Published in final edited form as:

Health Promot Pract. 2017 May ; 18(3): 400–409. doi:10.1177/1524839916681990.

Adapting an HIV Risk Reduction Curriculum: Processes and Outcomes

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Abstract

Becoming a Responsible Teen (BART) is a community-based, HIV risk reduction curriculum shown to increase safer sex behaviors among African American adolescents. However, BART does not address common barriers to sexual health care access, which may limit program efficacy. We used a community-engaged adaptation process to maximize program relevance and health outcomes by incorporating a broad ecological perspective. Adolescent and staff advisory boards at a community-based organization recommended modifications (e.g., delete references to Kwanzaa, update language, localize incentives) and supported inclusion of critical on-site health services, such as sexually transmitted infection testing and condom provision. We conducted a trial of adapted BART (one session/week for 8 weeks) with 36 adolescents at two community organizations (mean age = 15.5 years, 52% female; 61% reported previous sexual intercourse). Most received on-site sexually transmitted infection testing (61%) and condoms (70%). Adolescents demonstrated significant improvements in self-efficacy for safer sexual practices ($p < .02$), AIDS risk knowledge ($p < .001$), condom knowledge ($p < .001$), and condom attitudes ($p < .04$). Adolescents and staff were satisfied with the revised curriculum and found on-site services acceptable. Based on improvements in constructs influencing behavior and the successful delivery of services essential for optimal health, future studies to assess efficacy and sustainability of the adapted curriculum appear warranted.

Keywords

access to health care; child/adolescent health; health disparities; HIV/AIDS; minority health; program planning and evaluation

Preventable sexually transmitted infections (STIs), including infection with human immunodeficiency virus (HIV), are significant and costly public health problems that disproportionately affect adolescents, especially minorities and those with limited access to

health care (Finer & Zolna, 2011; Klein, 2005; The National Campaign to Prevent Teen and Unplanned Pregnancy, 2013; Satterwhite et al., 2013). Accordingly, the Healthy People 2020 objectives for adolescents call for efforts to “promote healthy sexual behaviors; strengthen community capacity; and increase access to quality services to prevent STIs” (Office of Disease Prevention and Health Promotion, 2014).

Evidence-based curricula can be used in community settings to decrease adolescent risk for STIs/HIV. One curriculum targeting HIV prevention, *Becoming a Responsible Teen* (BART), is tailored to African American youth and has been shown to decrease unprotected intercourse, increase condom use, and delay sexual debut (Centers for Disease Control and Prevention [CDC], 1999; St. Lawrence et al., 1995). This 8-week curriculum is based on the information-motivation-behavioral skills model (Fisher, Fisher, & Harman, 2003). The curriculum uses interactive strategies, technology, and behavioral skills training to target the three primary constructs that influence behavior change: information and knowledge about the behavior, the individual’s motivation to perform the behavior, and the skills needed to perform the behavior.

While BART has demonstrated efficacy, evidence suggests that adaptations specific to the target setting can amplify efficacy by incorporating a broader, ecological perspective (Bernstein et al., 2012; DiClemente, Salazar, & Crosby, 2007; Kraut-Becher et al., 2008; Robin et al., 2004; Schwartländer et al., 2011). Efficacy might be increased by addressing specific barriers, such as lack of access to health care or local constraints like transportation. Furthermore, bundling behavioral targets with biomedical prevention (e.g., STI testing), which was not a strategy in the original curriculum, has since been identified as a key component of efficacious programs. Such bundling is especially relevant to HIV prevention, since the presence of an STI increases the likelihood of HIV acquisition/transmission (Johnson, Scott-Sheldon, Huedo-Medina, & Carey, 2011; Kraut-Becher et al., 2008; Pedlow & Carey, 2004; Robin et al., 2004; Vermund & Hayes, 2013). Finally, BART was created in the 1990s and evaluated with youth in the southern United States. Despite updates in its third edition (2012), the curriculum uses language and cultural references that may not be generalizable, in our case to Midwestern adolescents (St. Lawrence, 2012).

The purpose of this study was to use a community-engaged approach to adapt BART to (1) address access to care by incorporating targeted health services and clinic referral, (2) expand content to include STIs other than HIV, and (3) improve relevance to Midwestern youth. We used a three-phase process to adapt the curriculum and evaluate the enhanced program using criteria from the RE-AIM model to assess program reach, effectiveness, adoption, implementation, and maintenance (Figure 1; Glasgow, Vogt, & Boles, 1999). We describe the practical adaptation and application of a community-based program that may inform implementation practice and future research for a broad base of professionals engaged in health promotion and disease prevention.

► CONTEXTUAL BACKGROUND

Community-Based Organizations

We partnered with two community-based organizations (CBOs) that provided a variety of services and programming (e.g., sports, mentoring) to primarily African American adolescents from urban, economically disadvantaged areas. CBO1 was a local chapter of a national organization, and attendance was not incentivized. CBO2 was a local organization that routinely provided adolescents a nominal amount for attending any CBO programming, a practice not altered by the research project.

Adolescent Participants

Adolescents aged 14 to 18 years receiving services from either CBO were eligible. Adolescents who did not speak English or had developmental delay were excluded. Any adolescent could attend any BART session regardless of enrollment status, but only enrolled youth could complete STI testing or written assessments.

Staff Participants

Staff who were identified as key stakeholders (e.g., either identified by adolescents as trustworthy or worked extensively in adolescent programming) were invited to participate in Phases 1 and 3.

Recruitment and Consent

The protocol was approved by our hospital institutional review board and included waiver of parental permission, consistent with national guidelines for adolescent research (Santelli et al., 2003). A liaison from each CBO assisted with adolescent and staff participant identification using verbal and written announcements. For Phases 1 and 3, the purpose of the community advisory board (CAB) was described to each group in detail, and verbal assent/consent was obtained from participants. For Phase 2, adolescents provided written assent/consent.

Health Educator

A 25-year-old African American female public health graduate student (JW) led all CBO interactions. She facilitated recruitment, moderated CAB meetings, conducted all BART sessions, and administered surveys.

► PHASE 1: USING A COMMUNITY-ENGAGED APPROACH TO ADAPT BART

Objective

We engaged one adolescent CAB and one staff CAB to inform curriculum adaptation to (1) incorporate health services and (2) increase relevance to Midwestern youth.

Method

Sessions.—CAB meetings were held when adolescents and staff were already scheduled to be present. Each group met twice, first to provide formative input about curriculum adaptations and again after the trial (described below). CAB meetings lasted 40 to 60 minutes and were audiotaped. A second study team member was present to take written notes. CAB participants each received a \$20 gift card and a meal.

Discussion Guides.—The educator introduced the CAB purpose and described the BART curriculum. The educator used guides developed by our multidisciplinary team that included broad, open-ended questions as well as probes to garner more detailed responses. The guides for Session 1 explored curriculum relevance, for example, “One way BART tries to help teens feel connected to their culture is by talking about Kwanzaa. What do you think about that?” The guide also included questions on interest in inclusion of other STIs and feasibility and acceptability of on-site health services (i.e., condoms and STI testing).

Analysis.—Two team members (MKM and JW) discussed responses immediately following each CAB. Using audio-recordings and written notes, they independently compiled summaries of recurrent themes, then met to discuss themes and reach consensus. All themes were identical across the two raters (100% concordance).

➤ PHASES 2 AND 3: IMPLEMENTING AND EVALUATING THE ADAPTED CURRICULUM USING THE RE-AIM framework

Objective

We conducted a pilot of the enhanced BART program (one session/week for 8 weeks).

Method

Recruitment and Retention.—Participants were provided refreshments and up to \$90 for completing all sessions and assessments. Adolescent CAB members were recruited to participate in Phases 2 and 3 as well.

Evaluation Model.—We used the RE-AIM framework to evaluate this real-world intervention on both individual and CBO levels across five dimensions: Reach, Effectiveness, Adoption, Implementation, and Maintenance (Kessler et al., 2013). As applied here, “Reach” focused on the penetration of the intervention into its intended audience, defined as attendance at 50% of curriculum sessions and participation in site-based services and/or clinic referral. “Effectiveness” involved the immediate impact on targets for behavioral change, including self-efficacy, AIDS risk knowledge, condom knowledge, attitudes, intention, and use. “Adoption” described facilitators (e.g., acceptability) and barriers to curriculum adoption. “Implementation” captured fidelity (e.g., the extent to which the adapted components were delivered as intended), audience composition, and teaching components. “Maintenance” assessed whether changes were maintained at individual and CBO levels (e.g., program continuation).

STI Testing and Treatment.—We performed testing on urine specimens to identify *Chlamydia trachomatis* and *Neisseria gonorrhoeae* (NAAT, Gen-Probe, San Diego, CA). One investigator (MKM) prescribed treatment when indicated. A nurse contacted participants to arrange free treatment at the hospital-affiliated Title X clinic.

Measures.—Participants completed three written assessments: preintervention (Time 1), immediately following the final BART session (Time 2), and follow-up (Time 3) at 12 to 14 weeks after the last session. Assessments were developed by our team and were based, in part, on national surveys and relevant literature (CDC, 2012, 2013). We collected data on sexual behaviors, health care utilization, and demographics.

Reach.—The educator documented attendance and health service receipt. We reviewed the medical record to determine completion of clinic referral, including treatment for study-identified STIs.

Effectiveness

- *Self-efficacy:* We used five Likert-type scale items to assess self-perceived power to negotiate condom use (1 = *strongly agree*, 5 = *strongly disagree*); higher score indicates greater self-efficacy (Jemmott, Jemmott, & Fong, 1998; Wise, Goggin, Gerkovich, Metcalf, & Kennedy, 2006). Used with African American youth, interitem reliability (Cronbach's $\alpha = .77$) was consistent with historical reports.
- *AIDS risk knowledge test:* This scale contained 20 true-false items assessing knowledge and perceptions regarding HIV transmission, higher score indicates greater knowledge (ETR Associates, 2010). This publically available tool has been modified slightly from the original instrument, which was validated with African American adolescents (Kuder-Richardson 20 estimate of internal consistency = .75; ETR Associates, 2010; St. Lawrence, 1993).
- *Condom knowledge:* This scale assessed actual (six true-false items) and perceived condom knowledge (one Likert-type scale item: 1 = *Know nothing about condoms*, 4 = *Know everything about condoms*) using publically available questions validated with a national sample of young adults (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2015). A summary score reflects the number of true-false items answered correctly combined with perceived knowledge; higher score indicates greater knowledge.
- *Condom intention and attitudes:* Intention was assessed with one Likert-type scale item: "How likely is it that you will decide to use a condom if you have sex in the next 3 months?" (1 = *extremely likely*, 5 = *extremely unlikely*; ETR Associates, 2010). We used the Condom Attitude Scale (23 Likert-type scale items, 1 = *strongly agree*, 5 = *strongly disagree*), modified for African American adolescents, to assess perceived risk, interpersonal impact, and safety (Cronbach's $\alpha = .80$; Sacco, Levine, Reed, & Thompson, 1991; St. Lawrence et al., 1994).

- *Condom use:* Condom use was assessed with one yes/no question, “The last time you had vaginal or anal sex; did you or your partner use a condom?” (CDC, 2012).

Adoption.—Following the procedures described in Phase 1, the CABs met a second time. The discussion guides for Session 2 explored satisfaction with revised curriculum, acceptability of health service delivery, and barriers to attendance, for example, “On some days, we had problems getting teens to show up. How can we improve attendance at the sessions?”

Implementation.—To assess implementation fidelity, the educator used a tool available from the publisher of BART to track how faithfully she delivered the adapted materials (“completely,” “with modifications,” or “not at all”; ETR Associates, 2011). The tool also contained questions about the audience (e.g., composition) and teaching components (e.g., confidence in delivering material).

Maintenance.—Individual level changes for Time 3 were assessed using measures described above (i.e., “effectiveness”). We determined BART maintenance via verbal report from CBO staff. Adolescents and staff at CAB meetings provided feedback on program sustainability.

Data Analysis

Demographics and health behaviors were summarized using descriptive statistics. Comparisons of responses between subgroups (i.e., gender, CBO site) were analyzed using chi-square test. To examine individual changes over time and to maximize matched sample sizes for knowledge, attitudes, and self-efficacy, we used separate matched-paired *t* tests to compare scores from Time 1 to Time 2 (“effectiveness”) and Time 1 to Time 3 (“maintenance”). Results are presented as means with standard deviations and *p* values. Data analysis was done with SPSS for Windows Version 20 (SPSS, Chicago, IL, USA).

➤ RESULTS

Phase 1: Session 1: Curriculum Adaptation

Adolescent CAB members (*n* = 16, 56% male, 100% African American) responded positively to the BART curriculum overall and felt it was appropriate for this setting. Specific suggestions included the following:

- BART refers to Kwanzaa as a way to help teens feel connected to their culture. Overall, youth were not familiar with Kwanzaa and did not identify with Kwanzaa principles. Instead, youth identified with their culture through churches, neighborhood recreation centers, and mentoring programs.
- BART suggests a printed wallet card could be used with partners to reinforce a message about condom use (i.e., “If it’s not on, it’s not on”). While some suggested different language (e.g., “No glove, no love”), most felt cards were not feasible or current.

- Adolescents supported inclusion of information about other STIs as well as on-site health service provision.
- To maintain privacy around STI testing, youth endorsed this process: All participants would get an opaque bag containing testing supplies before entering the bathroom, and all would return the bag and supplies regardless of whether they provided urine or not. None expressed concerns about confidentiality of testing results.

Staff CAB members ($n = 5$, 60% male, 100% African American) responded positively to the curriculum and felt it was appropriate for this setting. Some felt BART might be particularly relevant for these youth, as many lacked adequate adult guidance and economic resources. Key topics included the following:

- Most staff had heard of Kwanzaa but could not identify any Kwanzaa principles.
- Staff identified barbershops and schools as places where adolescents might feel connected to their culture.
- A few were concerned that condoms might be used for on-site sexual intercourse or inappropriately (e.g., as “water balloons”).
- Some were concerned about potential parental or community complaints, especially regarding STI testing. They felt it was difficult to communicate with parents about any programming that occurred and recommended notifying parents about BART (and potential STI testing) via announcements posted on-site.
- All supported having condoms available as part of BART programming, but none wanted to be directly involved in condom distribution, due to concerns about the possible perception of “promoting sex.” Staff felt it was acceptable for the educator to distribute condoms and STI tests because it was consistent with her expertise and training.

Based on CAB input, we made curriculum adaptations: deleted Kwanzaa references, updated language and incentives, removed printed wallet cards, expanded curriculum to include common STIs, provided printed materials with local health resources, and shortened the length of each BART session to 1 hour. Also, the educator incorporated references to church, neighborhood recreation centers, and mentoring programs to facilitate participant identification with their culture. We planned to have condoms and STI tests (using urine specimens) at each session, as well as printed resources for local health care including our hospital-affiliated clinic.

Phases 2 And 3: Implementing and Evaluating the Adapted Curriculum

Participants.—Participants were recruited in July 2013 at CBO1 and February 2014 at CBO2. Among 42 adolescents approached, 36 (86%) enrolled. Participants are described in Table 1, mean age was 15.5 ± 1.0 years, 97% were African American. Twenty-two (61%) reported previous vaginal and/or anal intercourse; among these, 47% reported using a condom at last intercourse. One female identified as bisexual; all others were heterosexual.

Reporting previous intercourse was associated with CBO site but not with gender or older age (≥ 16 years).

Influences.—Half (58%) identified their mother as their main adult influence, which did not vary between sites (CBO1 55% vs. CBO2 60%, $p = .09$). Most (58%) reported their main adult influence would *strongly approve/approve* of STI testing for the participant. Most (66%) reported “about half/about all” of their good friends used condoms every time they have sex, which did not vary between sites (CBO1 62% vs. CBO2 70%, $p = .25$). Among those reporting previous intercourse, many reported their partner would *strongly approve/approve* of condom use (52%) and STI testing (55%).

Attrition.—Ten (28%) participants were lost to follow-up and completed only baseline assessments; this did not vary by gender or CBO.

Reach.—Most (67%) attended 50% of sessions ($M = 5.2 \pm 2.1$ years, range 1–8). Compared to CBO1, participants at CBO2 were more likely to attend 50% of sessions (36% vs. 86%, $p < .001$). Gender, age, and reporting previous intercourse compared to not reporting previous intercourse were not associated with increased likelihood of attending 50% of sessions.

Most ($n = 22$, 61%) participated in STI testing; among these, two females tested positive for chlamydia. Two characteristics were associated with increased likelihood of completing STI testing: reporting previous intercourse compared to not reporting previous intercourse (83% vs. 44%, $p = .03$) and participation at CBO1 compared to CBO2 (86% vs. 55%, $p = .05$). Gender, age, perceived approval of STI testing by influential adult or sex partner, and use of a condom at last intercourse were not associated with increased likelihood of STI testing.

Most (70%) participants accepted condoms. Six (17%, 5 of whom were female) were seen at the referral clinic for STI testing ($n = 2$), STI treatment ($n = 2$), testing for pregnancy ($n = 4$), and Depo-Provera injection ($n = 4$).

Effectiveness.—From baseline (Time 1) to immediate postintervention (Time 2), participants demonstrated significant improvements in AIDS risk knowledge and condom knowledge (Table 2). Four reported having intercourse between Time 1 and Time 2; among these, 50% used a condom at last intercourse.

Adoption.—At CAB meetings, adolescents and staff were satisfied with the revised curriculum and found the point-of-care services acceptable. Adolescents reported no privacy concerns, but one felt that providing condoms “promoted sex.” Adolescents were comfortable with BART delivery using one female educator and appreciated that the educator used “their language.” Some females liked having sessions separated by gender because males “are immature.” Staff felt youth handled on-site health services appropriately, and there were no incidents of condom use on-site for sexual activity or other purposes (e.g., as water balloons). Conflicting sports and school obligations were barriers to attendance, and some staff and adolescents felt attendance would be improved if offered during the summer.

Implementation.—Nearly all (91%) planned activities were completed entirely. Some were completed with modifications (4%) or not at all (5%) due to time constraints or disruptive participants.

Sessions were conducted by a single female educator instead of a coed dyad as suggested by the original curriculum. Role-plays were completed as educator-adolescent or educator-CBO staff. To facilitate scheduling around after-school activities, participants were separated by gender for all sessions at CBO1. Nearly all sessions at CBO2 were mixed gender except those focusing on condom skill development, per BART recommendations.

For all programming, the educator reported she was “very comfortable” talking about sexual topics and “very confident” delivering sessions. The educator reported that classroom management issues (e.g., lack of privacy, disruptive participants) “somewhat” detracted from teaching. No classroom issues were reported with the female group at CBO1, and the educator adhered most closely to desired teaching strategies with this group (Table 3). The educator reported an increase in the effectiveness of teaching strategies at CBO1, which may be related to the exclusive use of gender-specific sessions at this site ($p = .59$, Table 3).

Maintenance.—Table 2 demonstrates that positive changes in knowledge were maintained at follow-up (Time 3). Additionally, new changes in condom attitudes and self-efficacy were noted. Among the four participants who reported intercourse during this interval, 50% used a condom at last intercourse. Neither CBO continued BART after study completion, in part due to lack of interest or lack of desired characteristics among CBO staff (i.e., curriculum specifies that leaders should reflect the racial composition of participants). Adolescents identified trusted CBO staff who could deliver BART and health services to sustain the program; staff felt having an outside educator fostered comfort among youth and staff. Both staff and adolescents supported on-site HIV testing with future programming.

➤ DISCUSSION

Adolescents and staff at urban CBOs guided adaptations to this HIV risk reduction curriculum to increase access to health services, expand the curriculum, and increase relevance to Midwestern youth. Using the RE-AIM framework to evaluate the enhanced curriculum, we demonstrated considerable health service uptake among participants, as well as improved self-efficacy for safer sex practices, AIDS risk and condom knowledge, and condom attitudes. Staff and adolescent participants found on-site health services acceptable and were satisfied with the revised curriculum. Despite efforts to encourage program continuation, neither CBO continued the curriculum following study completion.

Adaptations were successful in increasing access to health services and comprehensive care. Both adolescents and staff expressed comfort with receiving/having sensitive services—STI testing and condom distribution—available at their CBO, and a large majority of participants completed on-site STI testing and received condoms—services critical to reducing HIV and other STIs. Although few participants (17%) attended a visit to the referral clinic, those who attended received a range of comprehensive services. Similar to our findings, VanDevanter et

al. (2005) demonstrated that a community-based intervention to increase health care-seeking behaviors among urban youth was more effective among females than males.

Improving key behavioral targets is critical to facilitating behavior change (Pedlow & Carey, 2004; Robin et al., 2004). When compared to other evaluations of BART, our participants demonstrated greater improvements in AIDS risk knowledge (27% vs. 15%) and condom attitudes (23% vs. 3%) and similar improvements in self-efficacy (13% vs. 15%; Butts & Hartman, 2002; Cornelius et al., 2013). While our sample size was small and some evaluation tools varied, it is possible that our adaptations resulted in increased effectiveness. The overall purpose of this work was to demonstrate the adaptation process for an established curriculum; however, additional studies seem warranted to explore these potential effectiveness findings.

Lessons Learned and Future Directions

Due to budget constraints and a paucity of qualified males, we used one female educator for all sessions. Adolescents endorsed this adaptation, which may have important implications when considering attempts to disseminate evidence-based programming with limited resources. For practical reasons (i.e., scheduling), sessions at CBO1 were separated by gender. The educator's perception of increased teaching effectiveness may be related to the gender-specific sessions and warrants further investigation. Notably, participants had greater BART attendance at the CBO where financial incentives were provided at baseline. Because perceptions about financial incentives for research participation among disadvantaged youth have not been well described, exploration may be warranted.

Although we identified staff champions at each site and encouraged appropriate staff (e.g., African American, trusted by youth) to colead, neither CBO continued BART programming immediately following the study. The literature shows CBOs can successfully implement evidence-based programming (Jemmott, Jemmott, Fong, & Morales, 2010), but in the two CBOs in this study, staff participants on the advisory board preferred to have an outside educator provide both the programming and health services. Lack of resources for consultant facilitators or for training of stable CBO staff may be key barriers to program continuation. Rather than hoping for a top-down mode of dissemination, to facilitate future Diffusion of Effective Behavioral Interventions (Dworkin, Pinto, Hunter, Rapkin, & Remien, 2008), exploration of staff perspectives is needed. For example, adult leaders in CBOs may need training in BART program delivery that is not currently easily available.

Unexpectedly, several adolescents at each CBO elected to attend BART sessions but did not want to enroll as a study participant. Because of the fluid nature of CBO attendance, we were not able to offer study enrollment to those who were not present during recruitment. Thus, actual program reach was greater in practice than described in this article.

Limitations

Our findings may not generalize to adolescents with different geographic or socioeconomic backgrounds. Although this study had a small sample size and lacked a control group, the literature demonstrates that similar designs have been used for program development and/or adaptation (Nollen et al., 2013). Efficacy data are limited by the lack of matched control data

and are compared with historical data. Future work with a larger sample that can be stratified by key characteristics is needed to thoroughly test efficacy of the adapted program. Self-reported responses could be influenced by the effects of social desirability or concerns about confidentiality.

Conclusion

Our findings suggest the adapted BART curriculum, designed with adolescent and CBO staff input, holds promise to improve health outcomes for at-risk youth. Studies to assess efficacy and sustainability of the adapted curriculum appear warranted.

Acknowledgments

We are grateful for the support and participation from staff and adolescents at our partner organizations, Boys and Girls Clubs of America (J & D Wagner Unit) and Youth Ambassadors. This work would not be possible without their help. This work was supported in part by (1) The American Academy of Pediatrics (Community Access to Child Health grant) and (2) Frontiers: The Heartland Institute for Clinical and Translational Research (University of Kansas Medical Center's Clinical and Translational Science Award; UL1TR000001). The contents are solely the responsibility of the authors and do not necessarily represent the official views of the funding agencies.

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FIGURE 1. Three-Phase Process for Adapting, Implementing, and Evaluating the BART Curriculum

NOTE: BART = Becoming a Responsible Teen.

Table 1

Participant Characteristics at Enrollment in BART Implementation (Phase 2)

<i>Characteristic</i>	<i>Total (N = 36), n (%)</i>	<i>CBO1 (n = 14), n (%)</i>	<i>CBO2 (n = 22), n (%)</i>
Age in years, <i>M</i> ± <i>SD</i>	15.55 ± 1.03	15.71 ± 1.27	15.42 ± .84
Female	17 (52)	7 (50)	10 (45)
African American	32 ^a (97)	13 (92)	19 ^a (100)
Hispanic	0	0	0
Previous sexual activity			
Ever had oral sex	19 ^a (56)	9 ^a (69)	10 ^a (48)
Ever had anal sex	4 ^a (12)	3 ^a (23)	1 ^a (5)
Ever vaginal sex	18 ^a (53)	9 ^a (69)	9 ^a (43)

NOTE: BART = Becoming a Responsible Teen; CBO = community-based organization.

^aOne or more participants did not provide answer.

Table 2

Test of the Difference Between Participants With Matched Pairs (Mean Score With Standard Deviation; Time 1 = Baseline, Time 2 = Immediately After Final BART Session, and Time 3 = 12–14 weeks After Time 2)

Construct	Time 1 Versus Time 2			Time 1 Versus Time 3				
	n	Time 1	Time 2	p	n	Time 1	Time 3	p
Self-efficacy	27	19.3 (4.1)	20.7 (2.8)	>.05	21	19.5 (2.8)	22.1 (2.7)	.02
AIDS risk knowledge	30	11.6 (3.6)	14.7 (4.0)	<.001	24	11.5 (3.6)	14.8 (4.0)	<.001
Condom knowledge	23	6.2 (1.6)	8.0 (1.7)	<.001	16	6.1 (1.4)	8.3 (1.3)	<.001
Condom intention ^a	28	1.7 (0.9)	1.5 (0.9)	>.05	23	1.6 (1.0)	1.2 (0.5)	>.05
Condom attitudes ^a	18	39.1 (9.7)	35.8 (12.3)	>.05	16	39.6 (9.4)	32.1 (12.0)	.04

NOTE: BART = Becoming a Responsible Teen.

^a A lower score indicates more desired condom attitudes and intention to use condoms.

Table 3Educator Perception on Use of Teaching Strategies (1 = *Not at all* to 5 = *To a great extent*)

<i>To What Extent Were You Able to ...</i>	<i>CBO1</i>		<i>CBO2, Mixed</i>
	<i>Males</i>	<i>Females</i>	
Engage students in participatory activities?	3	5	4
Elicit information and opinions from youth?	5	5	5
Use praise and reinforcement?	5	5	5
Tailor the language to reflect African American culture?	5	5	5
Encourage youth to think about, discuss, and apply what they've learned from outside the classroom?	5	5	5
Reinforce learning with reviews and repetition?	4	5	5
Present the material visually?	4	4	5
Use these four steps to teach skills (1. explain, 2. demonstrate, 3. practice, 4. provide feedback)?	4	5	4
Provide ample time to practice skills?	5	5	4
Help participants personalize information about risk?	5	5	4
Emphasize clearly and repeatedly that abstinence is safest, but if you are sexually active, use condoms or engage in lower risk activities?	4	5	5
Sum (possible range = 11–55)	45	54	49
<i>M ± SD^a</i>	4.45 ± 0.66	4.91 ± 0.29	4.64 ± 0.48

NOTE: CBO = community-based organization.

^aUsing a Wilcoxon signed ranks test, the difference between males and females at CBO1 is statistically insignificant with a two-tailed test, $p = .059$.