



The Evaluation of It's Your Game: Keep It Real in rural South Carolina

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Intervention Name	It's Your Game: Keep It Real (IYG)
Intervention Description	<p>It's Your Game: Keep It Real (IYG) is an evidence-based program that consists of 12 50-minute lessons delivered in 7th grade and 12 50-minute lessons delivered in 8th grade, implemented within the participating middle school. In each grade, the program integrates group-based classroom activities with personalized journaling and individual, tailored, computer-based activities. A life skills decision-making paradigm (Select, Detect, Protect) underlies the activities, teaching students to select personal limits regarding risk behaviors, to detect signs or situations that might challenge these limits, and to use refusal skills and other tactics to protect these limits. The IYG program educates students on how to make good decisions and identify their personal rules about a variety of risk behaviors, including drugs, alcohol, and sexual behaviors. Students are taught to avoid a risky situation by either using a clear "No" or alternative action (for example, "My parent is calling me, I have to go."). These avoidance strategies are reiterated in the curriculum activities (such as role plays and journaling activities), computer activities, and take-home parent-child homework activities. The classroom curriculum also includes three parent-child homework activities at each grade level designed to facilitate dialogue on topics including friendship qualities, dating, and sexual behavior. The program is grounded in psycho-social models of behavior change.</p> <p>The program lessons are intended to be delivered by an IYG-trained facilitator within a variety of classroom instructional settings (for example, physical education, health course, or social studies). Facilitators are required to complete a three-day Training of Facilitators conducted by the curriculum developers before implementation. If teachers cannot attend this training, they instead received comparable one-on-one training by a trained technical assistance (TA) specialist and ongoing proactive TA. For this evaluation, most facilitators are the schools' physical education teachers, but some are district nurses and behavioral specialists. The lessons should be delivered during regular classroom time according to the schedule that works best for the participating school (for example, twice a week, once a week, or every day) with no more than two weeks between lessons. Because classrooms often vary in size (from 15 to 40 students), the optimal group size varies depending on the number of students enrolled in the classroom. The IYG program addresses eight of the state's (South Carolina's) health standards and meets the standards of the state's Comprehensive Health Education Act (CHEA), which mandated teaching comprehensive reproductive health education in public schools. IYG serves as the primary reproductive health content taught in the school and substitutes for any prior reproductive health education taught in the school.</p>
Counterfactual	Business as usual
Counterfactual Description	No systematic alternative program is offered in the control schools, including any evidence-based or promising program. The CHEA requires public middle schools in South Carolina to cover certain topics, including reproductive health education and sexually transmitted infection (STI) prevention. Specifically, in grades 6 through 8, this law mandates that health education must include reproductive health education and information on STIs. At its core, the state's CHEA, which guides all sexuality education instruction, emphasizes local control of content; thus, school districts have the authority to implement it with varying levels of fidelity.

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Counterfactual Description (continued)	Each school in the control group provides its usual health and sex education program, which varies by district. However, schools were not considered eligible for participation in the research study if an evidence-based program currently is being implemented in the middle school so that the research design would not be compromised by competing programs. For schools in the control group, the usual health and sex education would be defined as varying level of activities that addressed some or all of the following: puberty-reproductive health, healthy relationships, decision making (general health), decision making (sexual health), communicating values about sex, identifying and avoiding risky situations, teen pregnancy, HIV/AIDS/STIs, abstinence, condoms and contraception, media influences, and dating violence. One school covers all topics using the Sex Can Wait curriculum. All other schools addressed some but not all topics using typical 7th- and 8th-grade health education materials (for example, Holt). The evaluation design includes collecting data from the control school health teachers about the lessons that were conducted. These data will provide a more clear explanation of the extent and nature of sex and health education programs in the control schools.
Primary Research Question(s)	What is the impact of the IYG program relative to business as usual on initiation of vaginal sex one year after the end of the program on students reporting they never had sex at baseline?
Additional Outcomes	Number of times having sex without effective birth control in prior three months, number of sexual partners in prior three months, refusal skills, and self-efficacy.
Sample	<p>This study involves working with selected school districts and schools throughout South Carolina. Participating schools districts had to meet the following criteria: (1) be a public school district; (2) include schools with 7th and 8th grades; (3) be willing to participate and agree to the conditions of the study; and (4) provide SC Campaign with school-level statistics needed for the randomization process, if not available on the SC Department of Education website. Participating schools had to meet the following criteria: (1) be a mainstream school (not an alternative or special education school); (2) include 7th and 8th grades; (3) have at least 20 7th graders; (4) be willing to participate and agree to the conditions of the study; (5) not be involved in another federally funded project with the SC Campaign; (6) not currently be using an evidence-based teen pregnancy prevention program in 7th or 8th grades; and (7) not be intending to begin implementing an evidence-based teen pregnancy prevention program in 7th or 8th grades in the next three years.</p> <p>A total of 15 school districts representing 45 schools were screened. Screening criteria included approval of the curriculum used in the evaluation, IYG, at the district level through the mandated approval process (Comprehensive Health Education Committee, school improvement council, and school board approval). Of the 15 school districts representing 45 schools that were screened, 13 school districts representing 30 eligible schools agreed to participate in the study. Of the 13 school districts, the SC Campaign accepted memoranda of understanding (MOUs) from the first 24 schools (representing 10 school districts). Because the SC Campaign met with multiple districts over the same period, MOUs were finalized concurrently with many districts. When 24 schools were successfully recruited, the SC Campaign closed recruitment.</p> <p>Of the 24 recruited schools 12 were randomly assigned to the intervention group and 12 to the comparison group. After random assignment of schools, two criteria were used to screen students in schools: (1) enrolled in the 7th grade in fall 2011 and (2) not be special education students with limited abilities to complete the survey and/or engage in the intervention.</p> <p>The final enrolled sample size is $n = 3,156$ students for whom parental consent and student assent were obtained.</p>

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Setting	<p>The 24 study schools are rural middle schools across South Carolina with total enrollment sizes ranging from 213 to 1,486 students. Most study schools (n = 16) were defined as only teaching 6th through 8th grades; the remaining participating schools were defined as K through 8th grades (n = 2 schools), 5th through 8th grades (n = 3 schools), 7th and 8th grades (n = 1 school) or 7th through 12th grades (n = 2 schools).</p> <p>The average percentage of population living in poverty in South Carolina is 18.2 percent, whereas the range of the percentage of population living in poverty across the 10 school districts was 10.5 to 25.6 percent. Seven of the 10 school districts had higher percentages of population living in poverty than the state average. The state of South Carolina, although racially diverse, is predominately white (67 percent). In the evaluation sample, 11 of the 24 schools had more than 50 percent white students and 10 of the 24 schools had more than 50 percent black students (with 7 of those 10 having more than 70 percent black students). The remaining schools were mixed between white, black, Latino, and other races/ethnicities.</p>
Research Design	<p>This evaluation employs a group-randomized controlled trial design, with randomization at the school level. District was used as a stratification variable, so that school assignments to the intervention and control arm were balanced within districts. The randomization procedure involved identification of all possible combinations of two equal-size groups of schools and identification of the combination for which the groups were most similar to each other in terms of aggregate characteristics shown in literature to be related to the outcomes of interest (for example, racial composition, poverty indicators, academic performance indices, or urbanicity). One of these two groups was then randomly assigned to treatment and one to control. In other words, assignment was conducted with the goal of minimizing observable differences between the treatment and control groups. Schools were randomly assigned to treatment status in June 2011. Active parental consent for the study was obtained at the start of the 2011–2012 school year (early August to early October) across all 24 schools and then again in January 2012 for 6 of the 12 control schools that had low parental consent return rates in the fall. Students completed the baseline survey shortly after parental consent was obtained.</p> <p>Only select district administration staff, select school administration staff, school project site coordinators, and IYG teachers at treatment schools knew their schools' status before obtaining active parental consent and administering the baseline survey (IYG teachers knew because they were trained to implement IYG in August 2011). District and school staff were explicitly asked to not share group status information with anyone. To further minimize the likelihood that students or parents would learn group status, exactly the same evaluation parental consent form was used at all 24 schools, and schools were instructed to keep the distribution processes separate from program consent for their reproductive health programming. In addition to consenting to the evaluation, parents received consent forms for programming. The programming consent forms differed slightly between the treatment and control groups but were similar to diminish the likelihood that parents or students at treatment schools would associate the IYG program with the study. In treatment schools, explicit directions were provided to not tell students and teachers that IYG was being evaluated. To the evaluator's knowledge, no parent or other school staff asked or learned about their school's group status during the consent process.</p> <p>The intervention was implemented either in fall or spring of 7th grade and follow-up surveys were administered in spring of 7th and 8th grades. Surveys were administered on tablets in schools. For students who were absent or no longer in school, surveys were administered online (the majority of cases), via a mailed paper-and-pencil survey, or via an abbreviated telephone survey including just the primary outcomes.</p>
Impact Findings	To be determined when data collection and analysis are complete.
Implementation Findings	To be determined when data collection and analysis are complete.
Schedule/Timeline	Baseline data collection ended in February 2012. The first follow-up survey, conducted at the end of the sample's 8th-grade year, was completed in August 2013. The final follow-up survey, conducted at the end of the sample's 9th-grade year, ends August 2014. A final report, which focuses on one-year post-test data, will be available to the Office of Adolescent Health in 2015-2016.