



The Teen Pregnancy Prevention Replication Study: Implementing the Safer Sex Intervention

| REPORT SUMMARY |

Overview

The federal Teen Pregnancy Prevention (TPP) Program, administered by the Office of Adolescent Health (OAH), includes funding for interventions that address the issues of teenage pregnancy and sexually transmitted infections (STIs) by: (1) replicating program models that have shown some evidence of effectiveness in reducing rates of both and related behaviors; and (2) testing innovative strategies aimed at producing the same outcomes.

The TPP Replication Study, funded and overseen jointly by OAH and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), was designed to test whether three program models, each previously shown to be effective in a single study, continue to demonstrate effectiveness. The study had two components: an impact evaluation and an implementation study. The overarching goal of the impact evaluation was to estimate the impacts of three program models on adolescent sexual behavior. The implementation study sought to document program delivery, determine the feasibility of consistently replicating evidence-based programs with fidelity and high quality, describe the community contexts in which the program models operated, and explore the challenges faced by

The Implementation Study...

- **Describes** how the replications were implemented, the contexts in which they were implemented, and the implementation challenges encountered;
- **Evaluates** the extent to which program models were replicated with fidelity and met quality and performance standards; and
- **Identifies** lessons for future implementation efforts.

grantees. This summary presents highlights from a report¹ on the implementation of the *Safer Sex Intervention (SSI)*, a clinic-based STI prevention program, by three grantees.

¹ The report that accompanies this brief is one in a series that present findings from the TPP Replication Study. Two companion reports describe the implementation of the other two program models evaluated (*SSI and Cuidate!*). Six earlier reports present findings on the short-term and longer-term impacts of each of the three program models, which can be accessed from the TPP Replication study webpage: <https://aspe.hhs.gov/teen-pregnancy-prevention-tpp-replication-study>.

EXHIBIT 1: SUMMARY OF THE THREE *SAFER SEX INTERVENTION* REPLICATIONS

Program Model, Grantee	Study Location	Target Population	Participant Characteristics ^a	Program Duration and Intensity	Program Setting	Program Delivered By
Grantees Replicating the Program						
Hennepin County Human Services and Public Health Department (Hennepin)	19 clinics urban and suburban in Hennepin County, MN	Female adolescents ages 13-19	Sexually active or contemplating sexual activity; 17% Hispanic, 36% Black, 26% White, 21% Other	Initial session of 30-50 minutes; 3 booster sessions (20-30 minutes each) delivered at 1, 3, and 6 months post-initial session	Clinics	Trained health educators
Knox County Health Department (Knox)	17 clinics rural and urban, across 5 counties in Knox County, TN		Sexually active or contemplating sexual activity; 9% Hispanic, 25% Black, 60% White, 6% Other			
Planned Parenthood of Greater Orlando (PPGO)	2 clinics in urban Orlando, FL		Sexually active or contemplating sexual activity; 28% Hispanic, 46% Black, 21% White, 5% Other			

^a Data for participant characteristics in each of the replication sites comes from the baseline survey of program participants.

SSI is a clinic-based intervention intended to reduce the incidence of STIs and increase condom use among higher-risk, sexually active female adolescents. The intervention relies on motivational interviewing, whereby a female health educator guides and facilitates personalized counseling sessions that capture the participant's attention and take into account individual needs and challenges in working toward behavioral change. In this study, three organizations replicated *SSI* between 2010 and 2015. Each of the replication sites implemented *SSI* in clinic settings with young women aged 13 to 19 years old who were sexually active. Exhibit 1 summarizes the features of the program implemented by each grantee.

Summary of Findings

The three grantees were well-established in their communities with a record of providing health and educational services to youth. Two of the three grantees were county public health agencies that offered a variety of services to families and young people directly and through partnerships. The third was a nationally-known provider of sexual health education and services.

The communities served by the grantees differed in their urbanicity and racial and ethnic composition. Hennepin County Human Services and Public Health Department (Hennepin) and its partners focused services in eight communities with the highest teen birth rates, including Minneapolis. These communities were racially, ethnically, and economically diverse, and urban and suburban. Knox County Health Department (Knox) and its partners served youth in four counties including Knox. With the exception of Knoxville, the communities were primarily White, rural, and low-income. Planned Parenthood (PPGO) served two distinct areas of Orlando; half of the youth served were African-American, with the remainder equally divided between White and Hispanic, primarily low-income youth.

All three grantees delivered *SSI* in clinics but there was substantial variation in the number and types of clinics and the extent to which they were youth-friendly. Hennepin operated the program in 19 diverse clinic settings (community-based, teen health, hospital-based, STI/public health, school-based). Knox operated in almost as many clinics (17) but with less variation in type of setting (i.e. no school-based clinics). PPGO delivered the program in its own two clinics on different sides of Orlando.

The decision to replicate the program in multiple clinic types required different strategies to address recruitment (including referrals to the program), determine eligibility for the program, ensure participants' privacy and comfort in medical settings that were sometimes crowded, balance clinic and program demands, and ensure that participants remained with the program through the sequence of booster sessions. School-based clinics and other clinics that targeted a youth population were more youth-friendly in terms of the physical environment and their hours of operation. In other clinic types, *SS* health educators worked within space and schedule constraints to make the setting more welcoming for young people and to ensure access to the program.

Qualities of health educators such as interpersonal skills and emotional intelligence were critical to successfully incorporating motivational interviewing techniques. Beyond prior experience working with youth, grantees learned over time that health educators needed to be open-minded when talking with young women about sexual activities and experiences and be able to listen without judgement. Being an active and empathetic listener helped in establishing and maintaining trust, a critical foundation for effectively applying motivational interviewing. Grantees relied on a wide range of resources for training health educators. Trainings on MI were sometimes available in communities and grantees worked together to identify and/or develop additional supports for the monitoring and development of health educators.

Recruitment and retention of participants was challenging and required flexibility, persistence, and a range of strategies. An initial challenge for grantees was generating a pool of young women eligible for the program. Each of the grantees

created marketing campaigns to raise awareness of and increase access to clinics. Different strategies included public service announcements (PSAs) at movie theaters, billboards, bus wraps, an interactive website, and traditional and internet radio ads. Retaining young women in the program over the 6 month period required flexibility, persistence, and creative ways of maintaining contact. Health educators used texting, social media, and phone calls. Some grantees were able to successfully conduct booster sessions via Skype or other video platforms. All grantees used monetary and non-monetary incentives for recruitment and retention.

All three grantees successfully implemented strong interventions with fidelity, across a wide variety of clinic types and with a broader population than previously tested. The three grantees worked cooperatively with the developer, supported by OAH, to refine existing training protocols and identify training needs (for motivational interviewing, for example). They also proposed adaptations that met the criteria for approval (such as the use of video chat for booster sessions), and developed creative solutions to the challenge of assessing quality of program delivery for a one-on-one intervention (i.e., using youth actors in mock sessions to practice motivational interviewing). As grantees worked through these challenges, they established a cooperative relationship and shared experiences and solutions.



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