Curriculum Adaptations and Facilitator Training

Because this was a replication study, fidelity to the original BPBR curriculum was crucial. However, a few small but important adaptations to the curriculum were deemed necessary. First, because of objections from several urban as well as suburban schools, one 10-minute activity (How to Make Condoms Fun and Pleasurable) in the condom-use skills session was dropped; all other condom-related activities were retained in all schools. Second, the ethnocentric and urban focus of the curriculum was retained across all schools, except that the term “inner-city” was replaced with “community.” Third, both intervention and control groups received a message-specific booster session between four and 12 months after the initial programs. Students in the intervention arm attended an assembly featuring a young HIV-positive woman, while students in the control arm attended an assembly in which a speaker discussed healthy eating and exercise. Otherwise, the control curriculum was designed to match the BPBR curriculum in structure and nature of the activities (i.e., interactive exercises, role-playing, lecture).

The teacher and nurse facilitators for both curricula attended separate two-day training sessions (12 hours in total). The two individuals responsible for training the BPBR facilitators had previously attended a training session offered by the curriculum authors and had three years of experience teaching the curriculum in middle schools. Training was conducted on consecutive Saturdays, and facilitators were reimbursed for their time, as well as travel and parking expenses. They were instructed on how to complete a detailed checklist for each session, including rating their command of the materials, their rapport with the students, the orderliness of the classroom and the extent to which the material for each session was covered, while documenting any deviations from the original curriculum. In addition, each facilitator was observed at least once during the six curriculum sessions to assess his or her comfort level with the material and fidelity to the curriculum. A majority of the 27 facilitators were female (74%) and white (59%) and had a postgraduate education (78%); their average age was 44 (range, 25–62), and they had been teaching within their school systems for more than 15 years, on average (range, 1–30). The facilitators for the intervention and control groups possessed similar characteristics.

Measures

The measures were largely guided by the constructs included in the theoretical framework underlying the BPBR curriculum and tested in the primary evaluation of BPBR.9 This framework posits that the intervention will influence sex-related behaviors both directly and indirectly through cognitive processes that are assumed to mediate behavioral change. Five categories of sex-related cognitive mediators were included in the study: knowledge, efficacy, participants’ beliefs, perceived peer beliefs and behavioral intentions.

Knowledge. Three domains of knowledge were assessed, with questions that had possible responses of true, false and don’t know. Knowledge of condoms was measured by five questions (e.g., “A condom should be completely unrolled before it is placed on the penis”). Knowledge of HIV and other STDs was measured by seven questions (e.g., “There’s a good chance you’ll get AIDS if you share a sink, shower or toilet seat with a person who has AIDS”). Health promotion knowledge was measured by nine questions that focused on nutrition, fitness and stress (e.g., “Restaurants typically serve 2–3 times the normal portion size”). Health knowledge was included as an indicator of the success of the control program (i.e., only the control students would be expected to show improvement). The number of correctly answered items for each domain was summed, resulting in scores of 0–5 for condom knowledge, 0–7 for HIV and other STD knowledge, and 0–9 for health promotion knowledge. The higher the score, the higher the participant’s level of knowledge in each area.

Efficacy. Three types of self-efficacy were measured, using a five-point Likert scale (from strongly disagree to strongly agree). The scores of the items for each construct were summed and averaged. Impulse control was measured using two items (e.g., “How sure are you that you could keep from having sex until you feel ready?”); higher scores indicated students’ greater confidence in