexican immigrants feared the Immigration and Naturalization Service (INS); in New Orleans, the residents had a general distrust of social service providers), residents proved invaluable in creating and nurturing links between the initiative and the community.

Training adult residents to facilitate workshops and other kinds of community education events also enhanced the sites' capacity to give workshops to a large number of people in a relatively short amount of time. We do not know whether using other types of volunteers (e.g., training professionals, such as teachers, who work in the communities) would be equally effective in attracting large numbers of residents to workshops. To answer that question, we would need to know whether other kinds of volunteers would have the same legitimacy as resident facilitators. However, in the context of Plain Talk, using residents to give workshops compared favorably in terms of cost to using professional staff. In the sites that used resident facilitators, far more people went to workshops than in the sites that did not.

5. **The possibility of mobilizing residents to change a community's mores may be limited by the community's social structure.**

Even though the evaluation confirmed the importance of relying on resident core groups to take part in community education and outreach efforts, the data also suggest that community context is likely to influence the degree to which it is possible to use residents as Plain Talk messengers. In two sites, San Diego and New Orleans, we began to see strong resident development early in implementation. New Orleans' successes with resident mobilization was understandable, since the site had a strong community group, well-established relationships with key providers, and a philosophy of institutional and social change. We saw their success with Plain Talk as building on a structure that was already present because of the social activism that the Resident Council had been involved in throughout the 1980s.

At first, San Diego's success in organizing a community core group was more puzzling, since the site staff seemed to be starting from scratch. However, as we became more familiar with the communities involved, it became clear that San Diego was more similar to New Orleans than we had initially thought: while the San Diego Plain Talk staff needed to create a core group from scratch, the community itself had a strong social structure among residents on which staff came to depend. Extended families, networks of *comadres* and neighbors participated. Obligations among individuals were often strong, and core group members could draw on their networks to further the work of Plain Talk.

In contrast, the Plain Talk communities in Atlanta and Seattle were less cohesive. Atlanta Plain Talk was implemented in a community struggling to survive. Although there was a core of residents who participated in activities, including Plain Talk, at the community center, they found it difficult to recruit other people. Interviews with core group members and other residents suggested that, while the community was not completely without informal social networks

among relatives, friends and neighbors, the networks had lost some of the strength and vitality that had characterized them several decades ago. In Seattle, ethnic diversity in the population meant that the site staff worked with mixed success to organize a core group. In addition, a diverse population, such as the one in Seattle, can also mean that there is limited communication across groups. Different languages, somewhat different social structures, different levels of acculturation and even distrust among groups may all contribute to thin social networks.

Therefore, practitioners undertaking community change initiatives may want to assess communities' capacity to develop and use strong community core groups. In doing so, it is important not only to look at the existence of formal, institutional relationships among community members (such as existed in New Orleans through the Resident Council before Plain Talk) but also to assess the strength and type of informal relationships within communities. We suspect that communities with strengths in one or the other will have potential for using residents effectively at relatively early stages of initiatives.

In contrast, sites that lack strengths in both kinds of networks may find that it takes them longer to implement an initiative like Plain Talk. If the social networks of people within a community are small (e.g., where most people know only a few other people), staff may find that the size of the core group might need to be larger in order to reach large numbers of people. In addition, staff may find that they must engage in organizing the community. Perhaps Atlanta Plain Talk, if given time, would have been able to create a social structure that site staff could have relied on to spread the Plain Talk message. Toward the end of the initiative, some of the events organized by the staff (such as the yearly Mechanicsville "Family Reunion") were leading in that direction, and we were beginning to see the development of a strong core of people the site could rely on.

We suspect, however, that in some communities the time and resources necessary to create and nurture relationships among community members may outweigh the benefits. It is unclear to us whether, given its resources, Seattle could have strengthened its core group's capacity to spread the Plain Talk message among diverse local populations. Doing so might have required more outreach staff, more time for core group development, a larger core group and more resources to train multiple groups of people who speak different languages. The resources needed to implement an initiative with heavy resident involvement in a highly diverse community would likely be substantially greater than those required in more homogeneous communities. In ethnically and racially diverse communities, it might, therefore, be more effective for service providers to lead the efforts and do most of the work.

Institutional Reform

From the beginning, the designers of Plain Talk assumed that it was not enough to change the attitudes and behaviors of individuals living in communities; institutions serving the communities also needed to be changed. Health care services needed to be increased and made more accessible to youth. Schools' sex education curricula needed to be improved to recognize

that some youth were sexually active and those youth should protect themselves against pregnancy and disease. Without changes in institutions, it is difficult to support changes in the values and behaviors of individuals.

In addition to attempting to change local institutions so they could support the initiative's goals of increasing adult-youth communication and protecting sexually active youth, Plain Talk also assumed that it was necessary to spread its ideas to institutions outside the immediate target community. This section discusses promising approaches and challenges to sites' collaborations with institutions.

1. **In developing strategies for engaging institutions, sites had to learn about the importance of defining specific reasons for approaching particular institutions, developing strategic relationships and understanding institutions' political and social contexts.**

As we noted in Chapter VII, a number of strategies proved effective in the sites' efforts to engage institutions—including using local needs and service assessments, forming strategic relationships and identifying specific reasons for approaching particular institutions. Many of these strategies are well known in the field of technical assistance, and many were communicated to the sites throughout the initiative. That some sites were more aware than others of the effectiveness of some of the strategies, however, suggests that several points should be made about those strategies.

The evaluation indicated that what should be obvious—the need to determine from the outset what a collaborative relationship with another institution can accomplish—is not. In the attempt to bring people to the table, the sites sometimes lost sight of the importance of deciding what the relationships could realistically accomplish and what each partner would bring to the relationship. As a result, there were many times when sites extended invitations to institutions such as churches and businesses to participate in Plain Talk, but the invitations were not accepted or, if they were, the people from the institutions were unsure why they had been invited.

Beyond deciding how two institutions can benefit from collaboration, it is important to assess whether the political and social context around the institutions is conducive to the collaboration. As this report has discussed, all the Plain Talk sites made impressive gains in increasing and improving reproductive health services for their youth. In large part, this was because the medical community and Plain Talk had the shared agenda of safeguarding adolescents' health. While there were unique political and social contexts at each site that complicated the collaborative efforts, this shared agenda was powerful enough to prevail.

In other areas, however, Plain Talk's attempts to engage and change institutions were modest, in part because of the contextual barriers to collaboration. For instance, we noted that there was a desire on the part of Plain Talk staff as well as some school staff to have a close Plain Talk-school collaboration in some sites. School personnel are painfully cognizant of the problems of

teen pregnancy, and they often have a very pragmatic stance toward pregnancy prevention that is sympathetic to Plain Talk's approach. However, the social climate in many of the communities or cities in which Plain Talk was located and the high degree of centralization of many school districts meant that the desire for collaboration was unlikely to be realized. Schools must be responsive to public opinion, and in recent years traditionalists have been more active in public school politics than have liberals. To people with traditional values, the Plain Talk message is an anathema.

Despite the political and social climate that made some types of collaborations with the public schools unlikely, the sites found other ways of collaborating with them that were less ambitious but nonetheless provided important benefits. The use of school space for workshops was an important resource. Even more important was the use of social networks that spanned Plain Talk and the schools. Core group members who volunteered or worked as aides in their local schools conducted outreach for Plain Talk events among parents whose youth attended the schools.

2. **Staffing patterns and inadequate planning time contributed to the sites' relatively small gains in the area of institutional change.**

Engaging community residents was the sites' major priority during the first year and a half of implementation. Thus, they turned their attention to institutional engagement relatively late in the initiative, and they had done considerably less planning around institutional engagement than around resident engagement. By the end of the pilot phase, the sites had worked on resident engagement for three full years while they had spent approximately 18 months on institutional change (excluding their efforts to change adolescent reproductive health services, which had been a priority from the beginning and which the sites had substantial success doing). In those 18 months, sites set the stage for their future efforts, but they were unable to achieve much more.

Staffing patterns in the Plain Talk sites were also a factor in limiting efforts directed at institutional change. In general, the sites tended to have staff skilled in health education, grassroots mobilization, management and outreach. Such a staffing pattern meant that the sites were more likely to concentrate their energies on activities that capitalized on their staff's strengths—
community education and outreach. Executive staff time in the lead agencies tended to be included in the Plain Talk budgets at relatively low levels, just enough to ensure oversight of the site's work.

In other community initiatives we have observed, institutional collaborations are facilitated by the commitment of senior administrative staff from lead agencies who have extensive contacts within institutional communities. Senior staff often sit on local social service boards and committees, and they can thus disseminate ideas from initiatives. The one example of such cross-institutional fertilization in Plain Talk was Hartford's Breaking the Cycle Campaign, which the Action Plan staff initiated and which incorporated key reproduction health care

principles from Plain Talk. Overall, however, the Plain Talk design did not explicitly include plans for senior lead agency staff to disseminate Plain Talk ideas. For a variety of reasons, such as prior commitments, lack of time and a reluctance to spread controversial ideas, senior lead agency staff did not participate in Plain Talk.

WHAT DOES THE EVALUATION TELL US ABOUT COMMUNITY EDUCATION STRATEGIES IN PLAIN TALK?

In Chapter V we discussed a number of specific lessons learned about providing community education, from developing curricula to training core group members to facilitate workshops. However, two issues emerged as crucial in the effort to provide community education designed to persuade adults of the importance of protecting sexually active youth and of communicating with youth. First, we observed that each of the sites made a key choice about the workshop content: Should it focus on communication or on providing information about sexuality? By the end of the pilot, all sites had concluded that the workshops needed to include both elements (although they were, as yet, not always including both). The second issue that emerged from the evaluation was whether workshops targeted at parents were more or less effective than workshops targeted more broadly at community adults.

1. Workshops should include factual information about adolescent sexuality and its consequence as well as training in adult-youth communication.

Our observations of community education workshops and our discussions with workshop participants suggested that effective workshop curricula should include factual information about sexuality; anatomy; adolescent development; STDs and HIV/AIDs transmission, symptoms and prevention; and contraception—as well as information about effective communication techniques. However, as we detailed in Chapter V, every site focused on either communication or knowledge. The focus of the workshops depended on who drove development of the curricula—staff or residents.

Staff drove the development of the curricula that emphasized adult-youth communication and reported their belief that a focus on communication would be more effective in increasing adult-youth communication about sexuality than a focus on knowledge. As experienced health educators, they knew that providing facts does not necessarily lead to changes in behavior. They were hoping that providing parents with effective ways of communicating with youth would allow those parents to convey their values to their children. Further, it was clear from staff's comments that they thought that the workshops would be better received and less controversial in some communities if a focus on adolescent sexuality was downplayed.

In contrast to the communication-based workshops, residents drove the development of the knowledge-based curricula. They noted that, since they had lacked important knowledge about sexuality before joining Plain Talk, workshops should focus on educating community residents in basic facts about the subject. Observations of workshops as well as interviews with core group

members illuminated how little many adults in the communities knew about contraception; anatomy and physiology; and STD symptoms, transmission, and prevention. For them, having accurate information was a prerequisite to communication and would increase their level of comfort with youth.

In response to the questions and concerns raised by workshop participants, all sites eventually decided that they needed to implement workshops that covered both communication and knowledge. Participants requested more information about HIV/AIDS in sites that had been giving workshops on communication. In sites that had been giving knowledge-based workshops, participants wanted to know how they could speak with their youth more effectively. Our interviews with people who had participated in workshops across the sites support the idea that residents needed and would have been receptive to both communication skills and knowledge. Without knowledge, adults risked passing on inaccurate information to youth or feeling inadequate to speak with youth in the first place. Without information about useful communication skills, some adults did not know how to begin conversations with youth.

If community residents are facilitating the workshops, however, developing their capacity to integrate communication skill-building sessions into informational sessions would require significantly more training. Thus, sites would need to be prepared to either spend more resources on initial training—already a significant use of resources—or they would need to pair resident facilitators with professional staff. The latter option, however, has a tendency to make the resident facilitator very quiet unless the division of labor between the facilitators is well understood by both parties.

2. **"Askable parents" and "askable adults" play complementary roles in helping youth make responsible decisions about their sexual behavior.**

A basic assumption underlying Plain Talk is that youth need to receive clear and consistent messages about responsible sexual behavior from all the adults in their lives—from their parents as well as from nonparental adults with whom they interact. We found, however, that several sites explicitly targeted parents in community education workshops delivered to residents. Targeting parents for community education is politically attractive and emphasizes the role of the family in raising youth. Our findings confirmed that targeting parents for community education increases parents' knowledge and suggests to them that it is necessary to speak with youth about sexuality. It also appears to increase the likelihood that they will speak. It may not be enough, however, to engage only parents.

We observed that targeting both parents and other community adults in educational workshops was beneficial. The parental role is essential: parents provide youth with moral guideposts for sexual decision-making. They instill values and define what they believe is the appropriate age and context for sexual intimacy. They provide valuable lessons about what constitutes a healthy relationship, such as emotional intimacy, responsible behavior and respect for one's partner. They can provide their children with information about the risks of unprotected sex. Because of

the importance of their role as the child's primary sexuality educator, providing parents with the knowledge and skills they need to carry out this role is essential.

Despite the importance of supporting parents, there seems to be a limit to the role they can play. We found that even parents who were deeply involved in Plain Talk—and convinced of the importance of open communication—had difficulty discussing sexuality with their children once they reached puberty. Many of their children, too, indicated their reluctance to approach their parents with questions. Recent research on parent-youth communication indicates that even youth who are close to their parents may still be reluctant to reveal details about their own sexual relationships and behaviors for fear of disappointing them. Further, this research suggests that there may be good developmental reasons (e.g., adolescents' increasing need for autonomy) for parents' respecting this "zone of privacy." Our findings suggest that youth may be more comfortable approaching another trusted adult with concerns about their sexual relationships.

There is a further need to focus training on "askable adults." In many cases, youth's relationships with their parents can be so strained that open communication about sexuality is unlikely to occur. Although the literature on teen pregnancy indicates that youth who have close and open relationships with their parents are less likely to become pregnant, it does not necessarily speak to the power of even the best workshop to improve communication between youth and parents who have poor relationships.

For all these reasons, focusing training opportunities exclusively on parents may not be sufficient. Instead, training should include all community adults and, in particular, adults who work with youth either as volunteers or in a professional capacity (e.g., mentors, staff of youth-serving organizations). There are, however, cultural reasons why some communities might find it difficult to target both parents and interested adults. We are unsure whether Seattle Plain Talk could have effectively targeted community adults without generating a political battle. As we noted in the planning year report, a strongly conservative group of residents was active in local politics and civic life in White Center. Among the issues of concern to these residents was family privacy. The residents were clear that they did not "want anyone talking to my kid except me." It was not clear to us whether their statements about the family's primacy in socializing their children were generated by the importance of the family's role or by the parents' dislike of the Plain Talk message. However, appeals to family privacy may have a powerful effect on site staff's decisions about whom to target for community education, especially early in initiatives when staff are attempting to gain some legitimacy in the community.

Important tradeoffs need to be considered. If one assumes that creating community change requires the participation of a broad range of individuals and institutions and not just the family, risking the ire of a significant group of local residents at the outset of an initiative may be worthwhile. However, in today's political climate, groups that uphold the value of family privacy in order to deter efforts like Plain Talk can be very powerful. If one makes a politically strategic decision to gain legitimacy within the community by targeting efforts exclusively at

parents, one risks the possibility of losing a broader strategy. These are not choices that need to be made in communities that uphold the idea that "it takes a village to raise a child," a statement repeated often in several sites.

FINAL THOUGHTS

Early on, P/PV staff asked this research question: Is it feasible for neighborhood-based organizations to mount an initiative as complex as Plain Talk? It is only now, after examining the challenges and opportunities facing the sites in each major task area—resident recruitment, mobilization and outreach; institutional collaboration and outreach; and community education—that we can begin to answer that question. Given the ambitiousness of the undertaking, the sites showed great success, and we answer the question with a qualified "yes." As we have noted throughout this report, sites were more successful in some areas than in others. Their areas of achievement varied depending on a wide variety of factors: the capacity of the lead agency to complete particular tasks; the experience and expertise of the site staff; the ethnic, racial and cultural backgrounds of the targeted residents; the degree of cohesion within the neighborhoods; and the political and institutional cultures within the cities in which the neighborhoods were located. The Plain Talk sites that emphasized resident involvement generally had impressive results in their efforts to spread information about sexuality and the importance of protecting sexually active youth. Across the sites, neighborhood organizations with relatively small staff that included health educators and outreach workers were able to mobilize key residents.

Other kinds of community initiatives might be harder to implement. The topic of Plain Talk, adolescent sexuality, was a draw, and we heard repeatedly over the years that the initiative and the people who ran it had "heart." Nonetheless, the central strategies used by the sites should be applicable to other types of initiatives: targeting outreach to identify and recruit people with extensive networks within the community; demonstrating the problem by using local data; saturating people with information over a period of time; and using residents to carry messages to others in their networks and to recruit other people to the initiative.

Plain Talk's efforts in institutional change were much less successful, with the important exception of increasing reproductive health services. It was probably not feasible to think that neighborhood organizations, even the largest of them, had the political influence or motivation to take on major urban institutions that did not already support the Plain Talk goals. Given the small size of most of the Plain Talk organizations, had they devoted much staff time to institutional reform, they probably would have had to choose not to do some of their work in the community. Neighborhood institutions might be able to work in concert with other small organizations or with larger institutions, but having a neighborhood institution lead institutional reform is probably an unrealistic goal. We were unable to explore this question sufficiently, since the sites' implementation of institutional reform efforts lagged well behind their attempts at grassroots change.

Finally, we want to end with the observation with which we began this chapter: community initiatives are time consuming and arduous. The three years of the Plain Talk initiative was enough to glean rich information about a range of implementation issues but not enough to watch the full unfolding of a community change initiative.

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APPENDIX A

LITERATURE REVIEW

Teen birth rates have declined substantially in the United States over the past several years, down 15 percent from 1991 to 1997. Most recently, this decline has been seen in all states, in all age groups and across ethnic groups. Teenagers today are less likely to be sexually active, and those who are, are more likely to use contraception (Ventura et al., 1998).

This trend is encouraging, especially for program advocates who have developed and implemented a number of prevention strategies over the past several years in efforts to counter the increasing adolescent birth rates of the late 1980s. Despite the recent trends, however, the teen birth rate in the United States continues to be higher than in most other industrialized countries (Moore, Miller, Sugland et al., 1995). In the United States, approximately 60 percent of adolescents have had intercourse by age 18 (Alan Guttmacher Institute, 1998); and every year in America, nearly one million teens become pregnant (Ventura et al., 1998). Most of these youth are unmarried, and most of their pregnancies are unintended.

Those youth who go on to give birth experience negative repercussions. Relative to women who delay childbearing, teen mothers are less likely to complete school and more likely to have large families, live in poverty and be single parents. Although these teens are often disadvantaged before giving birth, having a child during adolescence is associated with negative outcomes over and above the effects of background (Brown and Eisenberg, 1995; National Campaign to Prevent Teen Pregnancy, 1997).

The children of teen mothers are also likely to contend with a number of hardships. Relative to infants of older mothers, they experience poorer prenatal care and are more likely to be born prematurely and at low birth weights. They have a higher mortality rate and receive less medical care throughout childhood. They live in homes that are of poorer overall quality, and they eventually do worse in school than do children born to older parents (National Campaign to Prevent Teen Pregnancy, 1997; Ventura et al., 1998). Children born to teen mothers also suffer higher rates of abuse and neglect (National Campaign to Prevent Teen Pregnancy, 1997).

Concern for early pregnancy and births is coupled with concern about STDs. About one in four sexually experienced teens in this country acquire an STD every year (Alan Guttmacher Institute, 1994). Women in their teens have higher rates of chlamydia and gonorrhea than do any other age group of women (Centers for Disease Control and Prevention, 1997), and close to one-quarter of all new HIV infections occur in youth under 22 years (Centers for Disease Control and Prevention, 1998). One recent study estimates the average annual cost for unintended pregnancy and STDs per adolescent using no contraception as $1,267 in the private sector and $677 in the public sector (Trussell et al., 1997).

The serious consequences of pregnancy and unprotected sexual intercourse have motivated a number of research studies designed to address a critical question: Who is at most risk for early pregnancy? These studies suggest that no particular characteristic sets these teens apart from their peers; instead, there are a number of factors related to economic and social circumstances that combine to put teens at greater risk. Social attitudes, such as permissive attitudes toward sex, ambivalence about having a child, and lower educational aspirations, increase the likelihood for early sexual behavior or childbirth (Kirby, 1997). Youth who are physically aggressive, have problems in school, date early, or use alcohol and other drugs are also more likely to become sexually active early (Sonenstein et al., 1997; Moore, Miller, Glei and Morrison, 1995).

Ethnicity is another important factor. Until 1996, the teen birth rate for blacks was higher than that for other ethnic groups. Hispanics now have the highest teen birth rate in the United States, and blacks are at the lowest rate ever recorded for them, although their birth rates are still higher than those of non-Hispanic white teens (Ventura et al., 1998). These racial differences are related to differences in economic and social circumstances; when income, parents' education and family structure are taken into consideration, differences are reduced significantly (Moore, Miller, Glei and Morrison, 1995; Moore, Miller, Sugland et al., 1995).

Several aspects of youth's surrounding social world also contribute to adolescent sexual behavior. Living with a single parent significantly increases youth's risks for early childbirth whereas maternal education and positive parental support, monitoring and discipline decrease the risks (Moore, Miller, Sugland et al., 1995; Moore, Miller, Glei and Morrison, 1995). Peers and siblings are also influential. Youth who have a sexually active best friend or sibling are more likely to hold permissive sexual attitudes and to initiate sex early (Moore, Miller, Sugland et al., 1995; Moore, Miller, Glei and Morrison, 1995). Teens from economically disadvantaged communities that have low educational levels, high divorce rates and high residential turnover are also at high risk of early pregnancy and childbirth (Kirby, 1997; Moore, Miller, Glei and Morrison, 1995).

PREGNANCY PREVENTION PROGRAMS

Given the complex combination of social and economic circumstances that are related to teen pregnancy and sexual behavior, it has been very difficult to design and implement effective teen pregnancy and STD prevention programs. Therefore, in addition to examining the factors that contribute to teen pregnancy and the spread of STDs among adolescents, researchers have also addressed two additional questions:

- # What efforts are being made to prevent teen pregnancy?
- # Have any of these strategies been successful?

Two of the most common goals in pregnancy prevention programs are to delay the initiation of sexual intercourse and to increase the effective use of contraception among adolescents who are currently sexually active. Delaying the age at first intercourse is important because it decreases the length of time during which the adolescent will be exposed to risk. In addition, youth who initiate

sex early are less likely to use contraception, and they go on to have more sexual partners more quickly (Moore, Miller, Glei and Morrison, 1995).

Increasing the effective use of contraception is another critical goal in some pregnancy prevention programs. Twenty percent of sexually active teens are not using any form of contraception. Nine out of 10 teens who have sexual intercourse with no contraception for one year will become pregnant (Moore, Miller, Glei and Morrison, 1995). Adolescents express many reasons for failing to use contraception, including a lack of planning, feelings of invulnerability to pregnancy, embarrassment, and ambivalence about sexuality, pregnancy and contraception (Kirby, 1997; Sonenstein et al., 1997; Moore, Miller, Sugland et al., 1995). Many teens are poorly informed about contraception and pregnancy, and negative attitudes about contraception predict less use (Moore, Miller, Glei and Morrison, 1995).

Abstinence-Only Programs

Abstinence-only programs are designed to address the former of the two goals, namely, preventing teens from initiating sex. Contraception is rarely, if ever, discussed in these programs. Some of these programs do appear to have a short-term influence on attitudes and intentions to have sex (Moore, Miller, Sugland et al., 1995). However, none of the abstinence programs analyzed in a review by Kirby (1997) had a consistent effect on sexual behavior. Wilcox and Wyatt (1997), in their meta-analysis of 52 abstinence programs, similarly concluded that these programs did not appear to influence the sexual behavior of participating youth. Yet, so few of these abstinence-only programs have been rigorously evaluated that conclusions about their effectiveness await further research.

Sex and HIV Education Programs

A more common approach to pregnancy prevention is sex education that covers both abstinence and contraceptive use. Some of these programs are based in clinics, shelters, agencies and churches, but most are offered in the public schools. A critical consistency across evaluations of these programs is that sex education does not cause teens to start having intercourse; nor does it increase the frequency of sexual activity or number of partners (Kirby, 1997; Moore, Miller, Sugland et al., 1995). In fact, several programs affect attitudes and increase short-term knowledge. Some, most notably AIDS education programs, also increase the use of contraception (Kirby, 1997). Few of these programs, however, have been actually demonstrated to change sexual behavior, given the paucity of rigorous evaluation research (Moore, Miller, Sugland et al., 1995; Moore, Sugland, Blumenthal et al., 1995).

In efforts to determine which characteristics of these programs were helpful in changing attitudes and behavior, Kirby et al. (1994) compared curricula from programs that showed positive behavioral effects with curricula from programs without positive results. Kirby (1997) notes nine common characteristics among effective programs:

- These programs focus fairly narrowly on reducing sexual behaviors that lead to pregnancy or STDs and present clear messages about what youth should do to prevent pregnancy or STDs. In other words, the programs do not just present information in a values-neutral way.

- They have goals and curricula that are appropriate for the age, culture and sexual experience of the youth.

- They are based on theoretical approaches that have been effective in influencing other health-related behaviors (e.g., social learning theories that consider social influences on attitude formation and change).

- The programs lasted long enough to complete targeted activities.

- They used teaching methods that involved the students and helped them to personalize the information.

- They provided basic facts about the risks of unprotected sex and how to avoid them.

- They addressed issues of social pressures on sexual behavior.

- They helped youth develop communication, negotiation and refusal skills.

- They selected and trained teachers or peers who believed in the program.

School-Based Health Centers

Clinics located on school grounds are designed to provide basic primary health care services to students. These clinics provide counseling and referrals, and some dispense contraceptives. Those that dispense contraceptives provide them to a large proportion of the sexually experienced teens within the school (Kirby, 1997). Several evaluations of these programs show no change in contraceptive use. Others show a slight increase but no impact on pregnancy rates (Kirby, 1997). Again, however, their presence does not seem to increase the frequency of sexual behavior. One major limitation of school-based centers is that they do not reach older youth and school dropouts, especially in such communities as poor Latino communities where the dropout rate is very high. It is a substantial drawback given that half of the fathers of babies born to teen mothers are 20 or older (Moore, Sugland, Blumenthal et al., 1995).

Family Planning Clinics

One of the main goals of family planning clinics is to improve information about and access to contraception. Many clinics tailor some of their services to teens; and some have made efforts to

improve their services for teens by, for example, designating a staff person as teen counselor, providing a follow-up phone call to patients to answer questions, and changing aspects of the clinic that were particularly problematic for teens, such as administering medical tests on the first visit (Moore, Sugland, Blumenthal et al., 1995). Some of these changes have increased contraceptive use among their clients. There is also evidence that two factors—the proportion of teens at risk for pregnancy who are served at these clinics and greater funding for family planning services—are associated with lower premarital childbearing among teens (Moore, Sugland, Blumenthal et al., 1995).

Programs Targeting Parent-Teen Communication

Some sex and HIV/AIDS education programs target not only youth but also their families, particularly communication within the family. These programs are based on research suggesting that parents may influence their teen's sexual behavior through their communication about sexual issues and contraception. In one study, for example, female adolescents from families that had ever discussed contraception were more than twice as likely to use contraception (Moore, Miller, Glei, and Morrison, 1995). Yet, only one out of three families include discussions of contraception in sexual discussions with their teens (Brown and Eisenberg, 1995). Findings from studies examining the effects of parent-teen sexual communication have not been entirely consistent, because of difficulties in measuring the frequency, content and quality of this communication. However, researchers have found that parental attitudes toward teen sex, the amount of parent-teen communication about sex and the quality of their discussions in combination can be powerful predictors of teen sexual intercourse (Jaccard and Dittus, 1991).

Some programs that target parent-teen communication are designed for parents only; others are made for parents and their children. For example, the Facts and Feelings program used an abstinence-based curriculum and included written materials and informational videos designed for parents to watch and discuss with their 7th- and 8th-grade children. These materials promoted sexual abstinence and covered sexual education, values and parent-teen communication (Miller, Norton, Jensen et al., 1993).

In the short term, programs like Facts and Feelings have increased parent-teen communication about sexuality and, in some cases, their comfort with this communication; but these positive effects have not been long lasting (Kirby, 1997; Moore, Sugland, Blumenthal et al., 1995). Some programs targeting parent-teen communication have also had positive behavioral effects, but only among certain groups. If the mother is the person communicating with her adolescent daughter, the discussions take place early, and the mother holds conservative beliefs regarding adolescent sexuality, parent-child communication seems to delay the initiation of sex (Kirby, 1997). Clearly, however, for long-lasting effects on parent-teen communication and, ultimately, sexual behavior, programs that target communication need to use approaches that make lasting changes in communication. They also need to consider multiple aspects of parent-teen discussions.

Multicomponent and Community-Based Approaches

There seems to be a growing consensus that combining approaches and using more pervasive techniques that address a number of risk factors may be part of the answer to preventing teen pregnancy. Many innovative programs have been created with this in mind, using some of the elements described above. These include such school-based components as classroom discussions, schoolwide activities and presentations, and peer workshops. Attempts to reach the wider community have also been incorporated, including door-to-door canvassing and condom distribution, media campaigns, improvement of clinic services, and presentations in health centers and other organizations. Several of these programs have been successful in affecting sexual behavior.

Some programs have also made links between services in the community. One of the most successful is the Self-Center, an adolescent reproductive health clinic in Baltimore that combines sex education in two schools with contraceptive services at a nearby clinic. This program has decreased rates of unprotected sex and delayed the initiation of teen sex (Kirby, 1997; Moore, Sugland, Blumenthal et al., 1995).

Although some of these multicomponent approaches seem very promising, their ability to sustain their effects has usually been limited to the duration of the program. One example is Project Action, which included a large media campaign, the installation of condom vending machines, and the creation of workshops to improve decision-making and assertiveness. The campaign increased youth's use of condoms with casual sexual partners, but this effect did not continue after the program ended. Another very intensive school- and community-based program in South Carolina coordinated efforts of the media as well as several organizations and schools. The program provided sex education training to teachers and community leaders, and integrated sex education into all grades in the schools. A school nurse counseled students and provided contraceptives and transportation to a family planning clinic. The program was quite successful and led to a decline in pregnancy rates for several years. When part of the program ended, however, pregnancy rates returned to their original levels (Kirby, 1997).

It is rare, if not impossible, to find one approach that has worked across the board at changing long-term sexual attitudes, behavior and, ultimately, pregnancy and birth rates in this country. Often, no program effects have been shown, although several innovative programs have shown significant effects. Most programs have focused on affecting the actions of individuals rather than trying to change their surrounding community. Such environments, however, strongly influence sexual attitudes and behavior and should be considered when designing long-term approaches to teen pregnancy prevention. Brown and Eisenberg (1995) speculate that programs targeting individual behavior may never achieve their goals when the surrounding socioeconomic and cultural environments do not support the behaviors and attitudes proposed in the prevention program. More pervasive changes in families and across communities might help programs to sustain their benefits, even after the program itself has concluded. Believing that efforts to make

more pervasive changes will make the most long-term, substantial progress toward decreasing teen pregnancy and childbirth in this country, The Annie E. Casey Foundation designed Plain Talk.

APPENDIX B

TECHNICAL ASSISTANCE PROVIDED IN PLAIN TALK

A broad range of technical assistance was provided to the sites over the course of the initiative. The evaluation did not systematically track the results of specific technical assistance, so it is not possible to draw firm conclusions about best practices in providing technical assistance. It is, however, possible to describe the kinds of technical assistance that were provided and to comment on that.

Community initiatives such as Plain Talk require considerable investment in capacity-building in a number of areas. Whether or not the technical assistance that is provided to build capacity is useful to a site appears to depend on a number of factors:

- *The readiness of a site to receive technical assistance in a given area*. Providing technical assistance is more likely to be effective when the assistance addresses the site's priorities.

- *The site's staff capacity to implement recommendations and products provided by technical assistance*. Two good examples of this in Plain Talk include the capacity of sites to carry out work plans around institutional collaboration and to implement management information systems—especially using database software. When sites had executive staff with the time to convene meetings with other institutions, technical assistance in creating such plans could be useful. Otherwise, the plans were not implemented. Likewise, developing databases for sites was useful only when there were staff on site who were trained to use them.

- *The site's response to the technical assistance providers themselves*. At times it was important that TA providers reflected the cultural or ethnic backgrounds of the communities they were aiding. At other times it did not matter. For example, if a TA provider was helping a site create a database for participation data, it did not matter whether he/she reflected the site's ethnic composition. On the other hand, finding bilingual providers was important when their task was to provide values clarification workshops to the community.

What all these factors suggest is that standardized technical assistance plans are unlikely to work in multisite community initiatives. Variations among sites are too great: even when sites need similar kinds of technical assistance, it may need to be delivered in different ways and at different times. Customized technical assistance, however, can be costly.

In Plain Talk, the sites received a mix of standardized technical assistance provided through cross-site conferences, as well as customized technical assistance that helped sites with specific tasks and goals. In general, technical assistance was provided in six major content areas: values

clarification, management information system development, community mobilization, curriculum development, collaborating with other institutions, and sustaining Plain Talk's work. Consultants were hired—generally by the Foundation, but occasionally by the sites—to give training workshops and provide follow-up. In addition, Foundation staff provided ongoing general technical assistance, such as helping sites develop their work plans and assessing their need for technical assistance. Below we list the major content areas in which sites received technical assistance, along with the specific forms that TA took.

VALUES CLARIFICATION

Values clarification was the process of clarifying how one's personal values about sexuality coincided or conflicted with Plain Talk's values. Although values clarification workshops could be perceived as community mobilization, we have considered it separately because it was a crucial process for the initiative, especially during the Planning Year. All sites had workshops designed to explore the core group members' values around sexuality, and several sites noted that the process was key to planning Plain Talk strategies. In New Orleans, for example, the values clarification sessions exposed how many adult residents had histories of sexual abuse and domestic violence. Further, it revealed the extent to which residents clung to myths about sexuality—myths that could lead to improper contraceptive practices or myths that presented women as dangerous for men. The curriculum that the site ultimately developed recognized the existence of issues around sexuality that were much broader than communicating with adolescents about effective contraception and protection.

COMMUNITY MOBILIZATION

The assumptions underlying Plain Talk's design required significant grassroots mobilization among community adults. Their involvement was seen as crucial to getting the community to accept the Plain Talk message. In addition, community adults who were core group members were identified as important in recruiting other adults to Plain Talk activities. As a result of their centrality to the Plain Talk design, the sites and the Foundation focused technical assistance on resident recruitment and participation. Although technical assistance was provided in the area of community mobilization throughout the initiative, its specific focus changed as the initiative developed. Early in the initiative, the TA focused on group process, team-building and decision-making as the sites worked to solidify core group membership. Later, sites received technical assistance that centered around how to handle hostile responses to the Plain Talk message, as well as how to assess residents' readiness to participate in a broad range of Plain Talk activities, such as recruitment and workshop facilitation. Technical assistance providers also helped sites develop strategies for reaching people in the Plain Talk neighborhoods.

MIS DEVELOPMENT

As in many initiatives, it was important for Plain Talk sites to track participation in a variety of activities for several reasons. First, as a way of assessing their progress, site managers needed to

know how many participants attended workshops and what their responses to the workshops were. Did residents show an increase in knowledge? What did they like about the workshops? How were they recruited? Second, site managers used participation data in reports to funders and in proposals for further funding.

Technical assistance in MIS development was provided midway through the initiative. Consultants were hired by the Foundation to assess the sites' needs for MIS and to make recommendations about the sites' needs to develop adequate systems. A site's capacity to staff and maintain a system, as well as a site's commitment to collecting the data, were crucial to the efficacy of the technical assistance that was provided around MIS development. Where staff did not have the time or specific skills (e.g., knowledge of a specific data base) necessary to maintain the system, the systems provided were not used. However, in sites where staff capacity was high, providing software allowed the sites to produce data with ease.

CURRICULUM DEVELOPMENT

Each site developed its own community education curriculum, a task that was very time consuming. The Foundation provided technical assistance to help sites organize and present their curricula in the hope that sites could share them with other communities. In some cases, technical assistance included helping the sites target the audience for the curricula: some sites had two curricula—one used for training residents to give community education workshops and one used for giving community education workshops. Others used only one. Technical assistance providers helped the sites with the presentation and organization of the material and provided training materials that could act as templates for sections of the curricula.

CREATING INSTITUTIONAL PARTNERSHIPS

In late Fall 1995, the Foundation decided to focus the sites' attention on the importance of forging institutional partnerships with a broad range of institutions: state and local governments, businesses, churches, social service providers and health care institutions. Throughout 1996 and 1997, therefore, the sites received considerable technical assistance in a variety of areas that contribute to forging partnerships.

Table B.1 lists the kinds of technical assistance and provides an overview of the time frames in which particular kinds of technical assistance were provided. Technical assistance in each area was available to every site, but not every site availed itself of specific kinds of technical assistance. Further, sometimes technical assistance was provided to all sites during a conference, but follow-up assistance in that area was provided unevenly on a site-by-site basis. A good example would be the technical assistance around forging institutional partnerships: In March 1996, the Foundation held a cross-site conference that focused primarily on getting the sites to strategize about potentially useful institutional partnerships. When the people from the sites went home, they received follow-up visits from consultants. In the coming months, the degree and kind of follow-up varied tremendously. At one end of the spectrum, the staff in Seattle were planning and

coordinating a forum on teen pregnancy to which stakeholders from across Washington State were invited. For this effort, the Foundation provided significant support in the planning process. At the other end of the spectrum, staff in San Diego received follow-up visits from consultants on external mobilization but did not request or receive substantial assistance for a major effort.

SUSTAINING THE WORK

In the last two years of the initiative, the sites and Foundation turned their attention to sustaining some of their efforts beyond the funding period. At conferences, the Foundation brought in speakers knowledgeable about changes in welfare laws and health care financing. Consultants held sessions with sites during conferences to discuss how staff could sustain particular pieces of their work. For instance, San Diego staff discussed the possibility of finding funding to continue the efforts of the *promotoras* by thinking about their work as leadership development among Latinas. Unfortunately, the possibility did not materialize. Seattle staff seriously discussed the possibility of taking the Plain Talk for Parents curriculum to a broader audience and, with the help of consultants provided by the Foundation, made initial efforts in that area. Atlanta staff focused their efforts on solidifying their relationship with the county health department in order to maintain the new adolescent clinic in the community.

AECF TECHNICAL ASSISTANCE

Throughout the initiative, AECF staff provided technical assistance to all the sites in the areas of planning and developing strategies. In some years, AECF staff held frequent telephone conferences with site staff to discuss common themes across the sites and identify areas where sites needed support. In other years, Foundation staff's work with the sites was more individualized. AECF staff also visited the sites with some regularity to talk with staff about their progress and meet with lead agencies when required. As is typical of community initiatives that are conceived and designed by a national Foundation, the work that Foundation staff did with sites was directive as well as responsive to their needs.

The following chart describes the major areas in which technical assistance was provided to the sites as a group throughout the initiative.

Table B.1
Technical Assistance Provided to Plain Talk Sites throughout the Plain Talk Initiative

Type of TA provided	1993	1994	1995	1996	1997
Values Clarification	✔	✔			
Community Mobilization	✔	✔	✔	✔	
MIS Development			✔	✔	
Curriculum Development			✔	✔	✔
Creating Institutional Partnerships				✔	✔
Sustaining the Work				✔	✔
General TA Provided by AECF Staff	✔	✔	✔	✔	✔

APPENDIX C

USING ETHNOGRAPHY IN THE PLAIN TALK IMPLEMENTATION STUDY

The Plain Talk evaluation differed from many evaluations because it included an ethnographic component. In the three sites in which baseline surveys were conducted and in which follow-up surveys were planned—Atlanta, San Diego and New Orleans—ethnographers worked approximately 20 hours a week for a period of 12 to 15 months. In Seattle, an ethnographer was hired late in the implementation process as a way of understanding more fully how service providers, including Plain Talk, worked with a diverse population.

Doing ethnographic work in Plain Talk allowed us to understand more fully the cultures of the communities and institutions in which Plain Talk was being implemented. As we looked back over the field notes from our site visits and the notes compiled by the ethnographers, it was not always easy to see differences between any given set of notes. P/PV staff were as likely to get certain kinds of information in interviews as the ethnographers were. Good ethnographic work, however, allows one to interpret the information one receives in a way that periodic site visits do not. To use an analogy, periodic site visits allow evaluators to create two-dimensional drawings of a community, whereas ethnographic work enables the creation of three-dimensional figures. Because both types of representations are bounded in time and space, neither represents perfectly the ever-changing nature of social life. However, each conveys information, and each has its advantages. Implementation research that relies on site visits is a relatively inexpensive research option and can be very useful if one already has a good understanding of what should and might happen in the course of implementation. Just as the artist drawing the human figure often relies on preexisting knowledge of the skeleton underneath to help shape the figure, the researcher who relies on site visits often has a preexisting knowledge about the kinds of events and processes that occur in the implementation of community initiatives.

Using ethnographers to conduct the research, in contrast, is costly—not only is more time put into collecting data and writing up field notes, but there is much more data to analyze. It has advantages, however, because ethnographers can examine a community from different angles and perspectives. They have many more points to help them determine the overall shape, size, and depth of the figure they are creating. They have more time to interview more people and observe more events; they also have opportunities to test their ideas about how to characterize the communities. Testing allows researchers to distinguish between accounts and perspectives heard in interviews that are representative of groups in the community and those that represent individuals. Thus, researchers can more accurately understand group perspectives instead of relying too much on individual perspectives not widely shared within the community.

The ability to interview participants at multiple points in time is also crucial to understanding how and why the initiative developed as it did. This is a task that takes time and immersion in a site. When events happen, ethnographers can record them as they unfold—which is often

preferable to getting retrospective accounts in which people have come to a particular interpretation of the event that they may or may not have held during the event itself.

Finally, ethnography is a flexible research method that allows us to confirm, disconfirm or refine the ideas that we have about the community or the initiative over a defined period. We can continuously go back into the site and ask community members and others if our ideas are accurate. In contrast, during site visit interviews we rely on relatively rigid sets of interview questions and schedules, and it is more difficult to engage in a process of discovery with the people at the site.

ETHNOGRAPHIC WORK IN PLAIN TALK

The Plain Talk ethnographers were broadly charged with providing background information about the community, observing community education sessions, interviewing staff and participants, and just hanging out to observe the daily work of staff and other participants. Monthly telephone conferences were held between P/PV staff and the ethnographers to talk about the issues that were surfacing in the sites and to think about which issues seemed to surface in all sites and which ones seemed to be site specific. To prepare for the telephone calls, ethnographers frequently wrote analytic memos on specific topics of interest that would serve as the basis of conversation and comparison.

The ethnographers worked between 12 and 15 months at each site. The first started in September 1995 and the last (in Seattle) started in December 1996. Over the course of the fieldwork, the ethnographers conducted interviews with community residents, Plain Talk staff and staff from local organizations. They observed multiple sessions of the Plain Talk community education workshops as well as sessions to train resident lay health educators. They also attended and observed meetings of Plain Talk core groups and staff and other community meetings that related to the work of Plain Talk. For example, the New Orleans ethnographer not only attended the monthly board meetings for the lead agency; but also attended community mobilization meetings to organize a protest against funding cuts that the city imposed on the local health clinic. In three sites—Atlanta, New Orleans and San Diego—the ethnographers hung around the Plain Talk offices getting to know staff and observing day-to-day activities. (The Seattle ethnography was designed separately to explore questions about the way a site as ethnically diverse as White Center deals with cultural differences among people. Because the work in Seattle had a different focus, the ethnographer spent somewhat less time focusing on Plain Talk.) Table C.1 enumerates the type and number of people the ethnographers interviewed as well as the approximate number of observations they made. The number of people interviewed underestimates the actual number of interviews conducted, since several people in each site were interviewed repeatedly. The remainder of this appendix presents examples of the kinds of information that were gathered through the ethnographic fieldwork.

Table C.1
Number of People Interviewed and Number of Observations Conducted in Each Site

Site	Number of community residents interviewed	Number of Plain Talk or other lead agency staff interviewed	Number of staff from local institutions interviewed	Observations of community education workshops	Other observations
Atlanta	13	5	10	15	40
New Orleans	27	9	7	9	68
San Diego	40	13	9	19	65
Seattle	37	10	25	15	26

OBSERVATIONS OF COMMUNITY EDUCATION WORKSHOPS

Whenever possible, the ethnographers made multiple observations of such activities as community education workshops. In Plain Talk, the fact that we had multiple observations of activities allowed us to assess the workshops, which we would have been reluctant to do had we observed workshops only during site visits. It is difficult to assess the overall quality and range of community education when one only observes one or two people give one or two workshops. If the workshop is poorly facilitated, what does that mean? Was the facilitator poorly trained or just having a bad day? If the workshop did not follow the written curriculum, is that something done by all the facilitators in the site or just the specific facilitator? Having ethnographers on site allowed us to observe entire workshop series, observe them more than once, and observe different people giving them. With data from multiple workshops, we could draw conclusions about the curricula, the quality of the workshops, and the quality of the training and support provided to facilitators.

During each session, an ethnographer would take detailed observational notes. She counted the number of people who were at the session, listing their first names and their gender. She noted the presence of new participants who had not attended the previous session. She noted where the workshop took place and how long it lasted. If there was an agenda or set of topics to be covered, she recorded these. She recorded, in detail, the content of all presentations made by the workshop facilitator and collected any handouts, worksheets, videos or other materials that were used during the session. She noted the appearance and behavior of the participants, whether some or all were actively engaged, attentive, listless or bored. She recorded their

questions, their responses to the facilitator's questions, and the content of group discussions. She noted the facilitator's style and pace, and the mood of the group. The ethnographer also recorded her impressions about the workshop, such as the atmosphere created by the facilitator, the depth with which topics were covered, and the accuracy of the information conveyed in the workshops. She compared these observations and impressions with those from workshops she had previously observed. If she had questions about what happened in the session, she asked the participants, the outreach worker or the facilitator for their interpretation.

Without the work of the ethnographers, we could not have satisfactorily addressed the question, "Can residents be used as effective facilitators in workshops?" Nor could we have understood so profoundly how little the adults in some of the communities, particularly San Diego, knew about sexuality, contraception and STDs. We also would not have known what challenges residents face when they learn how to become workshop facilitators and what can help them overcome these challenges.

INTERVIEWS WITH RESIDENT CORE GROUP MEMBERS AND PLAIN TALK STAFF

We were interested in the sites' attempts to engage residents in a number of ways. We wanted to understand how residents were recruited to various activities, what motivated residents, what residents' perspectives were on their involvement and how they benefitted from their participation. We also wanted to understand why core groups in some communities were functioning well while those in others were faltering. The ethnographers thus interviewed residents—both those in the core groups and those whose participation in Plain Talk was limited to attending workshops. Some of the residents were interviewed once; but in each site, several of the longtime core group members acted as informants—alerting the ethnographer to things she might want to follow up on, explaining some of the community's cultural norms, and interpreting events. It was through comparisons of interviews with residents in different sites that we came to understand the importance of community networks in determining each site's successes in recruiting people to workshops.

The ethnographers also interviewed staff on multiple occasions to gain an understanding of the rationale behind the development of the community education curriculum in each site. They interviewed the outreach workers to try to understand, in as much detail as possible, the practices that led to successful recruitment to the workshops. Because of the trust that the ethnographers built, staff began to express their concerns about issues facing the sites. This last point was important, because P/PV staff from Philadelphia often identified challenges during site visits but did not always know how to interpret them, especially if interpersonal dynamics were involved (site staff did not want to air their dirty laundry). Even as we were observing them, the people at the sites were engaged in a process of "impression management" and attempting to obscure some of the problems. This meant that we could badly misinterpret events or actions, which occasionally led to hard feelings between the sites and P/PV. However, because the ethnographers developed relationships with people in the site, there tended to be less concern with managing impressions

around them and limiting information. Thus, the ethnographers often had a better understanding of what was really happening.

OBSERVATIONS OF COMMUNITY EVENTS AND MEETINGS

Our ethnographers sat through many, many community meetings. (One sat through 27 core group meetings!) They took notes on the number of people present, recorded who facilitated the meeting, collected copies of the agenda, and took notes on who spoke in the meetings, what they said, and what decisions were made. The ethnographers and P/PV staff had questions about the utility of sitting through so many meetings, but there were periods when the ethnographers could not find willing interview participants without going to the meetings and recruiting people from them. There were other times when there were no workshops being held in the sites, and the core group meetings were the only activity.

Despite our concerns, observing meetings and speaking with residents after the meetings proved very useful in understanding the sites' successes in mobilizing the residents and sustaining their interest. Data collected in interviews proved a poor way of understanding why some sites were more successful than others. In interviews, staff had a tendency to overstate their successes and their strategies for mobilizing residents. Residents, in contrast, had a tendency to accentuate the negatives (especially if the site was in crisis) in their relationships with staff (not unlike the way that employees sometimes emphasize their bosses' flaws). Thus, we came to rely primarily on observations as a way of collecting data about the extent to which residents were involved in Plain Talk. Observations of meetings also helped us understand why San Diego continued to deal successfully with residents' reluctance to accept the Plain Talk message. The site director emphasized the importance of protecting sexually active youth, "our kids, *con carino and respeto* (with caring and respect)" in every meeting. It was only when we began to analyze the data that we realized how persistently she had made her points and how successful her strategy was.

Being on hand to observe community events was useful for gauging the community's knowledge of and interest in Plain Talk, as well as learning more about each community's social structure. It was also possible to observe firsthand how Plain Talk was identified to the community by both the residents who volunteered to work in community events and by the Plain Talk staff.

INTERVIEWS WITH SERVICE PROVIDERS AND OTHERS WORKING WITH THE COMMUNITIES

A major task of the ethnographer was to identify and interview key individuals who could serve as what anthropologists refer to as "native informants," or spokespersons who could identify core beliefs, perceptions and practices that are common to their cultural group. Given the dual goals of Plain Talk—to mobilize community residents and institutions—it was necessary to have informants among both the residents and people familiar with the local institutions and political environment. Often, the ethnographer became aware of the existence of individuals

who could comment on local institutions through the emerging network of contacts she established in the course of doing fieldwork. Without immersion in the community, it would be very difficult to learn of them. Having identified people, the ethnographer interviewed them to learn about norms governing institutional collaborations, as well as the local political and funding environment. This proved important in understanding the sites' progress toward institutional collaborations, since it brought into focus important contextual factors that we might otherwise have overlooked.