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Exit Interviews from Adolescent Girls who Participated in a Sexual Risk-Reduction Intervention: Implications for Community-Based, Health Education Promotion for Adolescents

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Abstract

Introduction—The purpose of this study was to invite girls who participated in a gender-specific, sexual risk-reduction intervention to describe their experiences and identify program characteristics most or least beneficial to their involvement.

Method—Semi-structured interviews were completed with 26 African American, low income girls ages 15–19 who had participated in a sexual risk reduction intervention as part of a randomized controlled trial. The girls were interviewed after completing a 12-month post-intervention survey. Interviews were recorded, transcribed and analyzed for categories.

Results—Analyses of the interview data identified six categories: 1) reasons for participating, 2) strategies for maintaining behavior changes, 3) interacting with others, 4) communicating with mothers, 5) disseminating information to friends and family, and 6) disseminating information to the males in the community.

Implications and Conclusions—Many of the girls participating in the theory-based behavior change intervention reported selecting from a “menu” of strategies learned through the intervention to reduce their sexual risk. Having the opportunity to discuss sexual health with peers and trained facilitators, particularly in an all-female environment, was cited as a positive benefit. Community health organizations and clinicians who care for adolescent girls can adapt many aspects of this intervention to help reduce their sexual risk.

Keywords

HIV; intervention studies; adolescents; female; safe sex

INTRODUCTION

The incidence of HIV has remained stable at 50,000 new infections per year[1]. Adolescents and emerging adults, ages 13 to 29, represent 39% of those diagnosed yearly with HIV, and 65% of these are African-American[2]. Adolescent risk factors include early age at sexual onset, unprotected sex, and sex with older partners. To reduce vulnerability to HIV, adolescents need targeted, detailed education, and condom use and partner negotiation skills [2,3]. However, a national survey of public secondary schools in 2010 found sexual risk-reduction education had not increased and there was a wide disparity regarding what is

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taught nationwide. In a large multi-site study of 1,654 adolescents, ages 13–18, HIV-related knowledge was found to be minimal[4].

Adolescent girls have unique prevention needs. Studies comparing males and females show disparate factors influencing sexual-risk behaviors[5,6]. Many HIV interventions targeting women and girls are ineffective because they do not address social-cultural situations faced by females most vulnerable to HIV infection[7–9]. One unique need for girls is communication skills to encourage partners to use condoms or modify risk behaviors. Studies of women, from pre-teen to middle age, have revealed that ability to negotiate with partners as the most significant predictor of condom use[9–12].

Several risk and protective factors are especially important for girls. One study of minority urban girls found they were less likely to engage in sexually-risky behaviors if their mothers had discussed resisting sexual-pressure from partners[13]. Girls have greater concerns about partners not being monogamous[14,15], and multiple concurrent sexual partners is an important driver of HIV and sexually-transmitted infections (STIs). Girls are more likely to fear partner violence, serving as a deterrent to condom negotiation[12]. Thus, it is important to provide girls with knowledge and skills unique to gender-based risks.

The Health Improvement Project for Teens (*HIPTeens*) was a randomized controlled trial (RCT) designed to evaluate a sexual risk-reduction for adolescent girls guided by the Information-Motivation-Behavioral Skills (IMB) model[16,17]. To understand experiences of girls who received the sexual risk-reduction intervention, we interviewed 26 adolescent girls after completing their 12-month follow-up. The purpose of this study was to provide participants with an opportunity to voice their experiences, to identify information about unanticipated effects or relevant contextual factors that could assist in refinement of interventions tailored to the needs of adolescent girl, and improve future research.

METHODS

We chose a qualitative descriptive approach for this study[18]. In the original RCT, 738 sexually-active urban adolescent girls were recruited from a mid-size, northeastern US city. Girls were randomized to a sexual risk-reduction intervention or structurally-equivalent health promotion control group. Both interventions involved four, small-group sessions led by two trained female facilitators, and supplemented by two booster sessions at 3 and 6-months. Evaluation data were collected through Audio Computer Assisted Self Interview (ACASI) and included psychosocial antecedents to behavioral change as well as behavioral and biological data at baseline and 3, 6 and 12-months post-intervention. Approvals from the Institutional Review Boards of the University of Rochester and the University of Syracuse were obtained for all phases of this study. A Federal Certificate of Confidentiality was obtained and the trial was registered at ClinicalTrials.gov (NCT 00161343).

For this study, 30 participants were invited from among those who completed the sexual risk-reduction group and returned for their 12-month follow-up. We selected a 4-week period during end of study assessments from which to recruit and randomly selected all intervention participants scheduled that month for appointments. These girls were pre-identified to research team personnel prior to their 12-month follow-up. Following survey completion these girls were asked to participate in the exit interview. Of this group, 26 agreed to participate while the remaining 4 cited transportation conflicts. Following detailed consent procedures, each participant signed a consent form and was paid $10.

A semi-structured interview guide was administered by one of three trained staff who had not been program facilitators (see Appendix 1). We anticipated data saturation based on number of recruited participants[19]. All interviews were conducted in private rooms at the

community-based recruitment sites. Audiotapes and transcriptions were identified only by each participant's identification code. All study materials were stored in a secure, locked storage site, and transcripts saved on a secure, password-protected, server site.

Interviews were audiotaped and transcribed verbatim by graduate research assistants. Two independent analysts coded statements manually in each transcript, categorizing participant responses into descriptive categories. A third individual who had no prior involvement with the study and had expertise in qualitative analysis confirmed results using the qualitative data analysis program ATLAS.ti (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany) and recommended refinement. A list of categories and related quotations were generated and reviewed with all team members to further refine data and select appropriate quotes describing the categories. An audit trail was maintained, linking categories to corroborating evidence, actual quotations validating the categories. These various approaches served to optimize data quality, and provide evidence of dependability and consistency.

RESULTS

The final sample consisted of 26 urban, impoverished (based on free lunch status) African-American adolescent girls, ages 15–19. Data regarding sexual history and concerns had been collected at baseline during the parent study. Most of the participants in this study reported having had multiple partners, and the majority had not used a condom during vaginal sex. About a fourth of the girls had been pregnant at one time, and a third tested positive for STIs at baseline. Participants reported fear of a partner refusing sex when asked to use a condom during sex more often for casual partners than steady partners. See Table 1 for details.

Coding of the interviews revealed six descriptive categories providing insight into the participants' experiences in the intervention, including: reasons for participating, strategies for maintaining behavior changes, interacting with others, communicating with mothers, disseminating information to friends and family, and disseminating information into the male community. The following narrative provides a description of each category.

Reasons for Participating

Enjoyment and Education—When asked why they had participated in the intervention, most girls reported that the incentive payments were initially why they enrolled in the intervention, but other factors brought them back. One girl explained that the money was not as important as the knowledge she had acquired, and others discussed enjoyment from attending and participating in activities. Some girls participated because the experience provided an opportunity for an activity outside the home. One teen talked about her enjoyment and her frustration with being at home.

> I wished it [the intervention] didn't end. I liked going. I like having something to do… When I'm at home, I'm yelling or arguing.

Many wanted the intervention to continue after the study ended, motivated by a desire for activity, knowledge acquisition, or opportunity for group participation.

Barriers to Attendance—Participants were encouraged by interviewers to identify what they liked least about the program. Transportation challenges were reported as the most difficult barrier to participation. One girl described the challenge.

> And that was, my hardest thing about it too is the transportation. There was times where I had to walk from [approximately 2 miles] to here but I still did … it was somethin' to do.

Girls having transportation issues could work with staff to determine which bus routes would work for individual participants, as sessions were held at community-based institutions. Having to walk long distances from bus stops or having to wait for busses in inclement weather, was considered a barrier, though not significant enough to deter girls from attending.

Strategies for Maintaining Behavior Changes

Assertive Statements—Participants were exposed to multiple strategies to reduce sexual risk and presented information and skill-building exercises in negotiation and communication, condom use, strategic risk approaches, and more. Participants reported that learning about strategies for making behavior changes to reduce sexual risk was the most valuable knowledge they acquired during the intervention. Many girls identified the assertive skills training for condom use and the right to refuse unsafe sex as particularly helpful. They practiced these skills with role-play exercises with facilitators and each other. One girl described what it meant to discuss condom use with a partner.

> Being assertive, saying no, like and really meaning, not like sitting and playing around. Like no means no, and wear condoms.

Another girl identified using assertive statements as a tool for communication strategies for other behaviors besides condom use which gave her more options in all relationships. Several girls also reported that assertive skill training had helped them make informed behavior choices and allowed them to more openly discuss risk-reduction with sexual partners.

Abstinence and Condom Use—Girls were asked what other strategies they had adopted to reduce sexual-risk. Having learned condoms were not always effective, one girl chose to practice secondary abstinence, that is deciding to practice abstinence despite a previous history of sexual activity. Choosing abstinence, reported another teen, eliminating her need for birth control. Another girl discussed her strategy to have sex less often while also increasing her use of condoms.

> My sexual history slowed down a little bit. Using more protection than ever. And I used to have like at least one or two sex partners. But now it be like months before I have sex, like before just the incident ago, it was about a good six months that I went without any..

One teen learned to avoid situations that led to sex with her boyfriend by ensuring a sibling was present when the boyfriend visited her home.

Trusting Partners—Several girls reported waiting until better acquainted with potential partners before having sex. Other participants learned that sexual partners may not always be monogamous increasing their need to employ various risk-reduction options to address concurrent sexual partners. One girl expressed her concern about her boyfriend's commitment.

> I wish there was a lie detector test… I trust him. But it be certain things, like, you know, somebody moving funny, you know something up.

Several participants expressed their belief that other participants in the groups who had discussed absolute trust in their partners were misguided or naïve. Several girls in our group reported using condoms even with steady partners due to mistrust and concerns they might be exposed to HIV/STIs.

Triggers and Testing—Interviewers also asked participants which intervention activities were most helpful or enjoyable. All participants reported enjoying the group activities with no activity receiving negative feedback. One girl felt activities helped her consider more frequent HIV testing,

> I don't think that we'd ever really sat down and like thought about [testing]…[this program] made me realize that I should get checked more often-because of the way I behave. I know my behavior isn't gonna change instantly.

After learning how HIV was spread, one teen reported avoiding social situations that could trigger risk behavior, such as parties, where according to her, a lot of sex is happening. Another girl explained that she now understands risks for using condoms incorrectly.

Interacting with Others

Peer Interaction—Our intervention was provided in small groups with two female facilitators. It was this group interaction participants stated enjoying the most. Many appreciated the opportunities to interact and role-play with other girls and facilitators, and said that they did not have in their everyday lives. One participant described how the intervention had provided her with opportunities to discuss sexual matters.

> There's not a lot [of] places or people to talk to about stuff like this. And when you get a bunch of girls together, it…it brings it to the table. And then you're able to talk about how you feel…and like your own experiences if you want to or not.

One girl explained that she had not planned to talk during groups, but discovered it was what she most needed to do. Several stated that talking to peers helped reinforce lessons learned in the group sessions. Many discussed their need to have someone to talk to about issues common to teens, such as sex. Overall, the intervention provided girls with what many described as a rare opportunity to talk with peers about sexual health with guidance from the facilitators.

Interaction with Trained Facilitators—When asked to provide feedback about women who facilitated each group, all but one of the participants reported positive reactions. A number of girls reported not feeling judged or criticized by facilitators. One of them described the facilitators' attitudes towards the girls.

> They was nice. They was polite. They wasn't rude. And they wasn't attitudy. Because you know some… alotta women have a nasty attitude.

A few expressed concerns that some facilitators being older might not be able to understand their experiences. However, one girl stated that she preferred having older facilitators feeling they delved deeper into topics and helped guide the girls around sensitive issues and concerns. Only one girl expressed her dislike, referring to them as "*boring old women*."

Inclusion of Boys—Given the limited number of interventions available for teens, our intervention was specifically developed through extensive formative and pilot-work for adolescent girls [20]. Girls unanimously felt that boys should not be included in the intervention, that an all-girl approach was preferred. As one girl described her reaction to an intervention that included both boys and girls:

> I think everybody would attend, but they wouldn't talk and conversate because the boys, well the boys would, but the girls wouldn't because they'd be so uncomfortable with the boys talking about sex.

Another participant felt that girls would "lose their voices" if boys were present. She explained that boys did not listen, especially to females, and they would hurt the usefulness of these groups.

Communicating with Mothers

Based on previous work highlighting the significance of mothers, participants were asked in their interviews whether they discussed intervention information with their mothers. One reported sharing everything, as she considered her mother her best friend. Most others expressed reluctance to talk with their mothers. One girl stated that generally she did not talk to her mother but had presented intervention information and found that it was surprisingly easy to discuss with her. Several reported trying to educate their mothers who were unfamiliar with sexual health information. Some participants discussed information with other female adults, such as sisters or grandmothers, who were important to them.

Disseminating Information with Friends and Family

Recruitment of Others—Girls were asked whether they discussed the information provided in the intervention with other girls in their communities. Most reported they had, hoping to educate or recruit friends or family into the ongoing intervention. One felt her friend needed the peer support and said that she shared the information from the group.

> She's still doing stupid stuff being with older guys and stuff like that. And I think if somebody was to like sit her down and talk to her besides her mom or her dad someone who she can like… like someone who's like in the same place as her.

Several participants expressed worries about younger girls having sex at a too-early age. Consistently, participants spoke of the need for programs tailored specifically for younger girls to address risk reduction before they became sexually active. One teen revealed that knowing girls who had started having sex by age 11.

Sharing Knowledge—Girls also shared the intervention knowledge they had acquired with their friends and family and repeated cautions about sexual risk taking. One girl stated that her friend "finally" listened to her after sharing her intervention experience. Another girl shared the informational brochures she acquired during the intervention with her sisters.

> I took it home and I showed my sisters and stuff. 'Oh yea we see this stuff in health' and I was' like, "yea, well, you need to pay attention to it in health."

Many girls reported having had exposure to some of the intervention material in health classes but felt that the intervention provided more in-depth information in a contextualized way. One girl stated that she was shocked by the amount of knowledge she had acquired through the intervention feeling she had not been taught these facts in health classes.

Disseminating Information into the Male Community

Fathers and Father Figures—To some extent, girls shared the sexual risk knowledge with males in their lives, although many girls did not discuss this information with their father/father surrogates. One girl, however, stated that she talked only to her father about sexual issues. One other girl wrote letters about the intervention to the father of her sisters, who, though he was in prison, responded back with encouragement. Some girls reported talking to older brothers and male cousins about what they learned in the intervention.

Sexual Partners—Girls reported having conversations with boyfriends about their intervention experience including educating them on the information they had learned. One girl compared her understanding of HIV risk and prevention to her sex partner's.

> Some of the stuff they taught me at HIPTeens, I was talking to one of the dudes I was messing with and he didn't know that stuff. And he's older than me.

Girls also used the survey questions to start conversations with their partners. One teen's partner expressed concern over her reporting their lack of condom use. Other sexual partners expressed surprise that participants did not already know the information being presented in the intervention or were uninterested in discussing what took place in the groups.

DISCUSSION

This study generated several findings that can be used in tailoring interventions for teen girls, and for clinicians providing care to them. These interviews provided a contextual glimpse into specific strategies participants garnered for accomplishing these aims. Several girls reported using assertive statements to negotiate safer sex, an important strategy given gender-power imbalances within sexual relationships [9,11,21]. Other participants discussed increased awareness of "triggers" that might facilitate risk behaviors and their need to avoid risky situations (eg, parties where drugs or alcohol are present). Girls also described using HIV testing, reducing number of sexual partners, and secondary abstinence as risk-reduction strategies. Each girl selected from a menu of options delivered in the intervention and focused on the options that they personally found useful. The preponderance of girls reporting safer sexual practices resulting from participation in this intervention suggests that involvement in sexual risk reduction intervention tailored for adolescent girls can provide the motivation and skills needed to reduce their risk.

Participants also appreciated the opportunity for peer discussions led by experienced female facilitators during interactive group sessions. They cited this as a unique opportunity to gain vital information and social support. The facilitators kept conversations on track, pushed conversations deeper, and provided clarifications and accurate information. Their guidance ensured that girls felt they were in a safe place where they could speak openly without fear of judgment. Though most girls were originally attracted to the intervention because of the monetary incentive for participation, the majority reported wanting to continue group participation even after the original intervention study was completed. (Indeed, at the end of the study, our staff received more than 100 phone calls requesting information on what program would be offered next.) Group sessions were held at community-based institutions requiring many of the girls to take public transportation or coordinate rides. This was a barrier to participation but the girls did not allow this to hinder attendance.

These results indicate that participating in interventions tailored for adolescent girls affords a positive experience for teens by providing them with knowledge, skills, and emotional support. It is noteworthy that no participants felt boys should have been a part of the experience as they felt that their networking and conversations would have been inhibited.

Many girls reported taking what they learned about sexual risk and disseminating this information to their families and communities, particularly to other girls they deemed at-risk and younger, pre-teen girls. Many indicated they would discuss sexual risk-reduction with their current and future sexual partners. An indirect result of such an intervention is the potential to influence community members who had not directly participated in the intervention by heightening their awareness and commitment to safer behaviors through interacting with the study participants.

Participants felt that the health classes offered in public schools were insufficient, aligning with national data showing that sexual health education is often substandard[3]. The girls reported that the information covered in the intervention extended significantly beyond what had been taught in school classes. The success of the intervention to reduce risk behaviors,

as well as inform and motivate, suggests that other health curricula may be improved by integrating our intervention into such programs.

Study limitations should be acknowledged. First, these participants do not ensure representativeness of all those enrolled in the parent study and included only girls who had attended the interventions. Although we did not use intervention facilitators as interviewers, the adolescents were interviewed by research team members and there may have been some reluctance to report negative feelings about the intervention. Our participants were African-American and were from one geographical region; whether their views transfer to other racial/ethnic subgroups or to adolescent girls from other regions requires further investigation.

IMPLICATIONS FOR PRACTICE

HIPTeens provides a model for how community-based organizations might structure sexual risk-reduction intervention programs. Using materials that are theory-based and gender-specific could allow trained staff to implement group sessions for adolescent girls. Many of the core elements reported as being most beneficial, such as group/peer discussion and detailed sexual-risk information, can be efficiently implemented.

Participants appreciated the non-judgmental attitudes of the facilitators and how the facilitators guided discussion despite initial resistance. We encourage the use of a supportive mentoring approach and the presentation of a range of risk reduction options (see Appendix 2). Midwives, nurse practitioners, and clinicians can initiate such conversations with adolescent girls in their clinical practice. Providing girls with a menu of risk-reduction options is critical because circumstances will differ among girls. Clinicians can motivate as well as identify discrepancies between girls' behaviors and future goals. Sexual risk-reduction skills were developed through role-play exercises, and these are often easier in a group setting. Nonetheless, individual visits with clinicians can also provide opportunities for providers and adolescent girls to role-play negotiation and communication skills. Sexual risk-reduction is a process and clinician support for each positive step is important. This can include, for example, focusing on a girl's decision to avoid a social situation with alcohol and discussing with her 'what did you do right on Tuesday that you can do again.' Identifying the utility of various approaches including secondary abstinence, partner number reduction, HIV/STI testing and avoiding situations that place the girl in high-risk environments in addition to condom use are all viable counseling strategies for providers.

CONCLUSION

Information from this investigation affirms the need for gender-tailored risk reduction. Girls expressed that they valued having a safe place within the community where they could meet to discuss sexual matters with other girls under the guidance of trained facilitators. Clinical and educational agencies that provide this accepting climate can help girls as they negotiate the challenges of adolescents. Intervention components that the girls found useful and enjoyable included developing a menu of risk-reduction options, role play strategies, and identifying and avoiding situations; these components can be integrated into clinical care. Positive aspects of the program included both the direct (eg, reduced sexual risk) as well as indirect benefits (eg, peer relationship development). Other areas that warrant further research include the need for interventions that involve mothers, tailoring interventions to address the needs of younger adolescents, and separate programming for males.

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Biographies

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Appendix 1. List of Exit Interview Questions

Section I. Your general experience with HIP Teens

1	Pretend I was someone you wanted to tell about participation in this project. What would you tell me you did?
2	In your own words, why do you think we're doing this project?
3	Why did you decide to participate in the Health Improvement Project for Teens?
4	What did you like about the project?
5	What did you not like about the project?
6	What could we do differently to make this project a better experience for girls?
7	What could we do to make girls feel more comfortable about joining the project?

Section II. Groups

1	Did you like or not like the group meetings with facilitators?
2	What did you like about being in groups?
3	What didn't you like about groups?
4	What were some of the most important things you learned or did in the group?
5	If you missed any groups, what was the reason (sick, transportation, not interested)?
6	What made you attend the sessions (money, information, social)?
7	Did you find that you changed any of your behaviors, based on what you learned in the groups?
	a. Can you tell me more about the ways you changed?

Section III. Talking with other people Let's talk now about any information or thoughts that you might have shared with family or friends.

1 Did you talk with your any of your friends about anything you learned or did in this project? About how many friends would you say you talked with about this project?

   a. If yes, what were some of the things you talked about with your friends that you learned or did in this project?

2 What did you tell your friends that was new or different (that you learned or did in this project)?

3 Did you talk with your mother about anything you learned or did on this project?

   a. If yes, what were some of the things you talked about with your mother that you learned or did in this project?

4 Did you talk with your father about anything you learned or did in this project?

   a. If yes, what were some of the things you talked about with your father that you learned or did in this project?

Section IV. Other Feedback

1 Is there anything else you'd like to add about your experience with HIP Teens?

2 Is there anything you think we could do differently to make this a better experience for other girls?

Appendix 2. Menu of Strategies to Reduce Sexual-Risk

Participants developed a menu of strategies to reduce risk such as those listed below. They select one or more strategies appropriate for a particular situation.

- Avoiding situations that could lead to risky sex
- Avoiding alcohol or drugs prior to having sex
- Avoiding sex when drunk or high
- Asking partner about HIV status
- Asking partner to get tested for HIV/STIs
- Talking with partner about using a condom
- Reducing the number of sexual partners
- Having only one sexual partner
- Refusing to have unprotected sex
- Avoiding sex rather than having risky sex
- Getting tested regularly for HIV/STIs
- Having oral sex or masturbating rather than having vaginal/anal sex
- Abstain from all sex
- Carrying condoms (or keeping them nearby) in case you decide to have sex
- Using a condom for vaginal and/or anal sex

Quick Points

- Twenty-six urban, sexually-active, African American adolescent girls who received a sexual-risk reduction intervention (*HIPTeens)* described their experiences after completing the 12-month follow-up.
- Findings indicate that participating in interventions tailored specifically for adolescent girls affords a positive experience for teens by providing them with knowledge, skills, and emotional support.
- Participants reported adopting a menu of strategies that they could employ for reducing sexual risk. Clinicians can incorporate these strategies into counseling and education for adolescent girls.
- *HIPTeens* provides a model for how community-based organizations might structure sexual risk-reduction intervention programs.

Table 1

Baseline[a] demographic and sexual history characteristics of sexually active African American adolescent girls participating in a HIV sexual risk-reduction intervention (n=26)[b]

Characteristics	Values
Age, mean (SD), y	16.2 (1.2)
Age at first vaginal sex, mean (SD), y	14.4 (1.5)
Age of participant's steady partner, mean (SD), y	17.6 (1.8)
Black/African American, n (%)	26 (100)
Living Situation, n (%)	
Family's apartment or home	23 (88%)
Own apartment or home	1 (3.8%)
Foster Care	1 (3.8%)
Other	1 (3.8%)
Poverty (based on "free lunch" status), n (%)	
Impoverished	18 (69%)
Not impoverished	8 (31%)
Sexual History, n (%)	
Had multiple lifetime partners (2 to 45)	22 (85%)
Ever been pregnant	7 (27%)
Use a condom during vaginal sex	7 (27%)
Presence of STI by either urine test or chart audit	8 (31%)
Sex for Money, Drugs, Food, Place to Stay	1 (3.8%)
If Asked to Use Condom, Fears that Steady Partner …, n (%)	
Might end relationship	1 (3.8%)
Might refuse sex	1 (3.8%)
Might get angry	3 (11%)
If Asked to Use Condom, Fears that Casual Partner …, n (%)	
Might end relationship	1 (3.8%)
Would end relationship	5 (19.2%)
Might refuse sex	1 (3.8%)
Would refuse sex	5 (19.2%)
Would get angry	6 (23%)

[a] Baseline refers to data that were collected prior to the start of girls' participation in the intervention

[b] Number who participated in exit interviews; total N for the intervention was 738 participants