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Moderator: Jaclyn Ruiz
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Jaclyn Ruiz: Good morning. Today we'll be interviewing Dr. Ralph DiClemente as part of our developer interview series. The Office of Adolescent Health will be hosting a series of interviews with developers of those programs identified by the Department of Health and Human Services Teen Pregnancy Prevention Evidence Review as having shown effectiveness in reducing teen pregnancy, sexually transmitted infections, or sexual risk behaviors.

The goal of these interviews is to ask developers some of the most frequently asked questions by OAH grantees. The webinar series was developed as a technical assistance product for use with OAH grant programs to provide additional guidance on selecting, planning, and implementing evidence-based programs for teen pregnancy prevention.

This webinar should not be used on its own but as a compliment to various other resources available online. Additional resources are identified later in the PowerPoint presentation. Please note that inclusion on the HHS TPP evidence review does not imply endorsement from OAH and that program selection is up to grantees.

As I mentioned, we're interviewing Dr. DiClemente today. Dr. Ralph DiClemente is a Charles Howard Candler Professor of Public Health, Associate Director of Prevention Sciences and Co-Director of the Emory University Center for AIDS Research Developmental Core. He holds concurrent appointments as professor in the School of Medicine, Department

of Medicine in the Division of Infectious Diseases, and in the Department of Pediatrics Division of Infectious Diseases, Epidemiology, and Immunology.

Dr. DiClemente's area of expertise is in the development and evaluation of prevention programs tailored to African-American adolescents and young adults. He's published extensively in the area of HIV STI prevention, particularly among African-American adolescents and young adults, as well as in the area of partner violence. He is the author of more than 500 publications including eighteen books, including the recent Handbook of Adolescent Health Risk Behaviors and the Handbook of HIV Prevention just to name a few.

Good morning Dr. DiClemente.

Dr. DiClemente: Good morning. How are you?

Jaclyn Ruiz: I'm doing well, thank you so much. Can you please briefly describe the program SiHLE and feel free to include the program goals and any core components you may want to mention.

Dr. DiClemente: Sure. I'd be delighted to. SiHLE is a program designed to be culturally and gender appropriate for young African-American girls fourteen to eighteen years of age who are sexually experienced. The goals of the program are pretty specific. One was to reduce the acquisition of new sexually transmitted infections and to reduce unintended pregnancy.

Secondary goals included changing protective behaviors such as increasing condom use and et cetera. Third was to enhance skills such as condom application skills, communication skills, reducing skills.

The program itself was comprised of four four-hour group sessions. And to facilitate these group sessions, we used a trained health educator and extensively trained near-peers. The program was to have a number of delivery modalities. We've conducted demonstrations, group discussion, and extensive role playing.

Jaclyn Ruiz: so it sounds like there may not need to be any sort of audiovisual component in this particular program.

Dr. DiClemente: No, I don't think so. At some point, that may be desirable as people begin to adapt the program or to update it to address some of the more pervasive threats to adolescent sexuality such as media or the norms that media can establish among young people.

Jacklyn Ruiz: Okay. A little bit about your previous evaluation results?

Dr. DiClemente: Well, the evaluation was conducted over twelve months and the key finding was a lower incidence of chlamydial infections in the SiHLE groups versus the comparison condition. In addition, there was a 38% reduction in pregnancy in the SiHLE group versus the control group. To my knowledge, there are a very few studies that can report both a reduction in a disease -- chlamydia -- and marked reduction in teen pregnancy. And both of those are assessed using biological markers.

Behavioral findings were also very, very robust. We had much more consistent condom use in the SiHLE group, higher use of condoms at last sex, increased condom use self-efficacy, higher percentage of overall condom protected sex acts, lower percent of unprotected vaginal sex acts.

The girls in the SiHLE group had a higher frequency of applying and putting condoms on their partner. They had higher skill acquisition. They had fewer perceived barriers to condom use. They had higher increased partner communication frequency and greater HIV knowledge.

So overall it was a range of findings from the biological to the skills to the behaviors to the mediators, which all indicated that SiHLE can be a very robust intervention.

Jaclyn Ruiz: I know. It's a very extensive list of findings, actually. Thank you for sharing them. Can you talk a little bit more about the population? I know you mentioned it was African-American women and they were sexually active. I don't know if you want to maybe share how those - that target population was screened for the actual study as well as maybe any other populations that you think the intervention may be applicable for?

Dr. DiClemente: Yes. Essentially, we recruited young women at a community clinic and women were screened as they were sitting in the waiting room. And they completed the pre-screener which was conducted using block screening, which is a technique that allows women to answer after they've heard all the screening criteria. And they would answer either yes or no. If they answered no, then they wouldn't be divulging whether they were sexually active or not because that one criteria would be rolled in with about five or six others.

So if someone says no to the block screen, it could be because they're not fourteen to eighteen. It could be because they don't' consider themselves or self-identify as African-American. So there are a number of ways that a person could answer that and not divulge his sexual status.

Now we've obviously done this study with a population which was exclusively African-American. The mean age was sixteen even though the range was fourteen to eighteen.

Jaclyn Ruiz: And so would you suggest that it's kept with African-American adolescent girls around that age range of fourteen to eighteen?

Dr. DiClemente: Yes, without a doubt.

Jaclyn Ruiz: Can you talk a little bit about the settings with which the program has been implemented and any other settings that you think may be applicable for the program?

Dr. DiClemente: Yes. The program was implemented at our site, again, with young women who were recruited from community clinics, but this is a program that can be implemented anywhere there's space available to conduct groups. Teen clinics would be a perfect example.

Teen youth centers would be another perfect example. And community centers would be another example. So essentially anywhere there's a space where you can have a confidential discussion is a perfect place to host SiHLE.

Jaclyn Ruiz: Fantastic. And so while adaptations require OAH prior approval and, at times, approval by the developer, it can be helpful for organizations to get a sense of previous adaptations that may have been successfully implemented. Can you describe any examples of some adaptations that have been implemented by other organizations?

Dr. DiClemente: Yes I can, and I think the key issue with adaptations is often developers are unaware that their program is being adapted. So in a sense it would be very

helpful if we could set up a system whereby if someone wants to adapt the program, that they notify the developers and OAH that yes, we're planning on adapting a particular intervention; and then provide a report back. How was that intervention reviewed? Was it effective, not effective? How was the adaptation? Et cetera. So we have that information for future grantees, potentially.

But SiHLE's been adapted a number of ways in a number of places. We've actually done SiHLE in Armenia for young sex workers - female sex workers. SiHLE has been implemented in Spain for young girls. SiHLE is also being translated to a web-based intervention here in the United States in a couple of different locales. So this is a program that's flexible in its adaptation ability.

The one barrier, of course, is the length of time and the number of sessions. Those are very related. So we have four four-hour sessions but moving to a web-based intervention really reduces the time-intensiveness and/or the time demands of the program.

Jaclyn Ruiz: Thank you for...

Dr. DiClemente: Yes. You know, again, our colleagues in Spain did a program as two sessions. And our colleagues in Armenia conducted the program as a single session. And they did it one-on-one rather than a group, which I found pretty interesting.

Jaclyn Ruiz: And are they currently evaluating those interventions that are happening abroad?

Dr. DiClemente: Yes, they are evaluated and they are published.

Jaclyn Ruiz: Oh, fantastic.

Dr. DiClemente: Well, one is. The other one is getting ready. Our friends in Spain actually came to the United States and spent three months with us because of our facility with evaluation and we went through their program and helped them a bit. And their program worked out superb. The program we did in Armenia was also robust and evaluated as part of a randomized control trial, and that worked out to be very effective as well.

So the program is robust. That's the key word and it is flexible. It can be delivered as a group. It can be delivered online, and as they've done in Armenia, it can be delivered in the one-to-one sessions.

Jaclyn Ruiz: Great. Can you describe any staffing recommendations or - as well as any training opportunities that are available through the program?

Dr. DiClemente: Yes. Staffing requires at least one adult health educator, psychologist, social worker - a facilitator; and two near-peer facilitators. And the near-peer facilitators are extensively trained to deliver SiHLE. We recommend that gender congruency and cultural congruency between the adult facilitator, the near-peer facilitators, and the groups.

We also recommend that both the adult facilitator and the peers have some group facilitation skills and require that they have comprehensive knowledge of SiHLE, that they go through the program themselves, essentially, and that they practice some of the skills and role plays to proficiency.

Now training considerations -- we have seen a train the trainer model used very effectively. So it is relatively straightforward to train and, in fact, the near-peers really enjoy the opportunity - is what we've learned subsequently.

It gives them the chance to flex their intellectual and creative muscles, so to speak.

There is a clause to train facilitators and we do have master trainers on staff who can, in fact, help train any agencies' facilitators. And we can also train the near-peers. We've done both of those -- the adults and the near-peers -- simultaneously. And that training can be arrange d with me by just calling me on cell or by contacting me via my email address.

Jaclyn Ruiz: And can you describe some implementation challenges that you're aware of and any possible strategies to overcome those challenges?

Dr. DiClemente: Yes, indeed. I think when SiHLE was developed, it was the first intervention that demonstrated efficacy with African-American girls, particularly biological efficacy -- marked reductions in STDs, chlamydia, and marked reductions in teen pregnancy. So it was a very intensive program and it was designed for sexually active young girls.

But to do that, the session length was long. They were four hours and there were four sessions. Now the four hours was not problematic in the least. Many of the girls wanted to stay longer. As long as they enjoy the discussion, they enjoy the activities, the time was not nearly as much a burden.

What was more problematic is the number of group sessions. Having to return three or four times to our training site was a challenge because there are transportation barriers. Many of the girls do not have adequate transportation. Their family may not own a car and the public transportation may be less than reliable.

Another challenge was the spacing of the sessions. In its original form, SiHLE was administered consecutive weeks. That can be problematic for some young people who have other activities to participate in -- sporting activities, band, other theater activities, academic activities -- which may limit their ability to come to a session that's concluded on a Saturday over four consecutive Saturdays.

The other challenge is the near-peers. They're wonderful young people who are motivated and certainly excited, and they can be trained very well to deliver the intervention. But they also have other activities in their life, and those activities compete with their ability to be consistently available to deliver SiHLE.

Those are the key challenges as we see it. Now there are some strategies which can be useful for overcoming these challenges. One is to modify the distribution of sessions as our colleagues have done overseas and as our colleagues in the US have done in terms of creating a web-based SiHLE. You can reduce the number of sessions, have two larger sessions, or have a whole weekend - a SiHLE weekend, if you will.

Another strategy may be to develop community partnerships so that you can move SiHLE out into the community, which increases the access of young people to the program. They don't have to come to us. The program can actually get to them.

A third is to identify near-peers and any strain or pull on your peers. One suggestion we have is partnering with local high schools, art schools, and even community colleges where you can actually recruit near-peers form those institutions. And you'll have a steady pool of near-peers as those institutions are still in existence for a number of years.

Jaclyn Ruiz: I'm so glad you mentioned that last point because I was going to ask a little bit about the near-peers. I'm sure probably people would love that - heard strategies on how they were recruited. So I think that was a very helpful point to make at the end.

Dr. DiClemente: Yes, and surprisingly when you develop these programs, you always think there are certain challenges - a priority. The challenge we thought a priority was getting near-peers to participate, particularly on Saturdays; but to our surprise, that was not a major challenge. The challenge was near-peers, as the programs were continued, had other competing activities on Saturday. It wasn't they didn't' want to participate or deliver SiHLE, but they had other responsibilities and obligations, one of whom being work.

So to have a pool of near-peers is really, really critical to sustain that flow of near-peers in the program.

Jaclyn Ruiz: Do you want to discuss any of your recent or planned revisions to the curriculum?

Dr. DiClemente: Well, we've talked a little bit about the revisions already, and the modifications or adaptations. But I think one of the things we would plan to be would be to increase the breadth and depth of information on teen pregnancy prevention. The original program was really focused on STDs and, to a much limited degree, on unintended pregnancy.

Now to its credit, both of those outcomes - incident chlamydial infections and unintended pregnancy -- showed very robust intervention effects. However, I think there's some recent advances in pregnancy prevention that young people need to be aware of, particularly the long-acting reversible contraceptives that

hitting the market now and young people can certainly use. I think - so certainly an issue of pregnancy prevention needs to be amplified a bit.

We need to update and utilize new videos or role plays and music to make them more contemporary. Most of these programs are going to have a shelf life. So to address that issue of the shelf life, we need to be able to constantly update the programs to keep them contemporary.

And then we need to adapt SiHLE for more ethnically diverse populations both in the US and globally.

Jaclyn Ruiz: Thank you for that information, Dr. DiClemente. On slide twelve, you'll find additional resources on SiHLE. We (unintelligible) these resources in conjunction with today's webinar will provide a comprehensive understanding of this evidence-based teen pregnancy prevention program, and will assist you in making not only an informed decision on which evidence-based program to select for your community, but how to best prepare for and implement the program.

Do you have any final words you want to add?

Dr. DiClemente: No, I think the key here for SiHLE is that it's a very intensive program. It's been modified or adapted to be fewer sessions delivered in different modalities -- one-on-one as well as web-administered. So it's robust, flexible - but the key is, once again, the effects. Reduced rates of chlamydia and reduced unintended teen pregnancy -- critical in terms of selecting programs. Again, we want to affect those outcomes not only the behaviors that we think are associated with those outcomes.

Jaclyn Ruiz: Well thank you so much for taking time today and putting this information together not only for OAH but especially our grantees. We know that they'll find this information incredibly helpful, so thank you for that.

Dr. DiClemente: Well, thank you for the interview and certainly any grantees that are interested - I am more than delighted to touch base about the program and how we could be of any help.

Jaclyn Ruiz: Thank you. And (Cordero), can we end the recording please?

Coordinator: Yes, we sure can. One moment.

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