

WEBINAR VIDEO TRANSCRIPT

Office of Population Affairs

TPP Tier 2 Showcase Webinar, Day 1

3 March 2020

ASYA LOUIS: Good afternoon, everyone. My name is Asya Louis and I'd like to welcome you to today's webinar. This webinar is brought to you by the Office of Population Affairs.

As an important note, we will not answer any questions related to open funding opportunity announcements during these webinars. Any questions about open FOAs should be directed to OPA and/or OASH, Office of Grants Management. I will now turn things over to Richmond Pajela for brief introductions and to talk a little about the purpose and format of the call. Richmond?

Webinar Series Purpose

[Displays text that reads: Please note that final-outcome results are not currently available].

RICHMOND PAJELA: Thank you, Asya. So the purpose of this webinar series is to showcase OPA teen pregnancy prevention tier two programs with promising results. The series will showcase grantees from our tier 2A and tier 2B grant programs. These grantees are finishing up a five-year grant program, and have focused on rigorously evaluating TPP programs or innovating new TPP interventions.

The tier 2A grantees support and enable early innovation to advance adolescent health and prevent teen pregnancy with a focus on implementation of evidence-based teen pregnancy prevention programs. They've also provided funding and community-based services to sub-awardees. The tier 2B grantees conduct rigorous evaluations of new or innovative approaches to prevent teen pregnancy with a focus on implementation of programs and evaluations. Please note that this webinar will only highlight promising results, as the final outcome results are not currently available.

Webinar Series Schedule

[Displays webinar series schedule: Tuesday, March 3, 2020: EngenderHealth, Inc., University of New Mexico Health Sciences Center, Healthy Teen Network.

Wednesday, March 4, 2020: Planned Parenthood of Greater New York, Boston Children's Hospital, MyHealthED, Inc., Waikiki Health

Thursday, March 5, 2020: Center for Innovative Public Research, Johns Hopkins University, Planned Parenthood of the Great NW & Hawaiian Islands.]

For this webinar series today, we will be focusing on three of our tier 2B grantees. Tomorrow, we'll be focusing, on Wednesday, March 4, 2020, focusing on our tier 2A sub-awardees. And on Thursday, we will also be focusing, again, on our tier 2B grantees.

I would like to say, a quick disclaimer, that the views expressed in this workshop do not reflect the official policies of the Office of Population Affairs or the US Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsements by the US government. Any statements expressed are those of the presenters and do not necessarily reflect the views of the Office of Population Affairs or the US Department of Health and Human Services. So to introduce everyone on the call, on the call here from the Office of Population Affairs is myself, Richmond Pajela. I am a project officer here. And then joining us from MayaTech Corporation TA team is Anna Ramos, who is a TTP TA lead, and Asya Louis, the TTP technical assistant.

Today's webinar will feature three tier 2B grantees who are conducting rigorous evaluations of new or innovative approaches to prevent teen pregnancy. We have EngenderHealth, Inc., who has a remix intervention, which is a three component sexual health program that pairs peer educators, who are young parents, with experienced adult health educators. We have Healthy Teen Network's Pulse app, that provides sexual and reproductive health information to young women using interactive and multimedia features, and the University of New Mexico Health Sciences Center, TEMPOS, Teen Exploring and Managing Prevention Options, a brief motivational interviewing-based intervention. The next presenters that you will be hearing from will be Rebecca Shirsat, the evaluation coordinator at EngenderHealth, and Kate Welti, who is a research assistant at Child Trends, presenting on the Remix implementation.

Re:MIX: Maximize, Imagine, Explore

Disclaimer

[Displays disclaimer language: This project was made possible by Grant Number TP2AH000033 from the Office of Population Affairs, U.S. Department of Health and Human Services (DHHS). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Office of Adolescent Health or DHHS.]

REBECCA SHIRSAT: Thank you so much, Richmond. So here's our disclaimer. We're going to be talking to you about the Remix project, and all of—the project and all of our work was made possible by a grant from the Office of Population Affairs.

Adolescent Sexual Health

So before we dive into what the Remix program is all about, it's very important to understand the why. So here's some data that provides a little bit of context to our program just so you know. First, we see that young people account for 50% of reported STI cases every year. And while there has been a steady decrease in teen birth rates over the past 20 or 30 years, Hispanic and black teens have two times the higher birth rate than those of white teens.

Zooming in on Texas where we work, we can see that young people aren't getting the support surrounding their sexual health that they deserve. Texas currently ranks fourth highest nationally in the rates of birth to teen parents and first highest in rates in birth to teen parents. Texas does not also mandate sex ed in school. And all of these statistics really indicate that the youth in our state, as well as across the US, aren't receiving comprehensive sexual education.

And all of these data ultimately led us to our decision to work with Austin charter schools that serve predominantly Latinx youth. Charter schools have more flexibility for implementing comprehensive sex ed curricula than public school systems do. And we also made it a priority to reach youth of color due to these disproportionalities. So let's get into what Remix is about.

Program Goals

Our program goals are to empower and educate youth so that they are prepared to make informed decisions about their sexual health and are better equipped to lead healthy lives. Our second goal is to reduce rates of unplanned pregnancies and STI rates among youth. Remix takes a three-pronged approach to achieving this goal.

Three-Pronged Approach

First, through the Remix curriculum that we teach in schools. Our curriculum is science-based, age appropriate, and evidence informed. We also incorporate interactive games and storytelling co-facilitated by a professional health educator and a peer educator, or a near-peer, who has the experience of being a young parent. Our educators are paid staff who concurrently participate in the peer educator professional development and leadership program, which includes mentoring, ongoing coaching, training, field practice in four core professional development domains. They get to level up their facilitation skills in the classroom as well as learn and build other professional skills.

The final tenant in our approach is linking young people to youth-friendly health resources in our communities. We worked with youth through various health services to ensure that their youth-friendly. And we link young people in the classroom to each resources as well as connect the peer educators to various resources in the community.

About Re:Mix

[Displays list of curriculum sessions:

Session 1: Introducing Re:MIX
Session 3: Understanding Relationships
Session 5: Consent and Setting Limits
Session 7: Condoms and Contraception
Session 9: A Baby Today

Session 2: Getting the Gender Message
Session 4: That's What I'm Talking About!
Session 6: Becoming an Adult
Session 8: The Final Stage
Session 10: Commitment to the Future

Remix is 10-sessions fact-based, evidence-informed health education curriculum designed for ages 13 through 17 to help young people identify their life goals and develop the skills for informed sexual health decision-making. Our curriculum builds on the idea that youth deserve the chance to maximize their strengths, imagine a healthy future, and explore their identities, which is the "mix" in Remix. Across 10 highly interactive 55-minute sessions, our curriculum teaches students about values on the gender spectrum, healthy relationships, communication styles, consent, puberty, reproduction, sexual decision-making, contraception, and planning for their futures.

Re:MIX Model

[Displays image of the Gender Unicorn tool which is used with activities to teach gender and sexual identity as existing on a spectrum versus just a binary, heteronormative lens. The spectrum categories are: gender identity, gender expression, physically attracted to, emotionally attracted to.]

Some very unique, excuse me, some very unique aspects to our sex ed curriculum are its gender transformative and sex-positive approaches. We bring young people of all genders together to explore rigid societal messages about gender so they're able to examine and redefine these messages for their own identities. We use the gender unicorn tool, that's pictured here, in activities to teach gender and sexual identity as existing on a spectrum versus just a binary heteronormative one. This inclusive approach is critical to ensuring all young people develop an expansive understanding of identities, which disrupt gender-based inequities and discrimination.

Our curriculum is sex-positive in that it doesn't only focus on prevention of pregnancy and STIs, nor does it prevent sex from an abstinence-only perspective. The curriculum content and facilitation message foster a safe, nonjudgmental environment that allows for shame-free exploration and support in line with the principles of positive youth development. Also unique to our curriculum is its peer education model.

Peer Education Model

Classes are co-facilitated by a Remix trained health educator and a peer educator. Peer educators are people who have experience parenting at a young age, and they tell their story of young parenthood throughout the 10 sessions as it relates to the sexual health content the

students are learning. This method builds upon empathy, and engages students in owning their own stories, and the opportunities available to them in their lives.

Alongside what occurs in the classroom, the Remix model provides professional development and leadership opportunities to participating peer educators. They receive training and coaching by Remix staff and community partners that build their professional skills and access to supportive resources. There is critical debate about peer education models in adolescent sex ed. But what's made Remix's implementation unique and more effective are that the peers are paid staff and not just volunteers.

This investment in each peer educator contributes to more buy in and consistent engagement within the program. They're also near the age of students as opposed to be of the same age. This allows them to be a little bit more relatable while still being viewed as mentors to the students they teach.

Since the start of our program, 12 peer educators, ranging in ages 18 through 26, have worked within our program. We invite you to check out our videos of peer educators and the work that they've done in the classroom by visiting the EngenderHealth YouTube channel. The storytelling component of our program is also currently being packaged and finalized, and we'd be happy to share this out with any interested organizations.

Community Health Services Linkages

The final approach of the Remix program is connecting young people to community health resources and preparing them to have conversations about their sexual health needs. The Remix curriculum includes one session dedicated to having students practice contract in clinics. After students complete the Remix program, we share copies of Austin area youth-friendly resources.

While we were developing the curriculum, we worked with young people to actually call in to the clinics and confirm they were truly youth-friendly. We wanted to make this information more widely available. We digitized this guide into an app for Austin area during year three of our project. We're also currently building a guide of resources that youth can utilize nationwide.

Partnerships

So here are some of our partnerships. So over the course of five years, we worked with several partners to implement and evaluate, as well as other third party partners to supplement and enhance certain pieces of the program. We worked within three Austin charter schools and identified a liaison at each school to help coordinate aspects of the evaluation and implementation.

During years one and two, we contracted with local health clinics to provide health educators to co-facilitate Remix. After a few semesters of implementation though, we realized these contracted health educators didn't have the capacity to teach and work with our team as we initially intended. So moving forward, we ultimately decided to hire internal health educators.

For the evaluation, we subcontracted with Child Trends to lead the evaluation as our national evaluator, and we've worked closely with them over the past five years. EngenderHealth and Child Trends also worked with a local evaluator, a child and family research partnership through UT Austin. They led on-site evaluation activities during years one through three.

Throughout the life of our program, we engaged several third party partners to elevate and innovate the work. We worked with photographers to take professional photos of Remix classes, videographers to create high-quality videos for our program, storytelling consultants to train our peer educators on their story share projects, an app developer to digitize the Austin area health resources, LGBTQ+ youth to review our curriculum and materials, licensed social workers and sexual health providers to train our peer educators as well as our team, and many more. If any audience member is interested in learning more about which partners we engaged and why, we'd be happy to share this information, and our experiences, as well as connect you to partners directly.

Student Demographics

[Displays pie chart of student ethnicity: 70.7% Latinx, 15.2% White, 7.5% Black, 6.7% Other.]

So let's switch gears and talk a little bit more about the average Remix students. Throughout the study, 626 students participated from three schools in Austin. The average age of the Remix student was 14 years old. The majority of our students are Latinx, which means their family origin is from Latin American countries, and the x signifies inclusivity of all genders.

30% of siblings, excuse me, 30% of students have a sibling or a cousin who is or was a teen parent, and 30% also have a parent who was a teen parent. This really shows the importance and the relevance of elevating the stories and experiences of young parents in the classroom. So now that you know a little bit more about the young people we serve, I'm going to pass the mic over to Kate, who will be walking you through the evaluation findings.

KATIE WELTI: Thank you, Rebecca. Hi, everybody. I'm Kate Welti from Child Trends, and I'll be reviewing the findings from our evaluation of Remix.

I wanted to start by highlighting that our study achieved high response and retention rates. Our team worked really hard to get students to return consent forms, follow-up with students at the time of the follow-up survey. And of the 952 eligible students, 88% returned consent forms. And among those students, 75% agreed to participate in our study. And among our 626 study participants, 533, which is 85%, completed the 12-month follow-up survey.

In the end, we had 518 students who completed all three surveys—the baseline, the immediate post-test, and the 12-month follow-up surveys. And these were the students that were included in our final impact analysis model. Our evaluation team gathered data on the implementation of Remix throughout the study.

Implementation Findings

We found that 90% of students participated in at least eight of the 10 the sessions. Approximately, 30% of class sessions were observed, and observers on average rated class session a 4.1 out of 5 in terms of overall quality. That overall quality scale encompasses the teaching performance of both the health educator and the young parent educator, as well as their ability to answer questions, and also measures students' engagement with the material.

Students' response to Remix was very positive. On the post-test survey, 98% said they learned something from Remix. 78% reported that they would recommend Remix to a friend. 89% said they liked the health educators, and 90% said they liked the young parent peer educators.

Evaluation Outcomes of Interest

On this slide, I've listed out some of our evaluation outcomes of interest. We included mediating outcomes that are associated with early and unprotected sex, including intentions regarding sexual activity and contraceptive use, knowledge about various reproductive health topics. We included several measures of attitudes, specifically attitudes around gender roles and relationships, attitudes about early sex and contraception, as well as students' attitudes about teen pregnancy and parenting. We have several measures of self-efficacy, including student's self-reported ability to avoid unwanted and unprotected sex, as well as students' self-reported ability to communicate with romantic partners. We also included a measure about positive future orientation.

We studied the program's impact on mediating outcomes at the time of the post-test survey, which was immediately after the implementation of Remix, and also at the time of the 12-month follow-up survey. Our behavioral outcomes of interest was whether students ever had vaginal sex and whether they had unprotected sex in the past three months. We studied the impact of Remix on behavioral outcomes only at the 12-month follow-up, as our study sample was relatively young—their average age was 14—and they were relatively inexperienced at baseline.

Post-test Findings: Mediators

So on the next several slides, I will show the impact of Remix on our median outcome at the time of the post-test survey. The program had a positive impact on students' intentions to use contraceptives. 43% of Remix students reported that they were definitely use long-acting or hormonal contraception if they had sex. This source is about half of the control students.

You'll see on this slide that Remix has a substantial impact on students' reproductive health knowledge across three topic areas. Remix students, on average, answered 73% of questions about condoms correctly. By comparison, control students answered approximately half correctly.

Remix students answered 63% of questions about STI prevention correctly, while control students answered approximately 44%. And finally, Remix students answered about a third of questions about contraception efficacy correctly, while control students answered only 12% correctly. Remix also had a positive impact on students' knowledge regarding where to obtain contraceptives. A post-test, 44% of Remix students reported knowing where to go to get contraceptives versus 18% of control students.

Additionally, Remix participants were more likely to report that they were confident in their ability to both ask for and give consent—32% compared to 22% of control students. All the post-test findings I shared here were sustained at the 12-month follow-up, except the impact on students' intentions to use long-acting or hormonal contraceptives, which did not reach statistical significance at the 12-month follow-up. We did not find statistically significant impacts of either post-test or 12-month follow-ups on our other mediating outcomes of interests, such as attitudes.

Behavioral Outcomes

For behavioral outcomes, we did not find an impact of Remix on whether students ever had sex. Additionally, because of the low proportion of students who were sexually active, ultimately we were not powered to find significant impacts on unprotected sex. In summary, our implementation and impact findings highlight the promising approach of pairing young parent peer educators with experienced health educators. Students were enthusiastic about the peer educators on the Remix curriculum overall.

Evaluation Summary

While our evaluations study did not detect significant impacts on the measured behavioral outcomes, we did find impacts on median outcomes associated with a lower likelihood of having unprotected sex. We found sustained impact on students' knowledge about condoms, STIs, and contraceptives, as well as their contraceptive self-efficacy. We also found sustained impact on students' ability to ask for and give consent, as well as our short-term outcomes on the intentions to use long-acting or hormonal contraception. Now I'll turn the presentation back over to Rebecca, who will discuss the work in gender health we'll be doing in the final year and beyond.

Final Year and Beyond

REBECCA SHIRSAT: Thank you so much, Kate. So in this final year of our grant, we've actually moved away from implementing in the classroom, and we've taken all the lessons learned from

implementation and are helping to build the capacity for other educators and youth serving professionals to be more effective in their work with you. We've established collaboration with community partners to deliver trainings.

Some of these partnerships include public school districts, community partners who work in gender-based and intimate partner violence prevention, as well as an organization that serves Latinx immigrant populations through outreach by community health workers. In addition to this, we're also supporting full and modulated implementation of the Remix curriculum and offer technical assistance to programs as needed. To give you a better idea of what this looks like, as I just mentioned we have a partnership with a local school district, who is actually traditionally pretty conservative, where we came in and delivered a training to their health educators of every grade level before they started the school year.

We guided these educators through activities that explore their values around an understanding of sexuality in adolescence, and we taught them strategies for creating safer spaces for lesbian, gay, bisexual, and transgender students. We pulled these training materials from our Training the Facilitators manual. In addition to providing trainings for these community partners, we've also offered free workshops that are open to the community. People from our community partner organizations, as well as interested community members, have attended these workshops. We've also worked with schools and we've taught—that we've taught within and provided them with full curriculum materials and the training to implement Remix in their own settings beyond the life of this grant.

So we're finalizing the designs of our digital tools, such as our Programming Implementation, Training, and Curriculum manual. We'll also releasing curriculum adaptations, such as a Spanish translated version, and additions that would incorporate peer educator story shared videos for programs that are unable to have a co-facilitator who is a young parent. We are excited to finalize and disseminate all of our materials to ensure that Remix serves adolescent and sexual reproductive health needs of many more communities into the future.

Thank you!

[Displays Engenderhealth's website: www.engenderhealth.org/youth. Displays presenters' contact information: Rebecca Shirsat rshirsat@engenderhealth.org, Kate Welti kwelti@childtrends.org]

Lastly, I want to share that after careful consideration, our small team has decided not to pursue funding opportunities, and we will be closing the EngenderHealth office in Austin in June. We intend to spend the final few months of our grant sharing all of our free materials and providing as much training and support as we can to our partners. If you have any interests in accessing our materials, learning more about the evaluation, or if you have any follow-up questions, please feel free to contact myself or Kate. You can also visit our website to learn more about our program. Thank you so much.

Prevention of Teen Pregnancy through Screening and Brief Intervention in Primary Care: Teens Exploring and Managing Prevention Options

RICHMOND PAJELA: Thank you, Rebecca and Kate. I appreciate the wonderful presentation. And so next, we will be hearing from Cade Arnink from the University of New Mexico Health Sciences Center.

CADE ARNINK: Hi, everyone. Good afternoon. So my name is Cade Arnink, and I am here representing the TEMPO team. And we're very excited to be able to talk to everyone today.

Disclaimer (TEMPO)

[Displays disclaimer language: This work was funded by a five-year grant from the DHHS Office of Population Affairs Tier 2B award # TP2AH000028.

Contents are solely the responsibility of the authors and do not necessarily represent the official views of the Office of Population Affairs, U.S. Department of Health and Human Services.]

And so this is our disclaimer. We were funded by the same five-year grant.

Brief Project Overview

Just briefly going over our project, the purpose of this project was to adapt and evaluate a brief intervention for teenage pregnancy prevention in primary care. And we were really looking to systematically evaluate the impact of a brief intervention plus standard care when compared to a standard care alone in a sample of diverse teenagers within a primary care setting.

And so the population we were working with was, of course, teenagers, aged 13 to 19, and those who self-reported past year unprotected sex. And we worked in a variety of primary care settings. So we worked within some high school-based university of New Mexico health clinics.

These are clinics that provide confidential and other health services to all the students in the various schools as well as teens in the surrounding communities. We worked out of the Albuquerque Job Corps Wellness Center. Job Corps is a national organization which helps students and teens pursue trade degrees. And then we also worked within the University of New Mexico Student Health and Counseling Center, so focusing more on college-aged teenagers.

Intervention Overview

Briefly going over our intervention, so we did—we started by doing over a year of formative work, getting input from teens kind of about the language that was appropriate to them, and how they felt an intervention like this should be structured. But finally, we came upon

developing this brief intervention, which incorporates principles and skills of motivational interviewing to facilitate a conversation around reproductive health and the teen's individual reproductive life plan. And so this included stuff like asking permission, assessing patient understanding prior to sharing information, sharing information in a manner that is tailored to the knowledge the patient already has, and assessing reactions to information or explicitly evoking ways in which the information impacts the patient's thinking about future sexual activity or contraception.

We used a lot of open-ended questions and reflections in a strategic fashion to evoke motivational speech. And then following information exchange, participants who were high in readiness to change engaged in action planning, which is a specific plan for reducing risk for unintended pregnancy, which we developed collaboratively with the patient. And the patients who were low in readiness to change completed a motivational interviewing-based roadmap activity that was designed to strategically evoke motivational speech. And so this intervention takes about 15 minutes to implement, and it's really focused on providing a collaborative space where teens feel they can openly communicate non-judgmentally and are really encouraged to be the expert on themselves and make the decision that's best for them.

Intervention Overview: Materials

So I just want to go a little more in depth with a few of the materials we used. So first, on the left is this river map we designed, which was used to evoke that motivational speech from teens. And so we kind of came up with a plan with them generally—wanting to maybe go to college, pursue an education, have a good job. A lot of teens talked about seeking a more independent lifestyle.

And then once we had established what that plan was, we would ask them to imagine following that plan and just talking about all the good things that could happen if they followed that plan and didn't become a parent in the next year. And then after kind of going through that, exploring these areas that you see, we would ask them to explore all the bad things that would happen if they didn't follow their plan and they did become a parent in the next year. And we found that this was very useful kind of getting teens to really dealing with their own thoughts and kind of voice their own reasons for why they might want to make this change to their own reproductive health.

And then on the right here is the change plan we used. And so this really just helped us provide teens with a plan, made sure they knew who their medical provider was when they are seeing them, helping them develop potential questions to ask them, establishing connections in their life—people who could support them, people we could talk to them—helping them answer any questions they had about contraceptive use. And then addressing any obstacles that could potentially come up and strategizing ways which they could overcome those obstacles.

And so we feel that this is a very innovative project and very needed. Although the American Academy of Pediatrics and the Society for Adolescent Health and Medicine recommends that

teen providers screen for sexual risk behaviors and provide education and counseling to those at risk, there are currently no specific guidelines or protocols available to guide such practices. And so really a lot of our work involves providing a guideline, developing this guideline, and really knowing and establishing what was a really good way to go about this. And then additionally, providing evidence that this—for evidence-based guidance for pregnancy prevention education and counseling.

Then we also felt that this was very innovative and that it helped conserve provider resources. Providers are typically very busy. It's hard for them to have a lot of one-on-one time with the patient.

And so this intervention is something that can be done quickly. It's something that allows providers to maintain a pretty busy schedule while still having a pretty effective conversation with the teens. And that we just feel that it helps to provide this information, helps standardize pregnancy prevention screening, and really provide some evidence for this area that has been asked for that has been lacking so far.

And then we also feel that this meets the needs of our population. Teens in New Mexico have among the highest rates of teen pregnancy in the nation. In 2010, we had the highest teen pregnancy rate in the nation with 8% of teen women becoming pregnant in a given year. And while rates of teen pregnancy are going down nationwide, there are disparities in reductions, with many of the populations we work with in New Mexico having not seen these same decreases we see across the nation.

And so this intervention is also useful, because it meets patients at their current points of contact with physicians. These settings that we established a work in are some of the few places where teens are seeking out medical advice or doctor's appointments many times not specifically for reproductive health, but it's something that comes up a lot in those conversations with their physicians. And so this intervention helps meet the teens at the places they're already going to be, and talking about these things, and then, again, providing this effective method of communicating with teens in a manner that does facilitate changes around their own reproductive health.

Project Highlights: Outcomes and Positive Results

[Displays two results of data collection; see following tables]

Proportion reporting at least 1 episode of engaging in unprotected sex in the last 3 months

	Control	Intervention
Baseline	N=228	N=217
	119 (52.2%)	122 (56.2%)
3 Months	N=197	N=193

	35(17.8%)	27 (14.0%)
9 months	N=166	N=168
	42 (25.3%)	22 (13.1%)

Odds of reporting at least 1 episode of unprotected sex in the last three months in the Intervention vs. Control arms

	Odds Ratio	Control	Intervention
Baseline	1.18	1.69	0.81
3 Months	0.76	1.32	0.44
9 Months	0.42	0.75	0.24

And so I want to share some of our positive results that we're looking at so far. And so these are preliminary. We're still finishing up our follow-up data collection, and that should be done in about the next month.

And so after our initial visit with the teens, we contacted them at a three-month interval and then a nine-month interval. So far we found that at nine months the participants in the intervention arm were 58% less likely than control participants to report unprotected sex in the last three months. And a repeated measure, logistic regression, found that there was a significant differential effect in the outcome over time between the two arms, while we did see that at three months there was a pretty similar reduction in unprotected sex. But at the nine-month interval, the control group really regressed, while the effect in the intervention group remained. And then we also found that there were greater odds of teens reporting unprotected sex in the control arm when compared to the intervention.

Project Highlights

Innovations—we talked briefly about this before—but we've been able to provide and develop a guideline for providers when screening for sexual risk behaviors as well as providing education and counseling. And really, this guidance to help professionals and physicians when engaging in these communications while continuing to conserve provider resources. And moving forward into the final stages of our project, we think that replication is one of the most important things moving forward.

And given our preliminary results, the replication of this project is highly important to us. And to that effect, we've developed a clinicians' guide, which really goes step by step in not only training, but providing that outline for how these conversations can go. And as well as we've developed a wide depth of fidelity data, ensuring that every session we did was coded, and that they were evaluated and reviewed to ensure that everything we were doing was consistent across everyone on our team to make sure that the effects we were seeing were there.

And then the clinicians' guide we've developed, we're in the process of developing a website to go along with that so that people have access to this, they have access to the different charts and forms we've developed. And we're really just working to train people, get this out there, and continue this work. Because we feel it's very important and that it is effective.

Thank You

[Displays presenter's information: Cade Arnink, B.S., clarnink@salud.unm.edu]

That's it. I really want to thank everyone for coming to this today. If anyone has any questions, please feel free to ask them at the end of the session.

And then if anyone wants any more information about the clinicians' guide we've developed, please reach out to me. And we'd be happy to get that information out to you when the website is live and more materials have been developed. Thank you.

Healthy Teen Network- Pulse

RICHMOND PAJELA: Thank you, Cade, for that wonderful presentation. So our next presentation will be from Healthy Teen Network on Pulse. And presenting are Mila Garrido the program manager, Genevieve Martinez Garcia, the principal investigator, and Brooke Whitfield, the research analyst from Child Trends.

[Displays disclaimer language: This product was made possible by Grant Number TP2AH000038 from the Department of Health and Human Services (HHS) Office of Populations Affairs (OPA).

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MILA GARRIDO: Good afternoon, everybody. This is just the standard disclaimer that you guys have seen for the last two presentations. All the contents are solely the responsibility of Brooke and I, that are represented on behalf of our teams, and don't represent the official views of HHS or OPA.

About Pulse Study

Today I will be talking a little bit about our Pulse project. The purpose of the Pulse project was to develop and test the efficacy of Pulse, which is a web-based mobile app intervention in increasing clinic use and effective use of birth control among Latinx and Black youth. Later on in the presentation, I will go into more details about how our intervention is set up.

Just to give you a little bit of information early on, it's a web-based mobile intervention that is complemented by text messages, includes information about sexual and reproductive topics, including animations, multimedia, clinic finder, reminders. The intervention is self-led, and it

was designed in English and Spanish. For the purpose of this project, we only evaluated the English version of the intervention.

For the participants to participate on our study, they needed to self-identify as women. They had to be ages 18 to 20. They couldn't be pregnant or trying to become pregnant at baseline. And they have to have daily access to on a smartphone, and they needed to speak English.

Most of our sample encompass non-Latinx Black and Latinx women. However, other ethnic and racial backgrounds were permitted to participate on the site. We also wanted to share a little bit about the structure of our study.

Pulse Study Recruitment Strategy

We conducted a two-arm randomized controlled trial, and we used an internet-based research approach, which means that all the participants, all the interaction with the participants, was done through digital platforms. For example, we conducted all our recruitment strategies through internet advertisement. We prioritized Instagram and Facebook to recruit our participants.

Once they were recruited, the participants were redirected to a study website where they completed their screener, their consent, their enrollment, and their baseline. When they made the eligibility, they were randomized into either the control or the treatment app. We didn't have any face-to-face contact with the participants throughout the duration of this study.

About Pulse Study

A little bit about our participants, we recruited a total of 2,317 participants. 70% of those participants identify as Black or Latinx. We conducted our study into two cohorts.

Cohort number one, we recruited a total of 1,304 participants. 661 participants were randomized to the treatment, and 643 to the control group. During cohort two, were recruited 1,013 participants. 504 participants were randomized to the treatment, and 509 to the control group.

Our study was set up in such a way that the participants were going to receive the first follow-up at six weeks post-randomization, and the second, six months post-randomization. Of our first cohort of our participants, 1,304 participants received the initial survey, and about 86% of them completed a survey. For the six-month follow-up, because of interruptions of the project and the funding, only 69 participants received the survey, and about 87% of them completed the survey.

However, on our second cohort, it looked a little bit different. Our whole sample, 1,013 participants received the survey, and 86% of them completed the survey. And then the six-month follow-up, 79% of our sample completed the survey.

Pulse Intervention Overview

A little bit about our intervention, Pulse is an intervention grounded in the theory of planned behavior and self-efficacy. Pulse is self-led, and does not require the user to follow any specific sequence or content. They can access the app anywhere as long as they have a mobile device and internet connection.

The user can interact with Pulse as frequently or as infrequently as they choose. Pulse has information that is comprehensive, medically accurate, and youth-friendly. We work with our youth advisory group to help us to define some of the content that we included in the intervention.

The intervention was developed in both English and Spanish. The content is the same, just the language is different. So we organized the content in six different buckets.

The section referred to as "Know Your Options" concentrated on content related to birth control methods, birth control reminders. The section called "Get Personal" speaks of healthy relationships, sex readiness, and consent. "Know Your body" focuses on issues related to anatomy, physiology, and sexually transmitted infections.

The "Take Action" is an area of the application where youth can find a provider, and they also get some information about what to expect when they're visiting a clinic, and how to set up an appointment reminder. The "Make a Plan" is a section that talks more specifically to pregnancy and pregnancy testing. And the "Get Savvy" focuses on frequently asked questions and provides a series of external resources.

The intervention covers approximately three hours of material, if a participant were to consume every single piece of content in the intervention. Pulse was set up in such a way that included different interactive and multimedia features. We have, for example, dynamic text. We have, of course, a clinic locator.

We also incorporated some comics that pose various scenarios. We have videos of racially diverse peers with real life models and scenarios. We have whiteboard animations. We also included short films that promoted birth control use and clinic use.

As I mentioned earlier, Pulse was a mobile-based application that was complemented by text messages. For the purpose of this study, we developed as a treatment a comparison app. We built it in such a way that looked almost identical to the intervention. The look and feel, the design, and the branding were identical. Just the content was different.

They comparison Pulse contained six areas similar to the treatment, but the content was different. The "Feed Your Body" spoke of healthy eating. The "Move Your Body" had exercise steps. The "Shut Your Eyes" included information about the importance of sleeping.

The "Connect with Body and Mind" talked about emotional health. The "Stress of Relationships" talked about the importance of establishing connections. And the "Get Savvy" also included frequently asked questions to the topic of more general health and well-being.

Text Messages and Pulse Control

[Displays pictures of iPhones with different Pulse App screens pulled up.]

Similarly, we wanted to mirror the text messaging experience that the treatment and control participants were going to receive. So as you can see on the left-hand side of the screen, we have with the purple color is an example of some of the text messages that our treatment participants received. And on the right-hand side in the blue is an example of the text messages that our control participants received.

The participants received approximately text messages every three days related to sexual health. For those in the treatment, for about six weeks. And similarly, the control participants received about every three days one text message, but it was more about general health. We really wanted the experience of the control and the treatment participants to be as close as possible.

BROOKE WHITFIELD: Great. Thank you so much, Mila. This is Brooke Whitfield from Child Trends.

Outcomes

So in evaluating Pulse, we focused on two primary outcomes of interest, which are increasing contraceptive use during sex, and then more specifically, increasing hormonal or LARC use during sex. LARC meaning long-acting or reversible contraceptive methods. This includes IUDs and implants. And we focused on hormone and LARC method use as an outcome rather than all forms of modern contraception, because the Pulse app focuses on increasing use of highly effective contraceptive methods.

And then in addition to these primary behavioral outcomes, we also had some secondary outcome measures of interest. And these included increasing contraceptive knowledge, improving attitudes toward birth control and accessing reproductive health services, improving birth control and reproductive health self-efficacy. And so this includes measures such as increasing participants' competence in their ability to use birth control during sex. And then lastly, increasing participants' intentions to use birth control during sex, and increasing their intentions to visit a provider of reproductive health services.

Survey Completion Rates

[Displays table showing intervention, control, and total survey completion rates. 6-week: 86%, 86%, and 87% for total, intervention, and control, respectively.]

6-month: 79%, 80%, and 78% for total, intervention, and control, respectively.]

So to assess our outcomes of interest, we conducted a six-week and six-month follow-up survey, as Mila mentioned. And you can see on this slide that 86% of all of our Pulse participants completed the six-week follow-up, and nearly 80% completed the six-month follow-up. And you can also see that we had similar response rates for the intervention and control groups. And these response rates are really high for pregnancy prevention programming, but in particular, they're really high for an online study.

As Mila mentioned, our participants did not have any contact with us, no personal contact with the program or study staff. So considering that 86% responded to the six-week and 79% of participants responded to the six-month follow-up was really promising in terms of the feasibility of online studies and getting high retention rates for these kinds of outreach. And the study did find some positive short-term impacts.

Positive Short-Term Impacts

[Displays bar graph of short-term impacts between the intervention and control group. Sex without a hormonal/LARC method in past 6 weeks^{**}: 22% and 30% for intervention and control, respectively.

Correct contraceptive knowledge^{***}: 52% and 45% for intervention and control, respectively
Confident in ability to use birth control during sex^{*}: 67% and 62% for intervention and control, respectively.

*p<0.05

**p<0.01

***p<0.001

(N=1,124)]

So the slide that you're looking at here shows that for our first cohort at the six-week follow-up, Pulse participants experienced lower rates of sex without a hormonal or LARC method, increased knowledge about contraception, and increased birth control self-efficacy. So these findings were all significant. We saw these promising differences between the intervention and control groups. However, these findings are just from the six-week follow-up for the first cohort. Aside from increases in knowledge about contraception, these findings were not sustained in our second cohort replication study or at six-month follow-up, which we can answer questions about as well.

App Usage

[Displays participant app usage information, see following list.]

- 3: average number of times an intervention participant logged into the app
- 4: average number of sections visited (out of six) by intervention participants
- 18: average number of minutes spent on the app by intervention participants
- 84%: of intervention participants logged into the app at least once

- 50%: of intervention participants visited the app more than once
- 46%: of intervention participants visited all six app sections

And so in addition to our primary and secondary outcomes of interest, our study was also really interested in looking at how often participants engaged with this app. So because this is an innovative intervention, we also wanted to look at not just our outcomes of interest, but are they using the app? Are they engaging with it?

And we found that on average, Pulse participants logged into the app three times and visited four out of the six app sections that Mila discussed earlier. And this came out to around 18 minutes spent on the app per intervention user on average. And we initially thought that this number may be a little low. But after consulting with the literature and some experts that were in the social media field, it turns out that this is actually slightly above average for the typical amount of time spent on an app by a user. So it's a promising finding. And you can also see on this slide that about half of Pulse participants visited the app more than once, and nearly half visited all six app sections.

Most Viewed Sections

[Displays most viewed sections, see following list.]

- Know your options: 35%
- Know your body: 27%
- Get personal: 19%
- Take action: 9%
- Make a plan: 6%
- Get savvy: 5%

And then in terms of what participants were reviewing on the app, the largest share of clicks occurred within the "Know Your Options" section, which as Mila mentioned, this section provides comprehensive information on each type of birth control available as well as what method may be best suited for a participant. And you can see that about 35% of all of our app traffic was in this section, followed by 27% in the "Know Your Body" section, and 19% in the "Get Personal" section.

And then within these six sections, participants spent more time on STI-related contents, or sexually transmitted infections, than on any other topic. In fact, for every 10 pages that were visited by participants, about six were related to STIs. So this really indicated to us that STIs are definitely a topic area that our participants are interested in learning more about.

Text Message Efficacy

And lastly, we wanted to evaluate the text messaging component of this intervention to see if it was a value add. And we found that 3/4 of Pulse participants received all text messages that were sent to them during the six-week intervention. And only 14% opted out of receiving text

messages. So they decided that they did not want to receive the follow-up or reminder text messages from the study.

And then our team is also currently assessing the efficacy of text messages and driving participants back to the app. So we're trying to see if these content reminders and messages that we send to participants were effective in getting them to go back and visit the app. So we're currently looking into that, and these findings could have really interesting implications for the cost-effectiveness of using text message components in future interventions. And I'm going to hand it back to Mila now for any next steps and closing remarks.

Thank You/Contact Info

[Displays contact information of Principal Investigator and Evaluator:

Jennifer Manlove Genevieve Martinez-Garcia
jmanlove@childtrends.org Genevieve@healthyteennetwork.org]

MILA GARRIDO: Yes. We included here information of our principal investigator and our evaluator at the Child Trends team in case you guys have any questions. For the remaining of our project, we are focusing on the dissemination and commercialization of Pulse.

We are working with an expert consultant that is helping us to find appropriate channels for the dissemination of Pulse. We are currently working on some social media strategies to disseminate the intervention so youth can get access to it. We are also in the process of moving our intervention to our local server so we can easily make changes, and update links, and change information as it becomes outdated.

More to come on this. And we look forward to questions that you all might have of our project. Thank you. Asya, back to you.

ASYA LOUIS: Thank you, Mila, and thank you to the rest of our presenters. Now we'll transition into our next section of the presentation, our question and answer period. Our first question is for Remix. Our question is, what will happen to Remix if people want to be able to implement it elsewhere?

REBECCA SHIRSAT: Hi. Thanks so much for your question. So we are currently doing all that we can to disseminate our materials for people who are interested in implementing in their own settings.

So we're currently finalizing our materials and digitizing them. So you can reach out to us to get on our newsletter so we can let you know when those materials will be out. And we're also doing some training with certain partners to help build their capacity to implement as well as to kind of answer some of their questions that might arise from looking at the curriculum

materials. So we would be open to sharing our materials, as well as sharing some of the lessons that we've learned, and our recommendations for implementing.

ASYA LOUIS: Great. Thank you so much, Rebecca. Our next question is for the TEMPO program. How did the TEMPO program address provider coercion around using contraception if patients identified they weren't sure if they wanted to become parents or not?

CADE ARNINK: So the—so yeah, that's a really good question. And so the way the intervention is developed, motivational interviewing really focuses on that area of ambivalence, where maybe teens have reasons why they should start using contraceptives. But they also may be not sure they're ready yet. And so the project is all about highlighting the teen's own decision-making and really providing a collaborative conversation.

And through what we know about motivational interviewing, as people voice their own reasons for making a change, they're more likely to make the change. So it's really moving away from that place where a teen might come in, and a provider identifies that they might need a contraceptive, and be telling them, you do this, you need do this, you need to do this. And hopefully, helping teens come to that decision on their own.

ASYA LOUIS: Thank you, Cade. Our next question is for Healthy Teen Network. Did you have an incentive built into the app or program to get the participants to do the six-week and/or six-month follow-up survey?

MILA GARRIDO: Thank you for the question. The incentive that we used for this study were Amazon gift cards. And the gift card number was texted to the youth through part of our text messaging system that we used as part of this study. But it wasn't built it within the app.

ASYA LOUIS: Thank you, Mila. Back to Remix, how did you identify or recruit your peer educators for your program?

REBECCA SHIRSAT: So we—thank you for your question first. We used quite a wide variety of different recruitment methods. We really tried to go to high schools, as well as community college campuses, to promote the program.

We also worked a lot with community members. So we built a lot of relationships with people who serve young people, as well as people who serve young parents, to just get our program out there. I also just wanted to mention that, of course, we also posted on online job boards as well, like Indeed. Thank you.

ASYA LOUIS: Thanks, Rebecca. Our next question is for Pulse. And our asker has said, we have looked at the app development as a strategy to complement our other programs, but are always deterred by fear of cost. Can you say anything about the app cost or ways you worked with tech folks to make this feasible?

MILA GARRIDO: Well, that is a very good question. So first, I want to say, Pulse is no native app. Native apps work very different than web-based apps.

So think about it. A web-based app is sort of like a glorified website that is phone responsive. So because a programming and web-based app is very different, we had an amazing partner that helped with a lot of the production of the content of the intervention, doing like the shooting of the videos, doing the animation, the comics. So we, in a sense, had somebody in-house in our project that helped us to develop that.

I think there are ways to go cheap when developing an app. Sometimes it's looking for a smaller team of developers that have the skills at the frontend and the backend of the app that can help you to develop the platform. Also, building your internal skills to know how to update your app yourself in the console of the app—modify.

Like I know on our team, when we started this process, we learned a lot by trial and error, and learned how to like—we are not programmers. We are not like media people. We trained ourselves. We learned so we could maintain some aspects of our app.

But whoever asked that question, if they want more details, and they want to pick off somebody's mind, there are so many elements related to the cause of an app creation. And we will be more than glad to share with you some of the things that we learned along the way, as well as some of the dos and don'ts of app development. I don't know, Genevieve, if you want to add anything.

GENEVIEVE MARTINEZ: No. Hi. So this is Genevieve Martinez.

So what I would suggest is to really take a hard look at your needs. And first, to consider whether you actually need an app or just a digital way to make the contents of your program a little bit more accessible. And once you identify your specific needs, then identify what will be the best channel.

Because, yes, once you develop a native app, there is a publication cost. There is the maintenance in the iOS platform and Android platform. So of course, there's a lot of cost variability. But like Mila said, we'll be very happy to walk you through our process and give you more tips on how you can decide what platform or approach is best for you.

MILA GARRIDO: Yeah, and I will add to that, there is a lot of small hidden costs, not necessarily like money, but human capital. There are little things, skills that you would need, something that's as simple as having your privacy. You might need the lawyers to set up the right language so your app can live in one of the marketplaces.

So there is a lot of little pieces that you have to take into account when deciding to develop an app. But I also—I would just want to put there that there are so many other technologies out there too that they might be more feasible now. Like this app was developed five years ago.

This is our last year of the project, so many things have changed, and the technology has advanced a lot. But again, email us at mila@healthyteennetwork or genevieve@healthyteennetwork, and we will be more than glad to talk more about this.

ASYA LOUIS: Thank you both. Our next question is for all of our presenters. What specific roles did youth have in the development and success of your programs? We'll start with Remix, and then TEMPO, and then Pulse.

REBECCA SHIRSAT: So before the Remix program actually got its funding, we worked with a different funder to conduct some needs assessments with students, with young people, in our community. So from those conversations with a wide range of youth we kind of learned that they were interested in talking to young parents. I think there was an interest in learning more about the stories of young parents compared to seeing them as a cautionary tale. So that was some of the formative research that led the program designers to incorporate young parents into the program. And we also—while we were developing the curriculum did a lot of focus groups with students as well as classroom teachers, who know what their students respond to, to get their feedback on improving the curriculum.

ASYA LOUIS: Thanks, Rebecca. Cabe, did you have anything to add?

CADE ARNINK: I wasn't involved with the development of the project. I was brought on later. I worked as an interventionist, and helping a lot with the fidelity, and a lot of the follow-ups and backend data collection. But we had a really great team who worked really hard to ensure that teams were heard on this project, that everything we were doing was appropriate, and was mindful and aware of how teens wanted to be talk to, and what was best for them. And so we feel that really helped to the success of our project, and that teens were an active collaborator in the project.

ASYA LOUIS: Great, and Pulse?

MILA GARRIDO: I would say, for most of us on the team, we have been working in this project from the beginning. So it's sort of like our baby. We saw it grow.

And I would say a big element of the success of our project has been having a cohesive team. I think we have a really good relationship with our partners and our evaluators at Child Trends. And we are a multidisciplinary team, and we bring very different strengths. Also, the fact that we were able to bring the youth voice early on in the process helped us and gave us a little bit of direction.

And I will say too, the fact that we are not, I would say, afraid of taking chances. We had to learn a lot of things as we were going, especially considering the fact that we were using an internet-based approach. And we have never done that before, and we really wanted to succeed on our recruitment strategy and our retention strategy.

So we tried everything. We tried every platform that was out there. We tried all sorts of apps.

So we tried a lot of things. And many of them failed, but many of them gave us insight of how to do it better. And I think that contributed greatly to the success of the project. And again, having really good partners, and people that we could bounce to ideas, and that we can process information in real time.

ASYA LOUIS: Thank you, Mila. We actually have one more question for you. How did you obtain consent from the parents if the participants were under age?

MILA GARRIDO: That is a great question. So our target population was 18 to 20. So we didn't have to deal with issues of parental consent.

However, I would say we were wrapping up a similar project through a CDC mechanism where we were recruiting younger youth, and we were able to get that IRB exemption. So we didn't require parental consent. But again, if somebody is trying to do that approach, we will be more than glad to share some of the resources and the research that we share with IRB to support our argument of why we didn't need parental consent.

ASYA LOUIS: And how did you gain consent from those participants?

MILA GARRIDO: The consent was started online through our study website. It was one of the screens that I shared early on. It had a bunch of details about.

Like any traditional consent, it provided information about the study, the conditions of the study, provided information about the fact that they could stop being part of the study at any moment. And they had to sign it, provide some key information that we requested, like date of birth, and their name, and their email. And that's how we obtained it. Everything was done online through the same website, the same mechanism, and they could do it from the comfort of their phone.

ASYA LOUIS: Thanks so much, Mila. And thank you to all of our presenters. This concludes our question and answer period. And at this time, I will turn the call back over to Richmond to close us out.

Current OPA Funding Opportunity Announcements (FOAs)

[Displays list of current funding opportunities, see following list. Find FOAs and FAQs at: hhs.gov/ash/oah/resources-and-publications/webinars.html]

- Optimally Changing the Map of Teen Pregnancy through Replication of Programs Proven Effective (Tier 1) (AH-TP1-20-001)
- Teen Pregnancy Prevention (Tier 2) -Phase II Rigorous Evaluation of Promising Interventions (AH-TP2-20-001)

- Innovation and Impact Network Grants (Tier 2) –Achieving Optimal Health and Preventing Teen Pregnancy in Key Priority Areas (AH-TP2-20-002)

RICHMOND PAJELA: Thank you, Asya. So before we wrap-up, I would like to make a note of our current—or OPA's current funding opportunity announcements. We have three of them open right now. You can see them on the screen.

I do want to note that the prefix of all of these FOAs have been changed. They were previously PA, and now they aren't AH. So I just want to repeat that again. The prefix of the application numbers have changed from PA to AH.

So if you're having trouble finding them, please contact OPA or OASH-OGM. And you can find these FOAs and FAQs on the [OPA website](#) on the URL on screen right now. And of course, I encourage you to please connect with us on our website as well as our [email](#), as you can see here on this slide.

And also, follow us on Twitter using the handle [@HHSPopAffairs](#). Thank you so much, everyone, for attending this webinar. Thank you so much.