REPLICATION: *Reducing the Risk*

Grantee	Better Family Life Inc., a private non-profit community development agency
Setting	Classes in six public high schools in St. Louis City, MO, St. Louis County, MO, and St. Clair County, IL
Target Population	9th graders (small number of 10th and 11th graders)
Curriculum & Delivery	16 sessions, delivered in 45-minute classes or eight 90-minute classes by health educators hired, trained and monitored by Better Family Life

Programmatic Context

Better Family Life

Better Family Life is one of nine organizations selected to participate in the Teen Pregnancy Prevention Replication Study. The study is a rigorous five-year evaluation of replications of evidence-based interventions aimed at preventing teen pregnancy, sexually-transmitted infections (STIs), and other sexual risk behaviors. The interventions are funded by the Office of Adolescent Health (OAH) through the federal Teen Pregnancy Prevention (TPP) Program. A brief overview of the study design and a description of the TPP Program can be found on the OAH website (http://www.hhs.gov/ash/oah/oah-initiatives/for-grantees/evaluation/#Federal-LedEvaluation).

Since its formation in 1983, Better Family Life Inc. (BFL), a not-for-profit community development corporation, has provided services and programs designed to support and strengthen families in the Greater St. Louis area. BFL has established partnerships with more than 50 organizations in the region and currently provides services to approximately 50,000 individuals each year, most of whom are low-income and African-American. BFL has five divisions: Cultural Arts; Community Outreach; Workforce Development; Housing/Asset Building; and Youth, Family and Clinical Services. The agency manages a variety of after-school programs in multiple school districts. Through its management of the St. Louis County's Metropolitan Employment and Training Center, and other workforce programs throughout the city and county, BFL has achieved national recognition as a leading provider of workforce development and other services for youth.

Adding to its focus on character development and workforce skills for youth, in 2004, BFL moved to address sexual health issues and skills needed to build and sustain healthy relationships through a series of grants received under the federal Healthy Relationship and Community-Based Abstinence-Education (CBAE) programs. Services funded by these grants were delivered in schools and community-based organizations in the St. Louis metropolitan area.

Selection of Reducing the Risk

In September 2010, BFL was competitively awarded a federal Teen Pregnancy Prevention Replication grant, administered by OAH. The grant is to implement *Reducing the Risk* in high schools in the St. Louis area.[1] The choice of *Reducing the Risk* reflected the agency's recognition that the services allowed under the CBAE grants did not fully meet the needs of St. Louis students. Specifically, federal CBAE grant requirements did not allow BFL or other grantees to provide contraceptive education, which was a service identified as a need by BFL's own behavioral surveys of youth.

Before preparing the grant application, BFL staff reviewed programs identified by the HHS Teen Pregnancy Prevention Evidence Review as having evidence of effectiveness, held meetings and focus groups with school principals, and pilot-tested the *Reducing the Risk* curriculum using non-federal resources. At the meetings with principals, BFL staff presented survey data that demonstrated the need for more comprehensive sexual health education, reviewed the content of the *Reducing the Risk* curriculum and provided reasons for its selection. Many principals voiced their preference for abstinence-only education but, in most cases, agreed that an abstinence-first approach (i.e., one that stressed abstinence from sex as the surest way to prevent pregnancy and STIs) would better meet the needs of their students. A small number of schools would not accept any contraceptive teaching and others requested that the condom demonstration be omitted. BFL held firm on the importance of including the condom demonstration, losing at least one school in the process; however, for the most part, BFL was able to convince principals of its importance. Although the relatively high number of sessions (16) has been an issue for schools in other places, BFL staff and school principals viewed its length as a strength of the curriculum compared with less intense programs.

Implementation of the Program Model

Settings for the Program

For the study, *Reducing the Risk* was delivered in six public high schools in St. Louis City, MO, St. Louis County, MO, and St. Clair County, IL. The schools are all in urban areas and the majority of their students are low-income African-Americans.

Population Served

The data described below are drawn from a baseline student survey completed before the intervention was implemented. Enrollment for the study began in the fall of 2012.

Demographic Profile: All students in selected 9th grade classes were eligible for the program. Often, these classes included a small number of students from higher grades who were also eligible. Almost 86% of those recruited were 9th graders. The remaining students were 10th graders (9%), 11th graders (3%) and 12th graders (2%). Their average age was 14.8 years. More than half (52%) were male and almost 90 % were African-American (Exhibit 1).[2]

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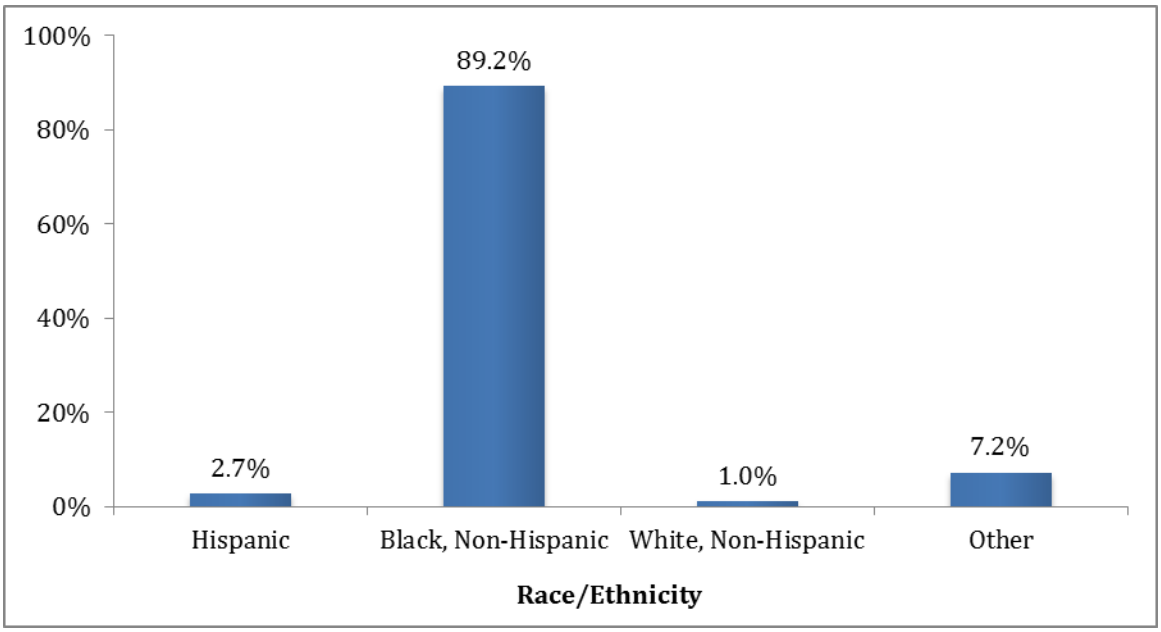
[1] A summary description of the curriculum and citations for the original research are provided in the Study Overview.

[2] The total sample size for Better Family Life is 1,020. The sample sizes for each of the risk variables vary depending on individual item non-response. The percentages shown in the figures are for those who responded to the baseline survey. The percentages of missing responses range from 1%- 5%, depending on the risk variable. More detailed tables with sample sizes can be found in the Appendix.

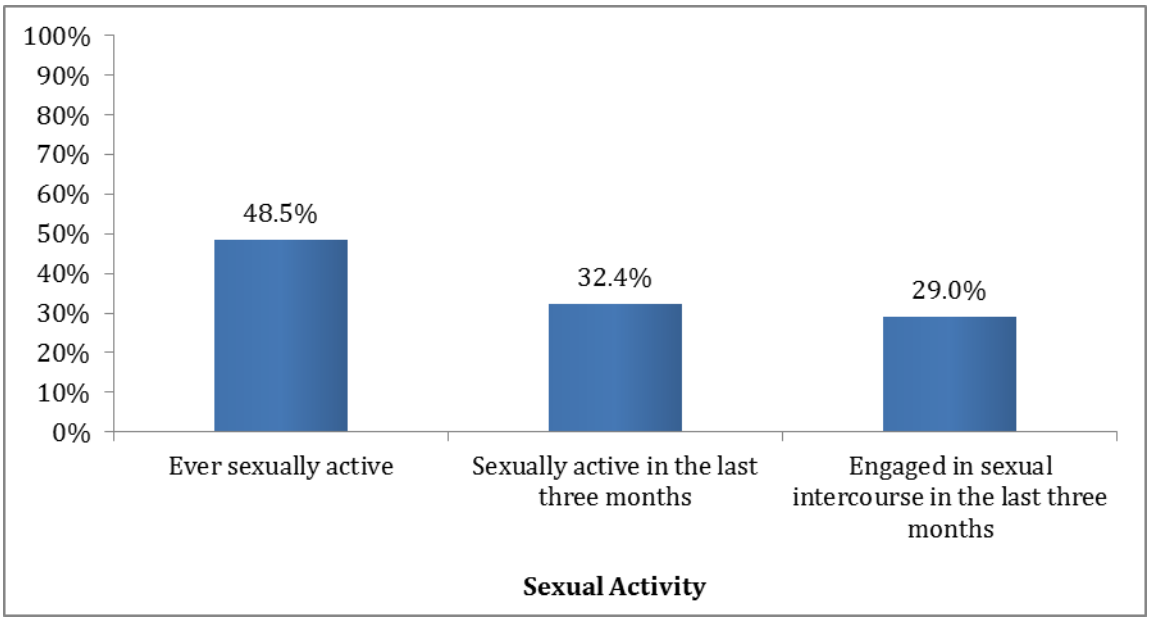
Exhibit 1: Race/Ethnicity of Youth in the Better Family Life Study Sample at Baseline



Risk Profile: Sexual Behavior

On entry into the study, almost half of the students reported that they had ever been sexually active (defined as sexual intercourse, and/or oral sex and/or anal sex). Close to one-third had been sexually active in the prior three months, and almost 30% had engaged in sexual intercourse during that same period (Exhibit 2).

Exhibit 2: Sexual Risk Behavior of Youth in the Better Family Life Study Sample at Baseline[3]

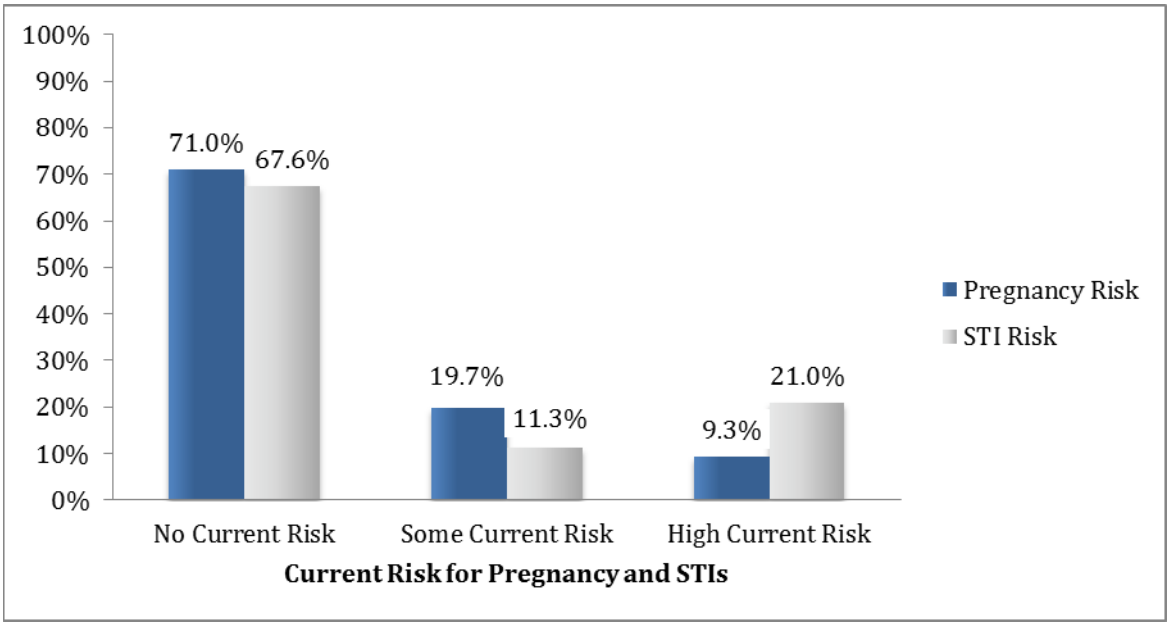


[3] Sexual activity is defined as sexual intercourse and/or oral sex and/or anal sex.

Exhibit 3 shows the distribution of study participants with respect to two kinds of risk, based on their sexual behavior in the 90 days prior to the survey: current risk of pregnancy, and current risk of sexually transmitted infection (STI). Those who had not engaged in sexual activity in the 90 days preceding the survey are categorized as at "no current risk" for either. In addition, a small number who, although sexually active, did not engage in sexual intercourse in the last 90 days are categorized as at "no current risk" for pregnancy (although they may be at some level of risk for infection). Youth are categorized as being at "some current risk" of pregnancy if they reported consistent use of birth control during sexual intercourse and at "some current risk" of infection if they reported consistent use of condoms during any sexual activity. At "high current risk" for infection are those who did not use condoms during intercourse and/or oral/anal sex. At "high current risk" for pregnancy are those who did not use condoms or birth control during sexual intercourse.

More than two-thirds of the students are considered not currently at risk for pregnancy or infection (i.e., they had not engaged in sexual intercourse or other sexual activity in the 90 days prior to the survey). Approximately 9% were at high current risk for pregnancy and more than twice as many (21%) were at high current risk for infection. Of those who engaged in sexual intercourse, two-thirds reported consistent use of birth control, placing them at some current risk for pregnancy. By contrast, twice as many youth failed to use condoms consistently when they engaged in any sexual activity (sexual intercourse, oral sex, or anal sex), placing them at high current risk for infection.

Exhibit 3: Current Risk of Pregnancy or Infection for Youth in the Better Family Life Study Sample at Baseline



Risk Profile: Perceptions about Sex

While two-thirds of the students reported no pressure from peers to have sex (Exhibit 4), more than 50% believed that most or all of their peers were engaging in sexual intercourse. By contrast, less than 25% believed that most or all of their peers were engaging in oral sex (Exhibit 5).

Exhibit 4: Extent of Peer Pressure to Have Sex for Youth in the Better Family Life Study Sample at Baseline

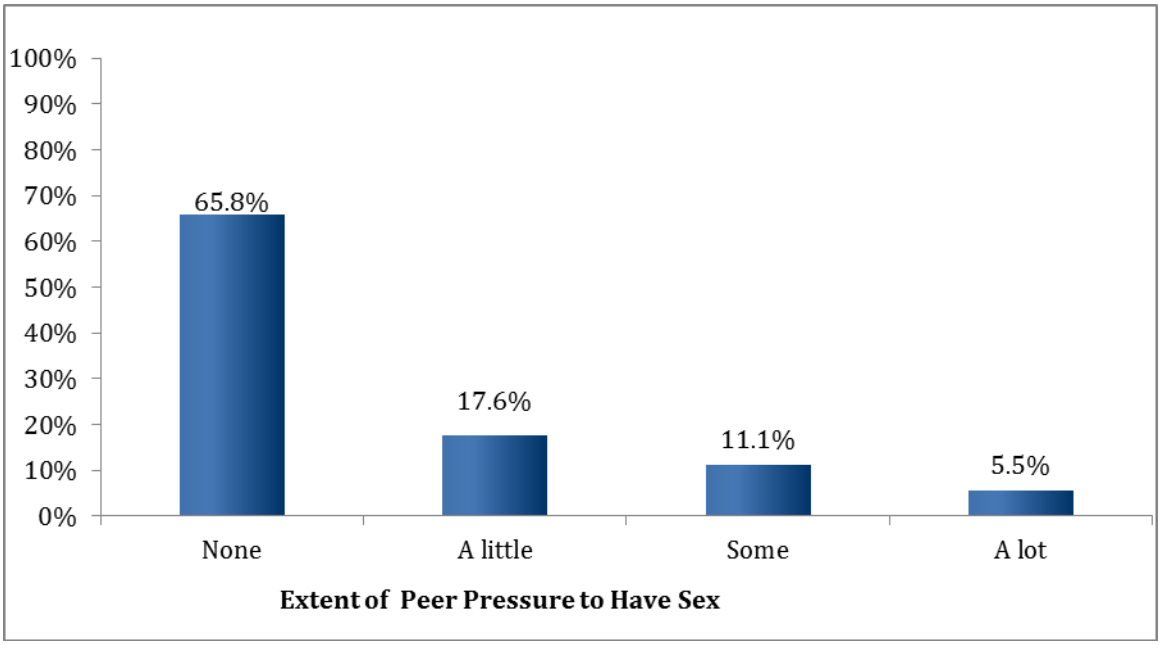
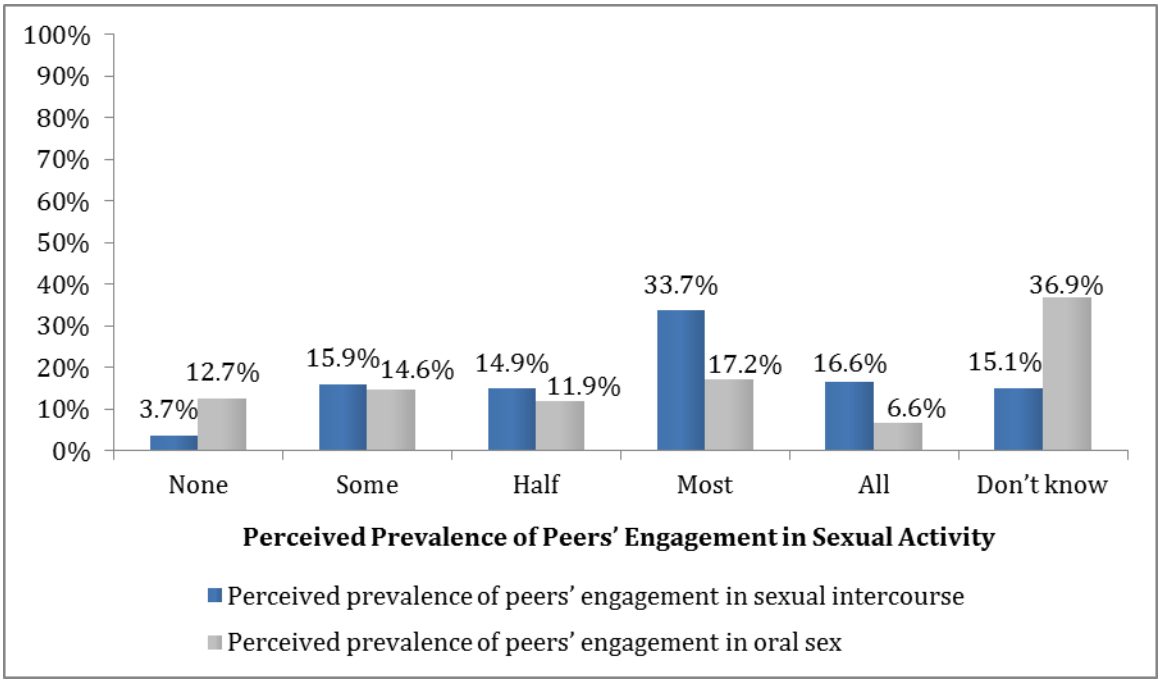


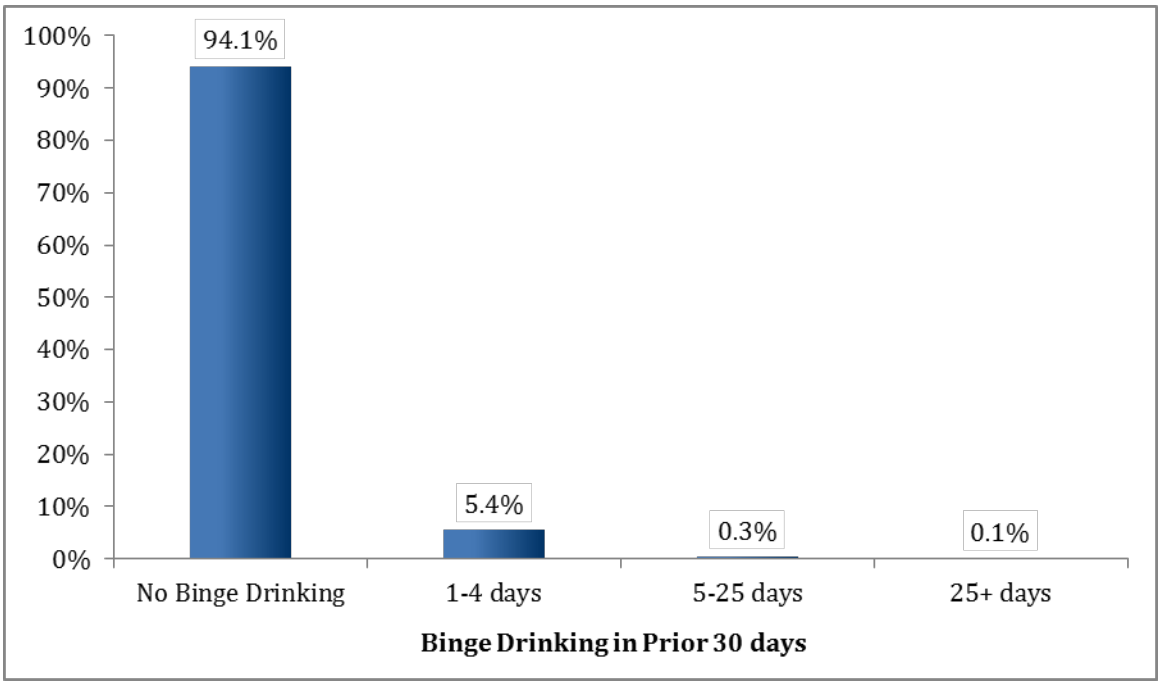
Exhibit 5: Perceived Prevalence of Peers' Engagement in Sexual Activity for the Better Family Life Study Sample at Baseline



Risk Profile: Other Risk Behaviors

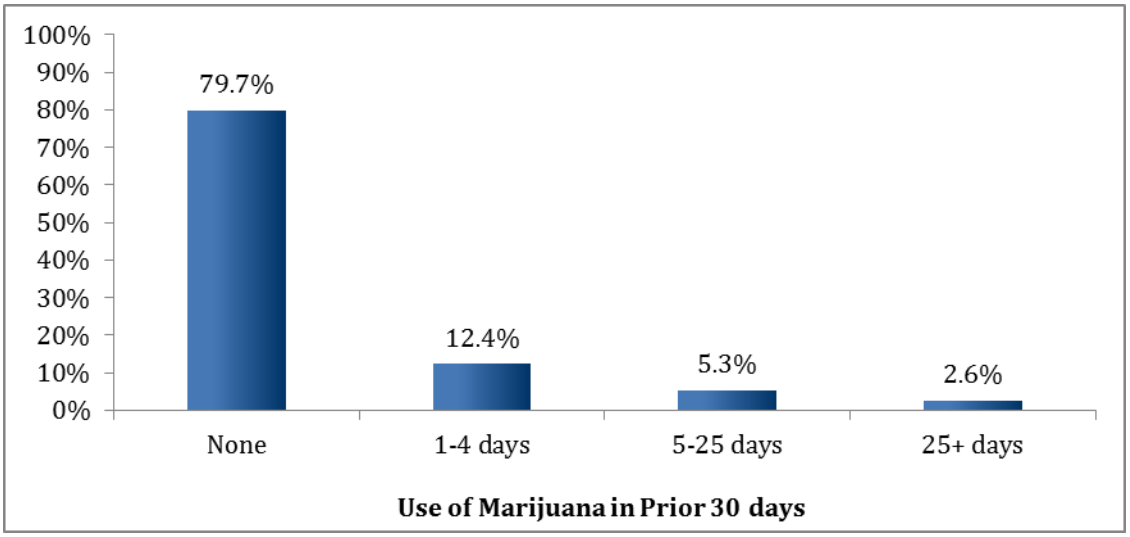
More than 93% of youth reported that they had not smoked cigarettes at all in the prior 30 days. Most of the others were occasional smokers; less than 1% reported smoking daily during the same period (See Appendix, Table 9). While 20% reported using alcohol during the prior 30 days, a smaller percentage (6%) reported at least one instance of binge drinking (five or more alcoholic drinks in a row) during the same period (Exhibit 6 and Appendix, Table 10).

Exhibit 6: Binge Drinking among Youth in the Better Family Life Study Sample at Baseline



Almost 80% of youth reported no use of marijuana in the prior 30 days while 8% reported smoking marijuana at least five days or more in the last 30 days (Exhibit 7).

Exhibit 7: Marijuana Use among Youth in the Better Family Life Study Sample at Baseline



The Appendix provides data tables for BFL and for the three *Reducing the Risk* replications combined.

Program Delivery

For their replication of *Reducing the Risk*, BFL requested that they be allowed to provide the program separately for boys and girls, with instructors of the same gender and was granted approval for this modification. While the agency is committed to ensuring that students learn how to use a condom, it requested permission to use a video or mini-lecture in place of a demonstration, to respond to concerns in one school. The adaptation was approved and, in one school, the boys-only class receives the video while the girls-only class receives the mini-lecture.

> *"I like the RtR role plays and real life scenarios, it gives the youth the opportunity to practice their refusal skills and build strong self – efficacy."*

Schools decided in which type of class the *Reducing the Risk* program would be delivered. Commonly, they chose to schedule the program during gym or U.S. Armed Forces Reserve Officers' Training Corp (ROTC) classes; however, some preferred to use home economics, health classes or home room/guidance classes. The curriculum is completed within a semester and classes may meet once or twice a week, depending on the school and the length of the class, which may vary from 45 to 90 minutes. In schools where the class length is 45 minutes, BFL staff try to arrange to have two classes per week. Characteristically, *Reducing the Risk* has sixteen 45-minute units or lessons that can be taught in single units or 8 block sessions of 90 minutes. For this replication, BFL delivers the curriculum either in 16 classes that correspond to the units, or in 8 block sessions, in both cases incorporating some supplementary information on reproductive anatomy into the existing units. Classes are taught by a single health educator with the teacher usually present. The size of the classes varies by school. For instance, the size of a class might be effectively halved, if the school experiences high levels of absenteeism.

Staffing and Training

BFL staff are responsible for implementing *Reducing the Risk* in the six high schools. The Project Director supervises the work of four full-time health educators, two of whom were existing staff who worked in the schools on earlier sexual health projects. Of the two hired for the project, one worked as a volunteer on the CBAE grant and was hired to teach *Reducing the Risk*. The second was a classroom health teacher. Both of the health educators hired for the project had backgrounds in public health.

In the first pilot year, all staff participated in a three-day training in the *Reducing the Risk* curriculum conducted by ETR, the curriculum developer. The group was large and had only two trainers. In the second year, supervisory staff attended train-the-trainer sessions also conducted by ETR, so that they could train staff more intensively and in a smaller group. Also in the first year, three staff attended an OAH training on adaptation.

Throughout the grant period, OAH offers regional trainings on topics, such as cultural awareness and implementing effective TPP programs. OAH also offers webinars on a variety of topics and hosts an annual conference, in all of which BFL staff participate.

Monitoring Program Implementation

A critical element of the replication of evidence-based programs is the extent to which the original model is implemented with fidelity. To support fidelity of implementation of *Reducing the Risk*, and in addition

to the initial training, the developer (ETR) provides a detailed manual and adaptation kit that offers a clear rationale for each unit in terms of content and pedagogic strategy, guidance about what can and cannot be modified, fidelity logs and observation protocols. As noted above, OAH provided additional guidance through training on what does and doesn't constitute an acceptable adaptation. BFL staff found that understanding and achieving fidelity took a long time, in large part because the health educators who had taught other sexual health curricula were accustomed to being creative, adding more engaging material and activities and dropping others that did not work as well.

In the BFL replication, health educators complete fidelity logs for each session, usually at the end of each week, and these are used both by the health educators for self-monitoring (to check that all the content was covered) and by the Project Director and Compliance Manager as a basis for regular review and feedback sessions with the health educators. The Project Director, with the Compliance Manager and two staff from the local evaluation team, observe more than 10% of sessions (the OAH requirement is at least 10%) using the observation tool provided by the developer. The observer meets with the health educator after the session to provide positive and negative feedback, including pointing out students who were not completely engaged, and suggesting strategies to increase student participation. The Compliance Manager carries the fidelity log, the curriculum, and the student workbook into the classroom, and conducts an independent check on the activities completed.

Summary of Better Family Life Grantee Profile

Better Family Life is replicating *Reducing the Risk* in three urban public high schools districts, all of which face multiple challenges.

The majority of students in the study sample were in 9th grade at baseline, with less than 15 % spread out over the later high school grades. Nearly one-half had ever been sexually active and one-third of them were sexually active in the three months preceding the survey. The majority of these sexually active youth did not use a condom consistently during any sexual activity, placing them at high risk for STIs (and for pregnancy, when another method of birth control was not used during intercourse).

This research is supported by the Office of Adolescent Health and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services under contract number HHSP23320095624WC Order No. HHSP23337011T awarded in September 2011.

Appendix: Better Family Life Baseline Data Tables

Table 1. Gender in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n= 1020)	Reducing the Risk Overall[1] (n= 3241)
Male	51.9%	51.2%
Female	48.1%	48.8%

[1]This represents the three replications of the program model.

Table 2. Race/Ethnicity in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n= 1020)	Reducing the Risk Overall (n= 3240)
Hispanic	2.8%	46.6%
Black[1]	89.2%	33.2%
White[1]	1.0%	11.0%
Other Race[2]	7.0%	9.3%

[1] Non-Hispanic
[2] "Other Race" includes Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Multiracial, and open-ended responses to the question "What is your race?"

Table 3. Age in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n= 1020)	Reducing the Risk Overall (n= 3240)
Mean (SD)	14.8 (0.9)	14.6 (1.1)
Range	13 – 19	13 -20

Table 4. Grade in School in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n= 1020)	Reducing the Risk Overall (n= 3240)
6th	0.0%	0.0%
7th	0.0%	0.0%
8th	0.0%	8.8%
9th	85.9%	67.9%
10th	9.2%	11.8%
11th	3.3%	7.4%
12th	1.6%	4.0%

Table 5. Sexual Activity in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n=1020)	Reducing the Risk Overall (n=3240)
Ever sexually active[1] (n=1002)	48.5%	33.1%
Sexually active in the past 3 months (n=998)	32.4%	21.6%
Engaged in sexual intercourse in the past 3 months (n=999)	29.0%	19.4%

[1] Sexual activity is defined as sexual intercourse, oral sex, and/or anal sex.

Table 6. Current Risk of Pregnancy[1] in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n = 999)	Reducing the Risk Overall (n=3168)
No Current Risk	71.0%	80.6%
Some Current Risk	19.7%	12.8%
High Current Risk	9.3%	6.6%

[1] *No Current Risk* is if the respondent did not have sexual intercourse in the past 90 days; *Some Current Risk* is if the respondent always used condoms or contraceptives during sexual intercourse in the past 90 days; and *High Current Risk* is if respondents engaged in unprotected sexual intercourse in the past 90 days.

Table 7. Current Risk of Infection[1] in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n = 998)	Reducing the Risk Overall (n=3166)
No Current Risk	67.6%	78.4%
Some Current Risk	11.3%	5.9%
High Current Risk	21.0%	15.7%

[1] *No Current Risk* is if the respondent did not engage in sexual intercourse, oral sex, and/or anal sex in the past 90 days; *Some Current Risk* is if the respondent always used a condom during sexual activity during the past 90 days; and *High Current Risk* is if respondents engaged in any sexual activity without a condom in the past 90 days.

Table 8. Risk of Infection and/or Pregnancy in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n = 999)	Reducing the Risk Overall (n=3166)
Sexual Activity and Condom Use		
Not sexually active	67.6%	78.4%
Sexually active with use of condoms	11.3%	5.8%
Sexually active without use of condoms	21.0%	15.7%
Sexual Intercourse and Birth Control Use		
No sexual intercourse	71.0%	80.6%
Sexual intercourse with birth control	19.7%	12.8%
Sexual intercourse without birth control	9.3%	6.6%

Table 9. Peer Pressure to Have Sex and Perceived Norms in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n= 999)	Reducing the Risk Overall (n= 3126)
Extent of peer pressure to have sex		
None	65.8%	73.1%
A little	17.6%	14.0%
Some	11.1%	9.2%
A lot	5.5%	3.7%
Prevalence of peer sexual intercourse		
None	3.7%	14.0%
Some	15.9%	22.4%
Half	14.9%	11.9%
Most	33.7%	22.5%
All	16.6%	8.3%
Don’t Know	15.1%	20.9%
Prevalence of peer oral sex		
None	12.7%	19.1%
Some	14.6%	18.1%
Half	11.9%	9.7%
Most	17.2%	12.6%
All	6.6%	4.0%
Don’t Know	36.9%	36.5%

Table 10. Frequency of Cigarette Use (past 30 days) in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n= 1010)	Reducing the Risk Overall (n= 3196)
0 days	93.8%	92.3%
1-4 days	4.8%	5.3%
5-25 days	0.8%	1.5%
> 25 days	0.7%	0.9%

Table 11. Frequency of Alcohol Use (past 30 days) in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n= 1011)	Reducing the Risk Overall (n= 3193)
Any alcohol use (last 30 days)[1]		
0 days	79.5%	78.6%
1-4 days	17.7%	17.0%
5-25 days	2.0%	3.4%
> 25 days	0.8%	1.1%
Binge drinking (last 30 days)[2]		
0 days	94.2%	91.2%
1-4 days	5.4%	7.6%
5-25 days	0.3%	0.9%
> 25 days	0.1%	0.3%

[1] Alcohol use is defined as having an alcoholic drink such as beer, wine, or other liquor ("just a sip" not counted).
[2] Binge drinking is defined as 5 or more alcoholic drinks in a row.

Table 12. Frequency of Marijuana Use (past 30 days) in Better Family Life and Overall *Reducing the Risk* Study Samples at Baseline

	BFL (n= 1012)	Reducing the Risk Overall (n= 3194)
0 days	79.7%	81.3%
1-4 days	12.4%	10.3%
5-25 days	5.3%	4.9%
> 25 days	2.6%	3.5%