The National Campaign to Prevent Teen and Unplanned Pregnancy

STAKEHOLDER EDUCATION
★Strategies Guided by Best Practice

INTRODUCTION

The National Campaign to Prevent Teen and Unplanned Pregnancy (The National Campaign) is one of five national partners funded by the Centers for Disease Control and Prevention (CDC) under the Teenage Pregnancy Prevention: Integrating Services, Programs and Strategies through Community-Wide Initiatives program. The National Campaign coordinates and provides leadership and support on the *Educating Stakeholders* component, and builds the capacity of Part A grantees and their local community partners to educate a broad and diverse set of stakeholders.

To effectively educate stakeholders, Part A Grantees should follow the outlined strategies guided by best practice and theory. This list of strategies provides guidance about what Part A grantees can do to engage and educate specific groups in their communities. The strategies include findings from peer-reviewed literature as well as expert opinion and lessons learned from the field. In general, these strategies have been organized as a process, beginning with some recommendations that will be helpful when initiating outreach to new stakeholder groups, followed by some strategies that will be appropriate for more established relationships (Section 4). Grantees may refer to different sections within the document depending on the status of the relationship with a specific stakeholder. Grantees should also use this document as a tool to assess progress on stakeholder education efforts—for example, if a particular stakeholder group has been especially challenging to engage, the grantee may identify certain strategies that might be helpful to revisit.

A few theories guiding these Best Practices include the Stages of Change/Transtheoretical Model of Change, Health Marketing Theory, and the Ecological Model. Stages of Change relates to anticipating and understanding a particular stakeholder's "stage of readiness" and meeting the stakeholder where they are, including tailoring the message to fit the stakeholder's stage of readiness (Edberg). Health Marketing Theory involves "creating, communicating, and delivering health information and interventions using consumer-centered and science-based strategies to protect and promote the health of diverse populations," as defined by the CDC (Bernhardt). The Ecological Model approaches teen pregnancy prevention using a multi-level approach which considers environmental factors, societal factors, organizational factors, policy factors, and individual factors (including predisposing, reinforcing, and enabling factors) (Parvanta).

Implicit in these behavioral theories is a natural connection between and among efforts to promote stakeholder education, community mobilization and working with diverse communities. In particular, you will note in the best practices below that high quality stakeholder education is an important aspect of community mobilization and attending to cultural differences and values is critical for effectively educating a wide variety of stakeholders. We've noted where these best practices directly overlap.

The National Campaign will work with Part A grantees to prioritize and implement these best practices strategies. Depending on an identified and chosen stakeholder group, certain strategies may make more sense than others at a given time. This document provides specific examples, when available, related to the following audiences: community colleges, parents, child welfare/foster care, and faith communities. The National Campaign will continue to assist grantees with tools, resources, training and technical assistance that will help facilitate prioritization and implementation of these best practice strategies.

STAKEHOLDER EDUCATION: The goal of this component is to support informed decision making on strategies for reducing teen pregnancy. As a result of training and technical assistance through this component, grantees will have the capacity to educate stakeholders (community leaders, parents, and other constituents) about relevant evidence-based and/or evidence-informed strategies to reduce teen pregnancy and data on needs and resources in target communities.

STRATEGIES GUIDED BY BEST PRACTICE

Section 1: Identify and know your stakeholders and your community's needs and resources

1. **Assess opportunities and challenges within the community** using the community needs assessment and/or research. Study the variety of community-based organizations and potential partners and stakeholders within your community. This could include assessing the OWANS (organization's wants and needs from stakeholders) or conducting a SWOT (strengths, weaknesses, opportunities, and threats) analysis.

   ✔ For community colleges, this might include surveys of students, faculty, staff, and administrators.

   a. Recognize differences in priorities when approaching stakeholders and organizations. Assess differences in organizational structures, missions, systems of accountability, and evaluation metrics. This might include a SWANS (stakeholders' wants and needs) analysis and assessing the partners' readiness to engage.

2. **Use the results from community needs assessments** and/or other research to identify key stakeholder groups and better understand the knowledge, attitudes, beliefs, needs and priorities related to teen pregnancy prevention in the community.

3. **Identify and recruit a few strong and dedicated leaders ("champions") and decision makers within the community** who will help you achieve key project outcomes by educating community stakeholders and promoting evidence-based programs or clinical services. [See also Best Practices for Community Mobilization] Identify gatekeepers within key organizations and stakeholder groups, establish and cultivate relationships, and actively engage them.

4. **Map out the demographic and key characteristics of stake-holder groups.**

   a. Understand the organizational culture of your stakeholders. Learn about the stakeholder group, review any laws or regulations that are pertinent to the issue (TPP), and identify where the information/education could provide meaningful effects for the stakeholders. This might also mean addressing a lack of knowledge about teen pregnancy or a reluctance to highlight the issue.

   b. Understand the stakeholder group or organization, including roles and titles within the organization, language used, governance structures, norms and values, and unique characteristics.

   ✔ For faith-based organizations, this will include understanding about the religion and its unique characteristics.

   ✔ For schools this includes understanding the district and school level policies as well as the structure of the administration

   c. Be aware of the unique strengths and needs of the stakeholder group or target audience.

5. **Ensure that your stakeholders include appropriate and diverse groups** who represent people of different gender, age, race, class, sexual orientation, education, religion, and/or other key dimensions, and understand how these factors can affect your work. Also include your target population in stakeholder engagement efforts (i.e. teens).

6. **Include nontraditional, hard to reach stakeholder groups in teen pregnancy prevention efforts.** Use innovative and strategic approaches to engage these groups. [See also Best Practices for Working with Diverse Communities]

7. **Work toward a common understanding of purpose** and a two-way flow of knowledge in order to build respect and trust. [See also Best Practices for Community Mobilization]

Section 2: Develop your plan

8. **Develop a strategic plan for stakeholder education** which includes goals, activities, timelines, and measurable outcomes.

   a. Involve key community stakeholders from the very beginning of the project. In particular, provide opportunities for stakeholders to provide input on project goals and show them how their contributions are valued and used. Opportunities may include leadership roles in small working groups, committees, or on aspects of the project. These roles are tailored to a stakeholder's unique skills, expertise, and interests. [See also Best Practices for Community Mobilization]

   b. Provide adequate resources for stakeholder education, including time and supporting resources. This should include assigning a staff member to act as a liaison between each key stakeholder group and the project (it could be the same staff member or multiple).

   c. Invest time to develop effective stakeholder education. Get to know your stakeholders in terms of their expertise, resources, and limits, as well as their potential roles and responsibilities through open discussion. [See also Best Practices for Community Mobilization]

   d. Consider how strategies already employed within an existing structure can be integrated into your education efforts.

   ✔ For example, with a faith-based organization, you may be able to integrate activities into prayer, faith-healing and music.

   e. Work to develop knowledge and skills among stakeholders so that they can provide key leadership to build support for the project among other community stakeholder groups.

9. **Develop a proactive means of communicating with stakeholders.** This might include incorporating health marketing and traditional marketing strategies into communications efforts. [See also Best Practices for Working with Diverse Communities (#18)]

   a. Plan to include a variety of educational and marketing tools depending on the chosen target audience including: fact sheets, information sharing (emails, blogs, newsletters), surveys, polls, workshops, expert panels, public meetings, interviews, and the Internet.

10. **Engage senior leadership at your organization in the education process i**ncluding the vision, strategy, and discussions with stakeholders.

Section 3: Develop your message

11. **Tailor the message to fit the appropriate stakeholder group,** and consider what competing messages exist in the community and how you might address them.

12. **Combine facts/data with an emotional appeal** or human side to the story. [See also Best Practices for Working with Diverse Communities (#16 & #18)]

13. **Communicate a results-driven approach—**that is, use the data to show the need for the program and how the program is making a difference in the community. This might include local data and local stories of needs and successes to the extent possible, and might connect teen pregnancy with other issues of interest in the community. [See also Best Practices for Working with Diverse Communities (#16)]

14. **Pre-test concepts, messages, materials and media strategies.**

15. **Be aware of and reduce the use of medical terminology,** acronyms or other jargon in outreach materials.

16. **Educate stakeholders through a process that is:**

    a. Interactive
    b. Encouraging
    c. Transparent
    d. Responsive
    e. Reciprocal
    f. Objective
    g. Inclusive
    h. Flexible to change

17. **Communication,** which is essential for education, should be:

    a. Clear
    b. Culturally relevant
    c. Ongoing and frequent
    d. Transparent
    e. Respectful

Section 4: Delineate the activities for your plan and implement according to the plan

18. **Develop and provide talking points or provide skill-building sessions** for stakeholders to effectively communicate about the project in the community and with their networks.

    a. Provide "blurbs" and logos for stakeholder/partner websites which include information about project goals and successes.

    b. Create a guide or glossary of common terms that can be shared with all stakeholders.

19. **Be visible in the community.** Utilize mass media to report to the community, celebrate successes, connect with the general public, and engage all community sectors.

    a. Actively and strategically disseminate informational materials with the community, funders and other key stakeholders.

20. **Utilize a range of techniques in order to engage stakeholders** depending on the group, including personal interviews, workshops, focus groups, town hall meetings, surveys, participatory tools, and stakeholder panels. Include diverse forms of communication such as print, verbal, and digital.

    a. Ensure that you are using an appropriate form of communication depending on the context, level of education, and target audience.

21. **When appropriate, address the concerns and interests of your stakeholders** by systematically exploring areas of shared interest and then building a shared understanding of goals and benefits of working together to address teen pregnancy through evidence-based programs and/or clinical services.

22. **Provide tangible incentives to stakeholders when possible,** but encourage voluntary participation. Considering location, time of day, intensity and length when seeking stakeholder engagement is important and can send a strong message that you welcome the involvement of a diverse group of stakeholders in your efforts.

    ✔ For parents you might consider providing child care and using computer or telephone based strategies when engaging them.

REFERENCES

Adksion-Bradley, C., Johnson, D., Sanders, J. L., Duncan, L., & Holcomb-McCoy, C. (2005). Forging a Collaborative Relationship between the Black Church and the Counseling Profession. *Counseling and Values, 49*(2), 147-154.

Alexander, L. B., & Dore, M. M. (1999). Making the Parents as Partners Principle a Reality: The Role of the Alliance. Journal of Child and Family Studies, 8(3), 255-270.

Aten, J. D., Topping, S., Denney, R. M., & Bayne, T. G. (2010). Collaborating With African American Churches to Overcome Minority Disaster Mental Health Disparities: What Mental Health Professionals Can Learn From Hurricane Katrina. *Professional Psychology: Research and Practice, 41*(2), 167-173.

Axford, N., Lehtonen, M., Kaoukji, D., Tobin, K., & Berry, V. (2012). Engaging parents in parenting programs: Lessons from research and practice. Children and Youth Services Review, 34(10), 2061.

Benes, K. M., Walsh, J. M., McMinn, M. R., Dominguez, A. W., & Aikins, D. C. (2000). Psychology and the Church: An Exemplar of Psychologist-Clergy Collaboration. *Professional Psychology: Research and Practice, 31*(5), 515-520.

Bernhardt, J.M. (2006). Improving Health through Health Marketing. *Prev Chronic Dis. 2006 July; 3(3)*: A73. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1636721/

Boulos, M.N.K., Maramba, I., Wheeler, S. (2006). Wikis, blogs and podcasts: a new generation of Web-based tools for virtual collaborative clinical practice and education. *BMC Medical Education, 6(41)*. Retrieved from http://www.biomedcentral.com/1472-6920/6/41.

Butler-Ajibade, P., Booth, W., & Burwell, C. (2012). Partnering with the black church: recipe for promoting heart health in the stroke belt. *The ABNF Journal, 23*(2), 34-37.

Carrillo, T. E., Packard, T., & Clapp, J. D. (2003). Nothing in—nothing out: Barriers to the use of performance data in social service programs. *Administration in Social Work, 27*(4), 61–75.

Centers for Disease Control (CDC). April 2006. Get Smart; Evaluation Manual, Engage Stakeholders. Retrieved from http://www.cdc.gov/getsmart/program-planner/Step1.html.

Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. Morbidity and Mortality Weekly Report, 48(RR-11), p. 1-40.

Corbie-Smith, G., Goldmon, M., Isler, M. R., Washington, C., Ammerman, A., & Bunton, A. (2010). Partnerships in health disparities research and the roles of pastors of black churches: potential conflict, synergy, and expectations. *Journal of the National Medical Association, 102*(9), 823-831.

Darch, C., Miao, Y., & Shippen, P. (2004). A Model for Involving Parents of Children with Learning and Behavior Problems in the Schools. Preventing School Failure, 48(3), 24-34.

Davidson,W.S., & Sturza,M.A. (2006). Issues facing the dissemination of prevention programs. *Journal of Preventive Intervention in the Community,* 32, 5-24.

De Marco, M., Godley, P., Corbie-Smith, G., Weiner, B., Meade, S.-A., Hadley, M., et al. (2001). Assessing the readiness of black churches to engage in health disparities research. *Journal of the National Medical Association, 103*(9-10), 960-967.

Dötterweich JA. (2006). Building effective community partnerships for youth development: Lessons learned from ACT for youth. *Journal of Public Health Management and Practice, Supplement.*

Dumas J., Moreland A., Gitter A., Pearl A., & Nordstrom A. (2008). Engaging Parents in Preventive Parenting Groups: Do Ethnic, Socioeconomic, and Belief Match Between Parents and Group Leaders Matter? Health Education & Behavior, 35(5), 619-633.

Edberg, M. (2007). Essentials of Health Behavior: Social and Behavioral Theory in Public Health. Jones & Bartlett Publishing.

The Environment Council. (N.D.). Principles of Authentic Engagement. Retrieved from http://www.the-environment-council.org.uk/resources/principles.pdf

Evans, WD. (2008). Applying Social Marketing in Health Care: Communicating Evidence to Change Consumer Behavior. *Med Decis Making September/October 2008,vol. 28(5), 781-792.* Retrieved from http://mdm.sagepub.com/content/28/5/781.short

The Finance Project. (2002). Sustaining Comprehensive Community Initiatives; Key Elements for Success. Financing Strategy Brief, April 2002. Retrieved from http://www.financeproject.org/publications/sustaining.pdf

Flynn, M.A.T., McNeil, D.A., Maloff, B., Mutasingwa, D., Wu, M., Ford, C., Tough, S.C. (2006). Reducing obesity and related chronic disease risk in children and youth: a synthesis of evidence with 'best practice' recommendations. Obesity Reviews, volume 7 (s1). Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1467-789X.2006.00242.x/full

Gee, L., Smucker, D. R., Chin, M. H., & Curlin, F. A. (2005). Partnering together? Relationships between faith-based community health centers and neighborhood congregations. *Southern Medical Journal, 98*(12), 1245-1250.

Goldmon, M. V., & Roberson, Jr., J. T. (2004). Churches, academic institutions, and public health: partnerships to eliminate health disparities. *North Carolina Medical Journal,* 65(6), 368-372.

Goodkind, J., LaNoue, M., Lee, C., Freeland, L., & Freund, R. (2012). Involving Parents in a Community-Based, Culturally Grounded Mental Health Intervention for American Indian Youth: Parent Perspectives, Challenges, and Results. Journal of Community Psychology, 40(4), 468-478.

Hardison-Moody, A., Dunn, C., Hall, D., Jones, L., Newkirk, J., & Thomas, C. (2011). Multi-Level Partnerships Support a Comprehensive Faith-Based Health Promotion Program. *Journal of Extension, 49*(6), 1-5.

Honeycutt, S., Carvalho, M., Glanz, K., Daniel, S. D., & Kegler, M. C. (2012). Research to reality: a process evaluation of a mini-grants program to disseminate evidence-based nutrition programs to rural churches and worksites. *Journal of Public Health Management and Practice, 18*(5), 431-439.

Jackson, R. S., & Reddick, B. (1999). The African American Church and University Partnerships: Establishing Lasting Collaborations. Health Education & Behavior, 26(5), 663-674.

Jarsky, K.M., McDonough, P.M. & Núñez, A. (2009). Establishing a College Culture in Secondary Schools Through P-20 Collaboration: A Case Study. Journal of Hispanic Higher Education, 8(4), 357-373.

Jeffery, N. (2009) Stakeholder Engagement: A Road Map to Meaningful Engagement Doughty Centre, Cranfield School of Management. Retrieved from https://www.som.cranfield.ac.uk/som/dinamic-content/think/documents/CR_Stakeholder.pdf

Johnson, L., Zorn, D., Tam, B., LaMontagne, M., & Johnson, S. (2003). Stakeholders' views of factors that impact successful interagency collaboration. *Exceptional Children, 68,* 195–209.

Kreulen, G. J., Bednarz, P. K., Wehrwein, T., & Davis, J. (2008). Clinical education partnership: a model for school district and college of nursing collaboration. The Journal of school nursing : the official publication of the National Association of School Nurses, 24(6), 360-369.

Krout, J. A., & Pogorzala, C. H. (2002). An intergenerational partnership between a college and congregate housing facility: how it works, what it means. The Gerontologist, 42(6), 853-858.

Massey, C., & Szente, J. (2007). Building Partnerships to Prepare Teachers for Urban Schools: The Case of Houghton College, AmeriCorps, the King Center Charter School, and Journey's End. Childhood Education, 83(3), 136-141.

Mayeske, G.W., & Lambur, M.T. (2001). How to design better programs: A staff-centered stakeholder approach to program logic modeling. Journal of Extension, 39(3).

McConnochie, A. (2008). Guns, gangs and young people - engaging faith communities. *Safer Communities, 7*(1), 40.

Mizrahi T, Rosenthal BB. Complexities of coalition building: leaders' successes, strategies, struggles and solutions. Social Work. 2001; 46(1): 63–78.

Moore, D., Onsomu, E. O., Timmons, S. M., Abuya, B. A., & Moore, C. (2012). Communicating HIV/AIDS Through African American Churches in North Carolina: Implications and Recommendations for HIV/AIDS Faith-Based Programs. *Journal of Religion and Health, 51*(3), 865-878.

The National Partnership for Women and Families. (2009). Effective Consumer Advocacy in a Multi-stakeholder setting. Retrieved from http://www.nationalpartnership.org/site/DocServer/Effective_Consumer_Advocacy_in_a_Multi_Stakeholder_Setti.pdf?docID=6161

The National Partnership for Women and Families. (N.D.) Consumer Engagement in Multi-stakeholder Group. Retrieved from http://www.nationalpartnership.org/site/DocServer/Stakeholder_Best_PracticesFINAL.pdf?docID=6001

National Partnership for Women and Families. (N.D.) Consumer Engagement Best Practices. Retrieved from http://www.nationalpartnership.org/site/DocServer/Consumer_Engagement_Best_Practices.pdf?docID=7161

The National Partnership for Women and Families. (N.D.). Collaborating with Consumer Advocates to Disseminate Health Information and Public Reports. Retrieved from http://www.nationalpartnership.org/site/DocServer/Collaborating_with_Consumer_Advocates_to_Disseminate_Pub.pdf?docID=6162

Parker, M. (2008). Building Partnerships with African American and White Churches to Promote a Good Old Age for All. *Generations, 32*(2), 38-41.

Parvanta, C. (2011). Essentials of Public Health Communication. http://samples.jbpub.com/9780763771157/71157_CH02_019_038.pdf

Pattillo, M. M., Chesley, D., Castles, P., & Sutter, R. (2002). Faith community nursing: parish nursing/health ministry collaboration model in central Texas. Family & Community Health, 25(3), 41-51.

Plante, T. G. (1999). A Collaborative Relationship Between Professional Psychology and the Roman Catholic Church: A Case Example and Suggested Principles for Success. *Professional Psychology: Research and Practice, 30*(6), 541-546.

Queener, J. E., & Martin, J. K. (2001). Providing Culturally Relevant Mental Health Services: Collaboration between Psychology and the African American Church. *Journal of Black Psychology, 27*(1), 112-122.

Simpson, M. R., & King, M. G. (1999). "God brought all these churches together": issues in developing religion-health partnerships in an Appalachian community. *Public Health Nursing, 16*(1), 41-49.

Skiff, D., Horwitz, S. H., LaRussa-Trott, M., Pearson, J., & Santiago, L. (2008). Engaging the Clergy in Addressing the Impact of Partner Violence in their Faith Communities. *Journal of Spirituality in Mental Health, 10*(2), 101-118.

Slovak, K., & Singer, J. B. (2012). Engaging parents of suicidal youth in a rural environment. Child & Family Social Work, 17(2), 212-221.

Stajura, M., Glik, D., Eisenman, D., Prelip, M., Martel, A., & Sammartinova, J. (2012). Perspectives of community- and faith-based organizations about partnering with local health departments for disasters. *International Journal of Environmental Research and Public Health, 9*(7), 2293-2311.

State of Victoria, Department of Education and Early Childhood Development. (2011). Stakeholder Engagement Framework. Retrieved from http://www.eduweb.vic.gov.au/edulibrary/public/commrel/policy/oct2011stakeholderengagement.pdf

St. Pierre, T. L., & Kaltreider, D. L. (1997). Strategies for involving parents of high-risk youth in drug prevention: A three-year longitudinal study in boys & girls clubs. Journal of Community Psychology, 25(5), 473-485.

Susskind, L., Thomas-Lamar, J.,McKearnan, S. (1999). *The Consensus Building Handbook: A Comprehensive Guide to Reaching Agreement.* Thousand Oaks, California: Sage Publications.

Taylor, B. D., Buckner, A. V., Walker, C. D., & Blumenthal, D. S. (2011). Faith-based partnerships in graduate medical education: the experience of the Morehouse School of Medicine Public Health/Preventive Medicine Residency Program. *American Journal of Preventive Medicine, 41*(4 Suppl 3), 283-289.

Williams, T. T., Griffith, D. M., Pichon, L. C., Campbell, B., Allen, J. O., & Sanchez , J. C. (2011). Involving Faith-Based Organizations in Adolescent HIV Prevention. *Progress in Community Health Partnerships: Research, Education, and Action, 5*(4), 425-431.

Wolfenden, L., Bell, C., Wiggers, J., Butler, M., James, E., & Chipperfield, K. (2012). Engaging parents in child obesity prevention: Support preferences of parents. Journal of Paediatrics and Child Health, 48(2), E4-E6.

Wurtele, S. K., & Kenny, M. C. (2010). Partnering with parents to prevent childhood sexual abuse. Child Abuse Review, 19(2), 130-152.

Zahner, S. J., & Corrado, S. M. (2004). Local health department partnerships with faith-based organizations. *Journal of Public Health Management and Practice, 10*(3), 258-264.