



The Evaluation of Teen Outreach Program (TOP) in Kansas City

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Intervention Name	Teen Outreach Program (TOP)
Intervention Description	<p>TOP is a youth development and service learning program for youth ages 12 to 17 designed to reduce teenage pregnancy and increase school success by helping youth develop a positive self-image, life management skills, and realistic goals. The TOP model consists of three components implemented in school, after school, or in community settings over nine months: (1) weekly curriculum sessions, (2) community service learning, and (3) positive adult guidance and support. The TOP Changing Scenes Curriculum is separated into four age-/stage-appropriate levels, Level 1 is typically for youth ages 12 or 13 and Level 4 is typically for youth age 17. The curriculum focuses on the presence of a consistent, caring adult; a supportive peer group; skill development; sexual health; and sexual behavior choices. The intended program dosage for each participant is a minimum of 25 weekly sessions (one per week at 40–50 minutes each) and at least 20 hours of community service learning over nine months. One or two facilitators who plan the order of sessions based on the needs and interest of youth implement TOP in a group of 10 to 25 youth.</p> <p>Trained and certified TOP facilitators who work for The Women's Clinic of Kansas City's Lifeguard Youth Development Program implement Levels 1-3 of TOP's Changing Scenes Curriculum to 7th- and 9th-grade students based upon class maturity levels and past TOP Curriculum delivery experience. Most clubs occur in 7th-grade social studies and 9th-grade world history classes (with a few schools electing to offer the program in English or physical education/health classes).</p>
Counterfactual	Business as usual
Counterfactual Description	Control group youth receive the business-as-usual classroom curriculum from their existing core content class teacher (for example, social studies or world history teacher) and have no interaction with TOP facilitators. TOP supplements the health education that the schools provide. This education does not include programming on reproductive health. A few partner organizations offer content on domestic violence issues and sexual abuse. There is also an on-site nurse at each school to provide pregnancy tests and pregnancy referral information, if needed.
Primary Research Question(s)	<ol style="list-style-type: none">1) What is TOP's impact on the treatment group's sexual activity, relative to the control group, at one year following the program?2) What is TOP's impact on the treatment group's contraception use, relative to the control group, at one year following the program?
Additional Outcomes	Grades and school suspensions
Sample	Twelve of the highest-risk (based on highest teen births per zip code ranking in 2008) middle and high schools in the Kansas City Metropolitan Area were recruited to participate in the evaluation. After finalizing agreements with seven schools that agreed to participate, 7th- and 9th-grade teachers of core subjects (such as social studies and English) were recruited to participate. During the two years of sample enrollment, 21 teachers participated. At the start of each school year of sample enrollment, the study team assessed whether each participating teacher's class sections would be eligible for the evaluation based on the number of students enrolled (class sections were eligible if they had at least 10 students). Across the two enrollment cohorts, 112 classes of 21 teachers were randomized, resulting in 59 treatment and 53 control classrooms. A total of 2,129 students enrolled in the evaluation.

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Setting	The evaluation is being conducted in six Kansas City public schools and one Kansas City charter school. In January 2012, about nine months before this study began, the school district lost its accreditation. The district is implementing a transformation plan according to the state requirement. The district serves more than 15,000 youth, most of whom are African American; nearly 90 percent of the students qualify for free or reduced-price lunch.
Research Design	This study is a cluster randomized controlled trial across two cohorts. Stratification occurred at the teacher level; each teacher's classes were randomized to either TOP or the control condition. Random assignment occurred after acquiring parental consent and youth assent and administering the baseline survey. A passive consent process was used to notify parents that their youth would be participating in a youth development survey unless they opted out of the process. In addition, youth were given the option to not assent to any specific survey. Overall, youth in cohort 1 completed four surveys: (1) baseline, (2) 9-month post-baseline (immediate follow-up), (3) 15-month post-baseline (6-month post-intervention follow-up), and (4) 21-month post-baseline (1-year post-intervention follow-up). Youth in cohort 2 completed three of the four surveys, and did not complete the 15-month post-baseline (6-month follow-up) due to resource constraints. Students were surveyed in class using paper-and-pencil surveys; make-up surveys occurred during follow-up visits to the school over the final few weeks of school. Those chronically absent or no longer enrolled in the study schools were contacted via telephone to complete a telephone survey. Final efforts were made to visit youth who dropped out or who had been otherwise unreachable by going directly to their homes (if they still lived in the area); these youth were given a paper-and-pencil survey to complete. Students received a modest incentive (a gift card) for completing each survey.
Impact Findings	To be determined when data collection and analysis are complete.
Implementation Findings	To be determined when data collection and analysis are complete.
Schedule/Time Line	Sample enrollment ended for both cohorts ended in September 2013. Across both cohorts baseline data collection ended September 2013, immediate follow-up data collection ended September 2014. For cohort 1 only 6-month post-intervention follow-up data collection ended January 2014 and 1-year post-intervention follow-up data collection ended September 2014. For cohort 2, the 1-year post-intervention follow-up data collection will end in summer 2015. A final report, which focuses on the one-year follow-up, will be available to the Office of Adolescent Health in 2015-2016.