Evaluation Abstract: Evaluation of Safer Sex Intervention in New Orleans, LA: Findings from the Replication of an Evidence-Based Teen Pregnancy Prevention Program.

Grantee

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Intervention Name

Safer Sex Intervention

Intervention Description

Safer Sex Intervention is an in-person, individual-level, clinic-based intervention that aims to reduce risky sexual behaviors among sexually active adolescent females. In addition to providing participants with factual information that might be typical in clinical programming, the program aims to motivate behavioral change by teaching participants social and self-regulative skills and helping them to evaluate social norms. The intervention consists of four one-on-one sessions, which are delivered over the course of six months by a trained health educator. The initial intervention session is typically 30 to 50 minutes long and delivered in a private setting. This session aims to capture the participant's attention; impart information; and promote intentional, attitudinal, and, ultimately, behavioral changes. There are three 10- to 30-minute booster sessions which are intended to be delivered one, three, and six months following the initial session. These booster sessions are intended to sustain behavioral change.

The program is intended to be delivered within a clinical setting by a female health educator trained in motivational interviewing and the intervention. Health educators are expected to motivate behavioral change by using individual-focused interviewing techniques to assess the participant's readiness for change. In addition to providing the participant with relevant facts, it is hypothesized that motivation to reduce risky behavior will result from the provision of social and self-regulative skills; resulting self-efficacies; and attitudinal and belief change that can result from the deliberation of risks, expectations, and modifications of perceived social norms.

Counterfactual

Female Sexual Health

Counterfactual Description

Female Sexual Health is an individual-level, information-only sex education program that aims to increase participants' knowledge about how sexually transmitted infections (STIs) are contracted, the consequences of contracting STIs, and how to prevent them. Female Sexual Health does not aim to modify or promote motivational and attitudinal changes that are theoretically expected to precede behavioral change; the counterfactual intervention only provides the participant with factual information about sexual health. A female health educator uses a Microsoft PowerPoint presentation to provide information about reproductive anatomy and STIs, including chlamydia, gonorrhea, trichomoniasis,

herpes, human papillomavirus, syphilis, and HIV/AIDS. Female Sexual Health is intended to be implemented in one 30- to 50-minute session and does not have any booster sessions.

Female Sexual Health includes the information-only component of the first session of Safer Sex Intervention and time spent with a health educator. By design, Female Sexual Health provides the same factual information and equivalent baseline exposure to a health educator as in Safer Sex Intervention. The purpose of this is to better ensure that any observed impacts are due to the intervention itself and not simply a result of the provision of factual information or exposure to a health educator; therefore, the evaluation is testing effects of an interpersonal intervention that aims to provide participants with skills and social motivational incentives in addition to factual information.

Primary Research Question

What is the impact of the offer to participate in Safer Sex Intervention relative to the offer to participate in Female Sexual Health on participants' reported inconsistent use of condoms six months after the end of intervention?

Secondary Research Questions

What is the impact of the offer to participate in Safer Sex Intervention relative to the offer to participate in Female Sexual Health on participants' a) reported inconsistent use of contraceptives six months after the end of intervention; and b) reported frequency of sex six months after the end of the intervention?

Sample

Five clinics in the New Orleans area that served young women between the ages of 14 and 19 participated in the study. Health educators at these sites assigned eligible, consenting participants to one of two conditions by random assignment, and they provided the indicated programming to these participants.

Potential participants were referred to the study from a number of possible sources. At participating clinics, clinicians and clinic staff referred female patients ages 14 to 19 to the research assistant/health educator, who then conducted a full eligibility screening. Additionally, staff from other clinics (not participating in the study) could have also referred females ages 14 to 19 to a health educator to learn more about the study. Study participants could also have referred their friends and family to the program.

To be enrolled, the referred adolescent had to meet with a health educator at a participating study clinic, respond to eligibility screening questions, and meet study eligibility criteria (which include the provision of consent). To be eligible, a participant had to be a female age 14 to 19 years at baseline, provide assent to participate (and consent from parents if required by the participating clinic), report having engaged in sex with a male at least once in the past three months, express a willingness to return for planned follow-up assessments, and be screened by the clinician for physical and mental health. In addition, to be eligible, the potential participant must not knowingly have been pregnant, trying to get pregnant, or have previously participated in a specified list of prevention programs. Three-hundred and nineteen participants were randomized into the study, and 268 of these participants constitute the analytic sample for all contrasts.

Setting

The study took place in five health clinics in the New Orleans, Louisiana, area.

Research Design

The study is an individual randomized controlled trial. All eligible, consenting individuals were randomly assigned to intervention or control conditions on a rolling basis before the provision of any

programming or collection of baseline data. Random assignment was administered at each site by the health educators, though the order of those assignments was masked prior to assignment. The random assignment of participants was achieved by way of randomly-ordered envelopes containing a study ID number and piece of paper indicating an experimental condition (i.e., Safer Sex Intervention or Female Sexual Health). Before giving the envelopes to the sites, the evaluator recorded each envelope's ID number and condition to enable confirmation of the assignment process. After each study participant provided consent, the health educator opened the next envelope in the stack, which would both randomize the participant into a condition and provide her with a study ID number. The consent and assignment processes for the intervention and control groups were the same.

Baseline, outcome, and covariate data were collected via a self-report questionnaire that was administered at baseline (before the first program session) and a six-month follow-up (12 months after baseline, which was 6 months after the end of treatment for intervention-assigned participants).

Impact Findings

Findings from this study indicate that Safer Sex Intervention did not have a significant impact on the sexual behaviors of the young women who were offered to participate in the intervention, relative to Female Sexual Health. Six months after exposure to the full program (i.e., initial and all booster sessions), there were no statistically significant differences between treatment and control groups' self-reported inconsistency of condom use, inconsistency of contraceptive use, or frequency of sex. Sensitivity analyses corroborate this finding and indicate that results are not sensitive to analytical decisions.

Implementation Findings

The implementation study focused on adherence to the intervention, quality of the programming, the counterfactual experience, and context. Though implementation findings are limited by the fidelity monitoring and session observation data available, some evidence suggests that intervention programming was implemented unevenly. While the average initial Safer Sex session was intended to be 30-50 minutes long, the average session was 50 minutes in length, and 26% of sessions were over 50 minutes. By contrast, the booster sessions were often shorter than the suggested 10-30 minutes, averaging 8-10 minutes. Despite the somewhat irregular session duration data, it appears that the intended intervention activities were largely completed at both initial and booster sessions. While overall quality of the program session was scored as good or better in 60.9% of initial sessions, the delivery of session information received a quality score of good or better in only one third of initial sessions. Our analysis of contextual factors shows that Orleans Parish was relatively saturated with other OAH-funded TPP programs during the study period, and many participants reported past-year exposure to other reproductive health educator at each data collection point.

Schedule/Timeline

Young women were recruited and enrolled in the study from February 2012 through May 2014. Data were collected on a rolling basis through May 2015.