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The development of an innovative, theory-driven, psychoeducational HIV/STI prevention intervention for heterosexually active black adolescents with mental illnesses

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Abstract

Sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), continue to disproportionately affect Black adolescents. Those experiencing the psychological sequelae of mental illnesses are at increased risk. Here, we outline the development of an HIV/STI prevention intervention for heterosexually-active Black adolescents with mental illnesses. This research was guided by a psychosocial expansion of the Theory of Planned Behavior, nested within a broader social determinants of health framework. A youth community advisory board provided study oversight. Heterosexually-active Black adolescents aged 14 to 17 were recruited from communitybased outpatient mental health providers for focus groups, surveys and two "dress rehearsals" of the intervention protocol (N= 68). The qualitative and quantitative findings indicated that knowledge, attitudes and skills related to consistent condom use, reduced number of sexual partners, routine HIV/STI testing, abstinence and emotion regulation were important areas to target. These elicitation data provided insight on the context of HIV/STI risk for the study population, and were used to develop the intervention content. "Project GOLD: We are Kings and Queens" was designed to be delivered over two days (three hours per day), with eight, 45-minute modules. The activities address behaviors, as well as cognitive, emotional, psychological and social processes associated with HIV/STI risk. Alongside evidence-based HIV/STI prevention

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strategies (e.g., sexual partner communication skills), the intervention activities are rooted in principles of Cognitive Behavioral Therapy. Dress rehearsal participants were in favor of the intervention and provided feedback on activity length, gender and cultural relevance, and strategies to sustain attention; this information was used to finalize the curriculum. In partnership with the community, we developed a theoretically-driven, gender and culturally relevant, developmentally and psychologically appropriate HIV/STI prevention program. Our ultimate goal is to standardize sexual health assessment and intervention in outpatient mental health treatment settings to meet sexual health needs in this underserved population.

Keywords

adolescents; Black; emotion regulation; HIV; intervention; sexual health

Introduction

In the United States (U.S.), sexual contact is the primary mode of HIV transmission (Centers for Disease Control and Prevention [CDC], 2016a). Black adolescent males aged 13 to 24 are diagnosed with HIV at a rate 2.5 times that of Hispanics/Latinos and 3.3 times that of Whites (CDC, 2016b). The disparity is even more pronounced among Black adolescent females in the same demographic wherein they are diagnosed at a rate almost 4 times that of Hispanics/Latinos and Whites (CDC, 2016b), thus warranting explicit focus on heterosexual populations. Similar trends are noted in Chlamydia rates (CDC, 2016c).

Despite advances in HIV/STI prevention research in the general adolescent population, adolescents with mental illnesses are a historically underserved group (Brawner, Fannin, Reason & Weissinger, 2016). This demographic is at greater risk for HIV/STIs because they engage in more sexual risk behaviors than their peers (Donenberg, Bryant, Emerson, Wilson, & Pasch, 2003). Currently, only a few HIV/STI prevention interventions exist for Black adolescents with mental illnesses in outpatient mental health treatment programs (Brown et al., 2014; Brown et al., 2013; Brown, Reynolds & Lourie, 1997; Brown et al., 2017; DiClemente et al., 2004; Donenberg et al., 2005; Esposito-Smythers, Hadley, Curby, & Brown, 2017; Ponton, DiClemente, & McKenna, 1991). Two interventions available for adolescents in psychiatric treatment decreased HIV-related myths, increased condom use intentions, and improved self-efficacy (Brown et al., 1997; Ponton, et al., 1991). Two family-based HIV prevention programs decreased involvement in unprotected sex, increased condom use, and increased the likelihood of avoiding sex (Brown et al., 2014; Esposito-Smythers, et al., 2017).

Among adults with mental illness, HIV prevention interventions had some effect on increasing condom use rates at 1-, 6- and 9-month follow-ups; however, the effects diminished at 12-months (Kalichman, 1995; Otto-Salaj, Kelly, Stevenson, Hoffmann, & Kalichman, 2001). Another intervention that used the Information-Motivation-Behavioral Skills Model reduced the frequency of unprotected sexual encounters, but had no effect on the rate of sexual activity or number of partners (Carey, 2004). Psychoeducational strategies (e.g., skills building) effectively convey HIV/STI information and support individuals'

mental health needs (Carmen and Brady, 1990; Pomeroy, Kiam, & Green, 2000). Investigators have demonstrated success with interventions that target unique emotional and cognitive factors among youth with maladaptive behaviors. These programs improved affect management and cognitive monitoring within the context of sexual situations, as well as HIV-related knowledge and attitudes (Brown et al., 2011; Brown et al., 2017).

Our aim was to develop an innovative, theory-driven, psychoeducational HIV/STI prevention intervention for heterosexually-active Black adolescents with mental illnesses. Here, we outline the intervention development process through: 1) focus groups and surveys to examine the context of sexual risk behaviors, 2) translation of these findings into intervention activities, and 3) overview of the final curriculum content. The resultant intervention merges effective strategies from psychology and behavioral science (e.g., positive coping skills, roleplaying), which we anticipate will reduce HIV/STI risk.

Materials and Methods

Theoretical framework

We used a psychosocial expansion of the Theory of Planned Behavior (Azjen, 1991), nested within a broader social determinants of health framework (see Figure 1). The theory suggests that sexual risk behaviors are predicted by one's intentions to perform behaviors. Moreover, one's intention to perform a behavior is presumed to be mediated by his/her behavioral beliefs (e.g., attitudes toward condom use), normative beliefs (e.g., subjective norms about condom use) and control beliefs (e.g., perceived behavioral control over condom use) about the behavior.

This was embedded in a social determinants of health framework to include factors such as poverty and gender socialization. The comprehensive approach allowed us to target non-traditional, multi-level factors to reduce risk behaviors.

The psychoeducational components were based on tenets of cognitive behavioral therapy (CBT). CBT, an evidence-based psychotherapy, is designed to help individuals solve current problems and modify dysfunctional thinking and behavior (A. T. Beck, 1976). The ultimate aim is to modify a person's beliefs about themselves, their world and others, which in turn brings about emotional and behavioral change (J. S. Beck, 2011). If one believes that he/she does not deserve love, and views sexual activity as a means to earn love, he/she may engage in sexual risk behaviors to meet emotional needs (Brawner, Gomes, Jemmott, Deatrick, & Coleman, 2012). Thus, modification of this belief system and development of emotion regulation skills could be therapeutic goals to reduce sexual risk behaviors. Homework assignments are given to allow time outside of sessions to reinforce the content and counteract symptoms. Others have successfully used similar approaches in HIV prevention programs (Melendez-Torres and Bonell, 2014), including for youth with difficulties with emotions and cognitions (Brown et al., 2017).

Procedures

Institutional Review Boards at the University of Pennsylvania and the Philadelphia Department of Public Health provided study approval. Black adolescents were recruited

Brawner et al.

from community-based mental health providers in the Philadelphia area (N= 68). Those aged 14 to 17 who self-identified as Black, had ever had vaginal sex, were receiving outpatient mental health treatment for at least one month, and were able to read and write in the English language were enrolled. Participants were excluded for: 1) cognitive deficits that would impair their ability to complete study procedures (assessed by trained research staff), 2) active suicidality (assessed with the Columbia-Suicide Severity Rating Scale (Posner et al., 2008)), or 3) if they currently needed psychiatric hospitalization. Eligible adolescents provided signed informed consent for participation. Parental permission was not required; in Pennsylvania youth aged 14 and older can consent to both HIV/STI testing and mental health treatment (Brawner & Sutton, 2018; Juvenille Law Center, 2006).

In year one, we engaged key stakeholders and trained the staff. We also established a youth community advisory board (CAB)—comprised of eight youth from the target demographic —who aided in study design, implementation and evaluation. Seven mixed-gender focus groups (n = 33) were conducted to elicit participants' attitudes and beliefs about the targeted behaviors, as well as on the feasibility and acceptability of the planned HIV/STI prevention intervention. Immediately prior to the start of the group, participants completed a 15-minute, self-administered computer-assisted personal interview (CAPI) on sociodemographics, mental health treatment details (e.g., diagnosis, length of time seeing provider), sexual behaviors, theoretical mediators of sexual risk behaviors (e.g., condom use prevention beliefs), emotion regulation, HIV knowledge and ideas for HIV/STI prevention programs. This was done to elicit their individual beliefs prior to any potential influences from the group discussion. Table 1 highlights sample questions from the survey on theoretical mediators of sexual risk behaviors.

These data were used to incorporate participants' voices into the intervention activities via direct quotes, and to refine and test the CAPI so that it could be used as the baseline assessment for the planned pilot randomized controlled trial (RCT). With findings from the focus groups, the CAPI was modified to include items on substance use, as well as validated scales on ethnic identity and gender role norms. The CAPI was given to an independent sample of adolescents (n = 20) to identify theoretical mediators of: a) consistent condom use, b) reduced number of sexual partners, c) routine HIV/STI testing, and d) abstinence. Participants received \$30 cash for the focus groups and \$20 cash for the CAPI.

In year two, we developed the intervention curriculum. The research team met weekly, engaging in an iterative process with the YCAB to review the data, investigators' interpretations and modifications to the curriculum content. In two "dress rehearsals" of the intervention protocol (n = 15; 8 and 7), trained facilitators delivered the intervention as planned (e.g., baseline CAPI, curriculum modules), with feedback elicited from participants and facilitators after each session. The intent was to evaluate whether the intervention was likely to affect the conceptual variables, if the participants viewed the content as valuable and engaging, and to ensure the study protocols were relevant to achieve the aims. Dress rehearsal participants received \$50 cash for completing the 2-day intervention; partial compensation was not provided.

Data analysis

The focus group analysis procedures are published elsewhere (Brawner, Jemmott, Reason, Wingood & Mack, 2018). Content analysis (Graneheim and Lundman, 2004) was conducted in NVivo 10 to elucidate the context of sexual risk behaviors in the target demographic. Quantitative data were analyzed through descriptive, correlational and linear regression analyses in SPSS 22. Given shared variables between the two surveys, datasets from the focus group survey (n = 33) and CAPI pilot (n = 20) were merged for a final sample of 53 for the regression analyses. These data helped determine the prevalence of different attitudes and beliefs, as well as the relationships among the theoretical mediators. This information was critical to determine salient factors to target in the intervention, as well as allocations for content and time. The CAPI survey data from dress rehearsal participants (n = 15) was also merged to create a master database to describe characteristics across participants in this elicitation phase of the study (N = 68).

Results

Sample demographics are provided in Table 2. Given time constraints, participants self-reported diagnoses from their mental health providers versus undergoing structured clinical interviews. Attention Deficit Hyperactivity Disorder was the most commonly reported diagnosis (27.9%), followed by Depression (16.2%) and Posttraumatic Stress Disorder (10.3%). Participants were mostly males (57.4%), 13.4 years old at first vaginal sex and reported an average of 8 lifetime vaginal sexual partners. The majority reported using condoms when they had sex in the past 3 months. Nearly 1 in 10 had ever tested positive for an STI.

The Context of Sexual Risk Behaviors

In the focus group data (N = 33), Blackness as a source of resilience and pride and unspoken expectations in sexual relationships emerged as themes (Brawner et al., 2018). Sex was viewed as a means to fit into societal norms and a natural step in the progression of relationships. Negative attitudes centered on the difficulty of monogamy and abstaining from sex after sexual debut, using sex as a stress reliever, and using illicit drugs and alcohol to cope with emotions. Some participants believed that youth were invincible to HIV/STIs. They lacked knowledge about proper condom use and reported a decline in condom use as trust developed. The focus group participants and YCAB were in favor of a group-level intervention; they noted that future versions might consider a personalized approach for youth who prefer one-on-one engagement. In the survey data (N = 53; focus group and CAPI pilot participants), Pearson's correlation showed significant associations between participants' condom use attitudes and perceived behavioral control to use condoms and their intention to use condoms in the next 3 months (r = .677, p < .01; r = .650, p < .01respectively). General condom use norms (e.g., friends) were not significantly associated with condom use intentions. However, sexual partner specific norms were significantly associated with intentions to use condoms in the next 3 months (r = .648, p < .01), condom use attitudes (r = .590, p < .01) and perceived behavioral control to use condoms (r = .769, p <.01). Participants also described both positive (e.g., writing) and negative (e.g., unwanted sex) coping strategies. Linear regression models demonstrated that anger coping was

associated with number of vaginal and oral sexual partners (p < .05; R^2 = .152 and .156 respectively).

Data Translation

The overall objectives of the intervention were to foster gender and cultural pride, and bolster positive attitudes while reducing risks of HIV/STIs. We designed the curriculum to build skills to negotiate consistent condom use, limit the number of sexual partners, encourage HIV testing and promote abstinence as an alternative to unwanted sexual activity. Seven goals were identified: (a) increase knowledge and awareness of perceived vulnerability to HIV/STIs and mental health outcomes; (b) encourage cultural pride and instill positive attitudes toward a safer sexual health future; (c) build self-efficacy to increase condom use and limit sexual partnerships; (d) de-stigmatize mental illness and HIV and teach strategies to aid in making healthier decisions; (e) demonstrate sexual behavior refusal skills and condom negotiation strategies; (f) increase skills and strategies to prevent HIV/STIs; and (g) encourage communication between sexual partners. Given the elicitation findings, the intervention also uses CBT strategies to target emotion regulation and coping with the psychopathology of mental illness as HIV/STI risk reduction strategies.

Alternatives to sex, emotion regulation strategies to deal with stress (e.g., identifying emotions, breathing), and interactive games to aid in understanding vulnerability to unwanted sexual health outcomes were key emphases. Relevant subjective norms included support or approval from sexual partners. Hence, we developed activities around partner communication to help participants negotiate safer sexual practices—particularly in the face of distorted cognitions and elevated psychological symptoms. Perceived behavioral control was also highlighted to help youth build self-efficacy to reduce their risk for HIV/STIs. For cultural relevance, we used direct quotes from elicitation participants that emphasized gender and cultural pride. Table 3 highlights translation of the study findings into intervention activities.

The Curriculum

The curriculum was developed for mixed-gender groups of eight participants. The content takes a psychoeducational approach to: a) regulate emotions such as anger and sadness; b) address attitudes and beliefs towards consistent condom use, multiple sexual partners, HIV/STI testing, and abstinence; c) provide knowledge and skills-based activities to teach proper condom use and negotiation techniques; and d) equip youth with strategies to prevent HIV/STI infection and aid them in their sexual decision-making processes (Table 4).

The curriculum title "Project GOLD: We are Kings and Queens" (Project GOLD) emerged from the investigators' interpretations of the focus group data, and was deemed appropriate by the YCAB. The message is threaded throughout the curriculum with the project's tagline: "We are kings and queens and make confident and royal decisions". In the development process, consideration was given to ease of adoption in outpatient settings. Thus, we designed the curriculum to be delivered over two days (three hours per day) via eight, 45-minute modules. On day one, in a mixed-gender group, participants are oriented to the curriculum and receive content to build gender and cultural pride, increase emotion

Brawner et al.

awareness and management skills, and increase HIV/STI knowledge. A homework assignment is given at the end of the day, the "Emotional Writing Worksheet," where participants write a short poem or letter about a real problem that teens their age face. They are asked to acknowledge how the situation might make them feel, and then in day two, the group shares the worksheets to offer advice for teens coping with the problems identified. During day two, participants are split into gender-specific groups for the first half of the day for a condom demonstration and to roleplay condom negotiation and refusal skills for unwanted sexual activity; afterwards, they return to the larger mixed-gender group to practice what they learned. With recommendations from the YCAB and our community partners, we included both mixed-gender and gender-specific content to provide opportunities for skills development with adolescents of the opposite gender, while also preserving "safe space" to process more sensitive issues in a smaller, same-gender context.

Project GOLD includes a series of interactive activities, such as: "Being My Own Thermometer" where participants label their emotions and come up with strategies for deescalation; a decision tree ("Steve's Story" [boys], "Mya's Story" [girls]) to help youth cognize decision-making processes affected by emotion regulation deficits; sexual partner network node posters to emphasize risks associated with concurrent partnerships; practice implementing strategies (e.g., meditation) to regulate emotions and challenge distorted cognitions; and roleplay activities to practice communication strategies, including alternatives to sexual activity in heightened emotional states. A resource guide and pocketsized brochure detailing health-related services was distributed, and participants concluded with a "Rights of Passage" ceremony to celebrate completion.

The first dress rehearsal (n = 8; 4 males and 4 females) provided insight on the activities' time and content, and knowledge and skills gained. Revisions were made accordingly and an independent sample (n = 7; 3 males and 4 females) participated in a final dress rehearsal. The overall content of the intervention was not changed as participants and facilitators unanimously reported that the goals of the study were addressed, and were in favor of delivering the program to the target demographic. Changes based on participant feedback included condensing activities, semantic changes to improve gender and cultural relevance, increasing participants' interactions with each other and re-ordering some of the activities to promote sustained attention. This information was key to finalize the protocol and materials for the pilot RCT.

Evaluation

We completed a pilot RCT to test the interventions' efficacy (N= 108; HIV n = 52; General Health n = 56; Brawner, Jemmott, Wingood, Lozano & Hanlon, in press). The evaluation included pretest, immediate posttest, and 3-, 6-, and 12-month follow-up assessments. We measured change from baseline in the proportion of condom use for vaginal sex and number of sexual partners. Preliminary analyses indicate that compared to the general health group, those in the HIV group had an average increase of 0.170 (SE = 0.13) in their proportion of condom use for vaginal sex from baseline to 3 months (p = 0.2013), with a moderate effect size of 0.40. Those in the HIV group also had an average decrease of 0.446 (SE = 0.59) in

their number of sexual partners from baseline to 6 months (p = 0.4476), with a small effect size of 0.28.

Discussion

This paper contributes to the literature by describing processes involved in the development of a novel psychoeducational HIV/STI prevention intervention. Participants were involved in three key elicitation research phases (focus groups, surveys and dress rehearsals of the intervention protocol), which helped prepare the materials for the subsequent RCT. The findings across the phases reveal behaviors that increase risk for HIV/STIs among Black adolescents with mental illnesses, theoretical mediators of these behaviors and strategies created to targeted content to help reduce HIV/STI risk. The engagement of a youth CAB throughout the research process helped ensure that the intervention and study protocol were culturally situated.

In our sample, the mean age at first vaginal intercourse (13.4 years) was comparable to other studies. However, they had an average of 8 lifetime vaginal sexual partners, and nearly 10% had ever tested positive for an STI—which is higher than other reports for this demographic (Valois et al., 2015; Vasilenko, Kugler, Butera, & Lanza, 2015). Thus our findings confirm that symptoms associated with different mental illnesses (e.g., loneliness) contribute to sexual risk behaviors (Brown et al., 2013). Further, we noted that sexual partners exhibited a greater influence than other referent groups, highlighting the need for additional mixed-gender research on relationship dynamics among adolescents (Lanier, Stewart, Schensul, & Guthrie, 2018; Towner, Dolcini, & Harper, 2015). Given reported difficulties to change behavior after sexual debut, more work is needed to understand sexual debut to promote earlier adoption of safer sexual practices (Lanier et al., 2017). Despite the documented risk behaviors, reported condom use was high, which can be used to encourage continued consistent condom use in addition to other strategies, such as routine HIV/STI testing.

Project GOLD's modular format promotes adaptability and ease of implementation. Lay community members can serve as facilitators as the detailed, structured format requires minimal training. The two-day timeframe might be a barrier to implementation, however, there is flexibility to spread the content over multiple sessions. For example, the structure can be adapted to offer an 8-week, one session per week program. Several of our community partners run weekly group sessions with their clients and favored a program that could be delivered over multiple weeks.

There are several limitations. The elicitation sample was small, which limits generalizability of the findings. The intervention targets heterosexually-active Black adolescents only and does not address the needs of youth in same-sex partnerships. Participants received up to \$200 after study completion; community settings cannot always incentivize participation. Recommendations on Project GOLD implementation should await further testing in a larger sample. If the intervention proves to be effective, the psychoeducational program can be adapted for other populations disproportionately affected by mental health concerns (e.g., transgender youth).

In partnership with the community, we designed a curriculum that was feasible, acceptable and relevant for the target demographic. In addition to knowledge and awareness regarding HIV/STI transmission, the intervention provides skills such as emotion regulation, proper condom use, and refusing unwanted sexual behaviors. We believe that the inclusion of developmentally and psychologically appropriate content will enhance the intervention's effect on preventing HIV/STIs. Few programs have been developed for adolescents with mental illnesses. Contextual nuances among those coping with mental illnesses should be attended to in HIV/STI prevention interventions, and psychoeducational strategies can be used to do this. Our program is an innovatively targeted intervention that incorporates the language of our community and addresses their cognitions, emotions, knowledge, beliefs, and perceived vulnerability to HIV/STIs in a relevant and appropriate way.

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Theoretical framework used to guide elicitation research and intervention development.

Table 1.

Sample elicitation questions.

Targeted construct	Response options
Knowledge	5-point Likert-type; strongly agree to strongly disagree
Condoms help prevent STDs	
Condoms help prevent pregnancy	
Condoms help prevent AIDS.	
Attitudes	5-point Likert-type; strongly agree to strongly disagree
If I used a condom, sex would not feel as good	
Condoms are embarrassing to use.	
Sex feels unnatural when a condom is used	
Subjective Norms	5-point Likert-type; strongly approve to strongly disapprove
Would most people who are important to you approve or disapprove of you using a condom if you have sex in the next 3 months?	
Would your sexual partner approve or disapprove of you using a condom if the two of you have sex in the next 3 months?	
Would your mother, or female guardian, approve or disapprove of you using a condom if you have sex in the next 3 months?	
Perceived Behavioral Control	5-point Likert-type; strongly agree to strongly disagree
It is easy for me to have a condom with me all of the time.	
I can't talk to my partner about using condoms	
Before we are ready to have sex, I can talk to my partner about using a condom.	
Intentions	5-point Likert-type; very likely to very unlikely
How likely is it that you will decide to use a condom if you have sex in the next 3 months?	
How likely is it that you will decide to have sex in the next 3 months?	

How do you feel about using a condom if you have sex in the next 3 months?

Table 2.

Demographic characteristics of elicitation participants (N = 68).

Characteristic	<i>M</i> (SD)
Age (years)	<i>16.3</i> (.891)
Age at 1 st vaginal sex (years; $n = 63$)	13.4 (1.84)
Number of vaginal sexual partners ($n = 57$)	<i>7.9</i> (8.84)
Number of anal sexual partners $(n = 8)$	5.5 (5.95)
Number of oral sexual partners $(n = 45)^{d}$	5.1 (6.1)
	N (%)
Gender	
Male	39 (57.4%)
Female	29 (42.6%)
Current Residence	
In a house that my parent/guardian owns	28 (41.2%)
In a house that my parent/guardian rents	23 (33.8%)
In an apartment that my parent/guardian rents	5 (7.4%)
With my parent/guardian in someone else's house or apartment	1 (1.5%)
In a shelter	1 (2.5%)
Other	10 (14.7%)
Current Mental Health Diagnosis	
Depression	11 (16.2%)
Anxiety	4 (5.9%)
Posttraumatic Stress Disorder	7 (10.3%)
Eating Disorder	1 (1.5%)
Attention Deficit Hyperactivity Disorder	19 (27.9%)
Conduct Disorder	1 (1.5%)
Other	6 (8.8%)
Frequency of Condom Use in the Past 3 Months $(n = 66)$	
Never	9 (13.6%)
Sometimes	22 (33.3%)
Every time	30 (45.5%)
Ever tested for an STI $(n = 67)$	
Yes	52 (77.6%)
Ever tested positive for an STI $(n = 52)$	
Yes	5 (9.6%)
Ever tested for HIV $(n = 66)$	
Yes	35 (53%)
Ever tested positive for HIV $(n = 34)$	
No	34 (100%)

Note:

^aOne participant reported 200 oral sexual partners and was excluded from the analyses as an outlier

Table 3.

Process of applying theory to the translation of data findings into intervention activities.

Finding	Theoretical Construct	Goal	Skill Needed	Objectives	Activity Examples
Participants believed that condoms interfered with sexual pleasure	Beliefs (Attitudes toward condom use)	Increase positive attitudes and knowledge of benefits of condom use	Increased knowledge and risk-benefit assessment	 Address the benefits of condom use and the negative health consequences of unprotected sex Discuss the barriers for condom use Identify strategies to make condom use fun and pleasurable 	Activity: Condom Demonstration "Wait until the penis is erect to put the condom on. To make using condoms more fun, you can include foreplay or other fun sexual acts (e.g., dancing) while putting it on. Lube helps to prevent friction and tearing of condoms, and also gives both partners better sensations. Using a lube does NOT mean that there is anything wrong with the male or female partner. Lube is good!"
Participants believed that multiple sexual partners is socially acceptable and encouraged; however, since virginity is valued in girls, sometimes girls lie about their sexual history to make themselves more appealing to boys.	Subjective norms (referent other reaction belief)	Increase skills and comfort in talking to others about benefits of one sexual partner and risks of multiple sexual partners.	Negotiation and communication	 Strengthen positive attitudes toward healthy lifestyles Encourage participants to challenge their negative assumptions Provide participants with rationales about the benefits of one sexual partner Demonstrates for participants the consequences of having sex with more than one person 	Activity: Staying Safe in My Community: Surviving in My Community and Maintaining Sexual Health Statement: It is okay for a boy to be like the celebrities and have a higher body count than girls (Agree or Disagree) Response: Whether you are a male or female, multiple sexual partners increase your risk for getting HIV/ STIs. This is why we must limit our number of sexual partners and use condoms every time.
Participants will use condoms if it is available during sexual activity	Control belief (perceived behavior control over decision making and condom use)	Develop skills in communication and negotiation to increase self- efficacy in condoms use	Negotiation and communication; increased self- efficacy	 Discuss the importance of sexual partner communication Discuss similarities and differences in the way we select sexual partners Demonstrate sexual behavior and condom negotiation strategies 	Activity: "What to say if my partner says" Turning Negative excuses into Positive Outcomes Reasons Sexual Partners Give: <i>Reason</i> : I don't have any condoms. Just let me put the head in for a minute. I got you, you won't get pregnant. <i>Feeling</i> : Confused, nervous, safe (because he said "I got you") <i>Response</i> : I can get pregnant from pre-cum, and besides, when you're about to cum, you won't be thinking about pulling out. Plus, we would still be at risk for HIV or another STI. We have to use condoms or we're not doing it.
Participants intended to use condoms over the next 3 months	Intention	Develop acceptable and achievable life goals and develop a plan for the future	Planning for the future	Express a sense of social responsibility Take steps to maintain sexual health Express a sense of commitment to a healthy future	Activity: Healthy Living Pledge Participants received a handout which features a general template for the "healthy living pledge." Each participant will add a personal health goal that they want to work towards after completing this program. These pledges will be collected and handed back to the participants at their 3-month follow-up visit. To conclude, participants will share something they have learned throughout the day.

Table 4.

Project GOLD: We Are Kings and Queens Curriculum.

We Are Kings and Queens	Time (minutes)
Day One	
Module 1: Introduction to "Project GOLD": We are Kings and Queens" Orientation and Building Pride	45
A. Welcome & Program Overview	5
B. Creating Group Rules and Guidelines	5
C. We are Kings and Queens	15
D. Are You Vulnerable? High risk-Low risk	10
E. Timeline Activity	10
Module 2: Staying Safe in My Community	45
A. Taking Pride in Who I Am	5
B. Surviving in My Community and Maintaining Sexual Health: Preventing HIV and STIs	15
C. Queen Sheena and King Shawn Radio Caller Show	25
Module 3: Mental Health and Wellness	45
A. Relationships and Connectedness: Fact or Crap	10
B. Faces Activity	10
C. Impact of Mental Health on Sexual Decision Making: Steve's Story	15
D. Emotion Charade Game	10
Module 4: HIV and STIs	40
A. Intro to HIV/STIs	10
B. STD Handshake	15
C. HIV Prevention Bingo	15

Day Two

Module 5: Preserving the Health of Future Generations (Gender specific content)	45
A. Project Gold Welcome Back and Review	10
B. Loving Myself and Protecting My Palace (Girls); Respecting Myself and Guarding My Kingdom (Boys)	5
C. S.M.A.R.T Technique	15
D. Sexual Networks: The Tangled Web	15
Module 6: Partner Selection & Communication (Gender specific content)	40
A. Partner Selection	5
B. "What to say if my partner says"	15
C. Condom Negotiation Activity	20
Module 7: Stopping the Spread	45
A. Real life situations—Sexual Negotiation	25
B. Condom Demonstration practice	20
Module 8: "United we stand, divided we fall"	45
A. HIV/STI Jeopardy- Battle of the Sexes	20
B. Timeline Activity	5
C. Healthy Living Pledge and Closing	20
Rites of Passage Ceremony	