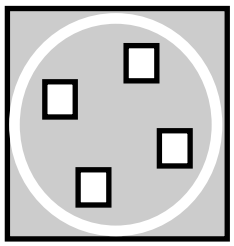

Program Abstract

Summary

Data from the Centers for Disease Control and Prevention suggest that over 50% (and in some years, as high as two-thirds) of the population who contract a sexually transmitted infection (STI) are under the age of 25, and disportionately, are adolescent girls. Adolescent girls with an STI infection are at risk for recurrence and more long-term reproductive health issues such as pelvic inflammatory disease (PID) and infertility.

SAFER SEX INTERVENTION (SSI) is an individualized STI intervention program aimed at sexually active young women, ages 13-23, who have been diagnosed with an STI. The *SSI* framework is grounded in Social Cognitive Theory, the Transtheoretical Model of Behavior Change, and principles of motivational interviewing. The overall goals are to reduce high-risk sexual behaviors, increase condom use and prevent the recurrence of STIs among sexually active young women. *SSI* was developed as a single-session intervention specifically for young women that would:

(a) capture their attention;
(b) deliver safer sex information; and
(c) promote attitudinal and behavioral changes.

The program is appropriate for use in clinics or community based organizations led by a female health educator. This individualized intervention was designed to be delivered at the time of STI diagnosis/treatment, when the participant is most likely to be contemplating her diagnosis relative to her sexual risk behaviors. The intervention is administered one-on-one and face-to-face using one of two discrete 30- to 50-minute sessions. The health educator determines which version to use with each participant based on the participant's self-identified stage of behavior change (using the Wheel of Change exercise).

The effectiveness of *SSI* was evaluated with a randomized control trial. Study participants were female, under 24 years old, and in need of treatment for cervicitis or pelvic inflammatory disease. At baseline, less than half of the participants reported condom use during their last sexual encounter and for those with a regular 'main' sexual partner, only 28% used condoms. Condom use was reported more frequently with non-regular partners. More than one-third (36%) had been pregnant sometime in the past and 18% were mothers. Almost half (45%) had used alcohol or drugs at some point before having sex.

At 1-month post-*SSI*, the program participants had increased sexual risk knowledge (P=.02), and more positive attitudes towards condom use (P=.007) than control participants. Program participants also reported using condoms with non-main partners more often (P=.08), and more consistently (P=.09), than participants in the control group, although these differences did not reach statistical significance. At the 6-month follow-up, program participants were significantly less likely to have had sex with a non-main partner (P=.01). They were also somewhat more likely to report condom use during their last sexual encounter (P=.09, though this did not reach statistical significance). Intervention participants also had greater increases in positive attitudes toward condoms than did the control participants (P=.007).

One year after *SSI*, the girls who received the program were somewhat less likely to have a main sexual partner and thus, decreased their risk (P=.07, not significant). They were also less likely to have recurrence of an STI than the control group, but this was not statistically significant (P=.17). The program participants also showed steady progression along the Wheel of Change stages at each follow up time point. By the conclusion of the evaluation (at 12 months post), most of those that completed the Wheel of Change exercise moved from the pre-action stage to the action or maintenance stages (P=.04).

Although results with P > .05 are not statistically significant and must be interpreted with caution, these findings suggest that an individualized safer sex intervention can work to change attitudes and behaviors about condom use, reduce the numbers of sexual partners that an STI-infected adolescent girl may have and suggest secondary abstinence as an option.

Focus

- ☐ Primary pregnancy prevention
- ☑ Secondary pregnancy prevention
- ☑ STI/HIV/AIDS prevention

Original Site

- ☐ School-based
- ☐ Community-based
- ☑ Clinic-based

Suitable for Use In:

SSI was designed to be used in clinic settings, at the time the young woman is being treated for an STI. The intervention may also be suitable for use in some community settings.

Approach

- ☑ Abstinence
- ☑ Behavioral Skills Development
- ☐ Community Outreach
- ☑ Contraceptive Access
- ☑ Contraceptive Education

- ☐ Life Option Enhancement
- ☑ Self-Efficacy/Self-Esteem
- ☑ Sexuality/HIV/AIDS/STI Education

Original Intervention Sample

Age, Gender	The original intervention sample consisted of 123 adolescent girls with a mean age of 17.2 (range 13.9-22.0)
Race/ Ethnicity	The sample self-identified as non-Hispanic Black (49%), Hispanic (18%), White (14%), and Other (17%)

Program Components

- ☐ Adult Involvement
- ☐ Case Management
- ☐ Group Discussion
- ☑ Lectures
- ☐ Peer Counseling/Instruction
- ☐ Public Service Announcements
- ☑ Role Play
- ☑ DVD
- ☑ Other: 1-on-1 discussions

Program Length

SSI is delivered in an intensive single session, customized to the participant, lasting 30-50 minutes.

In the original implementation, there were follow-up booster sessions at 1-, 3-, and 6-months following enrollment.

Staffing Requirements/ Training

In the original implementation, *SSI* was conducted by a female health educator on a one-on-one basis. Booster sessions were also conducted individually by the health educator. The health educators received training in the theoretical underpinnings of the intervention and in motivational interviewing techniques.

Although all PASHA programs have been designed to minimize the effort of implementation at each individual adopter site, some may want more formalized training other than the technical support offered as part of each PASHA program purchase. The original developer (Dr. Lydia Shrier) is available for consultation during the first year of a replication project and may also be available past that year. Please contact Dr. Shrier directly via email(lydia.shrier@childrens.harvard.edu) for more information.

In the event that the original developer is unable to provide training, Sociometrics has trainers on staff who can conduct training for any

PASHA program. To discuss your training needs, please contact Sociometrics (650) 949-3282 between 9 a.m. and 5 p.m. Pacific Standard Time.

Notes about Evaluation

Resources for evaluation are also included in the replication kit:

(1) Evaluation Instruments used in the evaluation of the original implementation of *SSI*.

(2) *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic questionnaire that can be adapted to suit most prevention programs, and

(3) *Local Evaluator Consultant Network Directory.*

These evaluation materials are included as a starting point for evaluating your program, should you choose to do so. Before using these or any survey instruments with your teens, it is very important that approval is received from the appropriate people in your community (e.g., school officials, parents, etc.). Most programs can benefit from outside help in designing and carrying out an evaluation. Your local university may be a good place to look for outside help—or you may refer to the *Local Evaluator Consultant Network Directory.* For further information, call PASHA staff (see below).

Contact Information

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Bibliography

Shrier, L.A., Ancheta, R., Goodman, E., Chiou, M.V., Lyden, M.R.,and Emans, S.J. (2001). Randomized controlled trial of a safer sex intervention for high-risk adolescent girls. *Archives of Pediatrics and Adolescent Medicine, 155,* 73-79.