Public Health Promotion Program Plan for STD/HIV Education

Final Term Paper

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Introduction

The increasing incident rates of sexually transmitted diseases (STDs) and the human immunodeficiency virus (HIV) especially in minority populations have become both large public health and economic problems in the United States. According to the Centers for Disease Control and Prevention (CDC), STDs and HIV are hidden epidemics due to the reluctance of many Americans to openly address issues related to sexual health due to the biologic and social characteristics of the diseases (2014). This reluctance to openly speak about sexual practices has led to health disparities across our nation in terms of sexual health. However, these health barriers can be removed by providing at risk individuals and communities with information on sexual health and health services to empower all people to make smarter and healthier sexual health choices.

The increase in STD and HIV prevalence has become an economic burden for American taxpayers. According to Chesson, Blandford, Gift, Tao, & Irwin, in 2000, over nine million new STD cases were identified in American youth aged 15-24. The estimated medical costs for treatment of the STDs was $6.5 billion. Approximately 90 percent of these costs ($5.9 billion) were the direct result of HIV and HPV treatment (2004). Furthermore, reduction of STDs and HIV prevalence will reduce the economic burden on taxpayers and the healthcare system. From 1990 to 2003, reductions in syphilis and gonorrhea led to approximately $5 billion in savings (Chesson, Gift, & Pulver, 2006). Therefore, reducing racial disparities for sexual health will lead to a healthier nation and greatly reduce the economic burden placed on the healthcare system and taxpayers.

Needs Assessment
The prevalence of STDs (chlamydia, gonorrhea, and syphilis) and HIV in the United States poses a large public health problem. In addition to high rates of STDs and HIV, several health disparities were found as a result of geographic location, age, sex, and ethnicity/race. These sexual health disparities exist due to differences in socioeconomic status and education levels, unequal access to quality medical care, sexual network structure, and cultural differences that affect individual health behaviors and sexual partner dynamics (Mocello, Samuel, & Smith, 2008). In addition, areas with high rates of poverty and unemployment, income inequality, and geographic isolation are at higher risks for becoming infected with STDs/HIV (CDC, 2014). Thus, a health promotion program that encourages youth and young adults to practice safer sex in these areas will greatly help in reducing STD prevalence rates.

From a population-based perspective, the sexual health needs of low-income and other high risk areas of the South must become a public health priority in order to overcome the STD/HIV epidemic. Adimora & Schoenbach explain that black people are more likely to become infected with STDs/HIV due to sexual networks. A sexual network is the group of people that can be directly or indirectly linked together through sexual contact. Social norms within the black community indicate that black people are more likely to have sexual contact with other black persons (2005). Therefore, the sexual networks in black communities are likely to spread STDs/HIV quickly and infect more individuals indicating a need for STD/HIV education in low-income areas of the South with high ethnic diversity.

Many resources are available to address the public health problems associated with STDs and HIV. For example, the National Chlamydia Coalition provides materials to use in teaching healthcare providers, sources of public education materials for patients, and clinical practice tools about STD prevention and safe sex practices (2012). In addition, the American Sexual
Health Association provides educational information for health education specialists, parents, and teachers (2014). These national organizations in conjunction with previous research in the field of STD/HIV prevention will provide the resources necessary in order to meet the promotion objectives.

Chlamydia incident rates for 2012 were over 450 cases per 100,000 population for the entire nation. The southern portion of the U.S. had the highest incident rates of chlamydia with 496.9 case per 100,000 persons. The age adjusted incident rate was highest for persons aged 15-24 with over 2000 cases per 100,000 population. Black men and women were found to be nearly seven times more likely to become infected with chlamydia than their white counterparts with incident rates of 1,229.4 and 179.6 cases per 100,000 population, respectively (CDC, 2014).

The prevalence of gonorrhea for the whole U.S. was 107.5 cases per 100,000 whereas the South had the highest rate with 131.9 cases. Furthermore, the highest rates of gonorrhea were observed among women aged 20–24 years (578.5) and 15–19 years (521.2). Similar to chlamydia, gonorrhea rates were significantly higher in African American populations. Gonorrhea prevalence was found to be nearly 15 times higher in blacks than whites with rates of 462.0 and 31.0 cases per 100,000 person respectively (CDC, 2014)

Over 15,600 cases of primary and secondary syphilis were reported in 2012 giving rise to an incident rate of 5.0 cases per 100,000 population. In addition, over 43 percent of P&S syphilis cases were from the southern portion of the U.S. Men aged 20-29 had the highest incident rate of any other age groups with 25.3 cases per 100,000. Syphilis rates continue to remain highest in the black population, and over 6 times higher than the white population (CDC, 2014).

According to the CDC over 1.1 million people in the U.S. have been infected with HIV, and nearly 16 percent of these people are unaware of their infection (2014). In 2011, the South
reported nearly half (48%) of HIV diagnoses (The Henry J. Kaiser Family Foundation, 2014). Young adults aged 25-34 years accounted for an estimated 31 percent of new HIV cases 2010, the highest among any age group. In addition, the black population infection rate is nearly eight times higher than the population with incident rates of 68.9 and 8.7 cases per 100,000 population (CDC, 2014). Therefore, the STD/HIV incident rates are significantly higher in the young adult black population residing in the southern portion of the United States than the white population.

**Program Strategic Plan**

**Mission, Vision and Values**

The current mission for the Safe, Responsible Sexual Education Initiative is to provide young Americans with open and honest, age appropriate sexual health education. The Safe, Responsible Sexual Education Initiative aims to help young people take responsibility over their sexual health in order to protect their health and overall well-being. The vision of the program is a nation free of STDs/HIV that emphasizes the importance of protecting all individuals’ sexual health. The community populations will benefit now and in the future from the STD/HIV comprehensive sex education program. Providing youth and young adults in the community with free comprehensive sex education will decrease the prevalence of STDs/HIV in the target community. In addition, youth enrolled in the program will learn skills and behaviors to protect their sexual health now and into the future.

The Safe, Responsible Sexual Education Initiative has the similar core values and philosophy of Advocates for Youth. All American youth have the right to complete, comprehensive sexual health education and reproductive and sexual health services. Our youth deserve respect; therefore, our program aims to involve the priority population in design, planning, implementation, and evaluation of health promotion programs that affect and benefit
their health. It is the responsibility of all Americans to provide youth with the skills, behaviors, and education to protect their sexual health. In addition, young people have a responsibility to themselves to protect against unwanted pregnancies and STDs/HIV (Advocates for Youth, 2008). On the whole, the Safe, Responsible Sexual Education Initiative aims to provide comprehensive sexual education to youth and young adults in order to decrease STD/HIV incident rates.

**SWOT Analysis**

One strength of comprehensive sexual education is the support from various organizations and health professionals. For example, the partnership with Advocates for Youth will provide adolescents and young adults with education solely focused on their sexual and reproductive health (2008). Moreover, the mission and vision for the program is one of the program’s biggest strengths. The Smart, Responsible Sexual Education Initiative aims to decrease the prevalence of STDs/HIV in the target population by providing age appropriate sexual health education to adolescents and young adults over a five year period.

Like all public health promotion programs the Smart, Responsible Sexual Education Initiative has its weaknesses. One weakness is going against the cultural norm of abstinence only sexual health education. This concept may decrease the number of participants in the program due to their religious beliefs or the willingness of parents to allow their children (under 18) to participate in the afterschool program. In addition, the public’s unwillingness to speak openly about sexual education continues to weaken the program. The newness of the concept of comprehensive sexual education in the South may prevent public officials including medical personnel and government officials from openly supporting the program.
Many opportunities exist for implementing comprehensive sexual health programs in the southern portion of the U.S. The South has the highest prevalence of chlamydia, gonorrhea, syphilis, and HIV than any other region in the nation (CDC, 2014). Due to this health disparity, planning and implementing a comprehensive sexual education program that aims to improve sexual health and decrease STDs/HIV will provide a positive impact on the at risk populations. The Smart, Responsible Sexual Education Initiative will have the opportunity to improve the overall well-being and health of the target population. Financial support from stakeholders will continue to create opportunities for the program’s mission and vision to be achieved within the target population.

Threats to planning and program success include lack of support by community and government officials. The South can be considered a prominently Conservative area with strong backgrounds in religion. Therefore, providing age appropriate comprehensive sex education instead of an abstinence only approach may hinder program support. In addition, the target population includes a high percentage of African Americans. Due to past events such as the Tuskegee Syphilis Study, many members of the Black community may fear public health intervention that focuses on reducing the prevalence of STDs/HIV infections in the target population (Heintzelman, 2003). Furthermore, government officials will be less likely to support comprehensive sexual education programs due to the values and beliefs of their constituents.

**Program Objectives**

**Process objectives.** Program planners will increase the number of comprehensive sexual education classes offered in the region to adolescents and young adults by at least 10 percent in 3
years. In addition, by the end of 2014, the mobile application will deliver STD/HIV information to at least 30 percent of youth/young adults in the region.

**Impact objectives.** Several impact objective will be measured to determine the effectiveness of the Safe, Responsible Sexual Education Initiative. After receiving STD/HIV messages through the mobile application, at least 30 percent of youth and young adults will be able to identify at least two high risk behaviors for developing STDs or HIV. Upon completion of sexual health course, 60 percent of participants will be able to perform the 10 steps to correct condom use. In addition, after completion of the sexual health course, at least half of the participants will defend their reasons for condom use during sexual activity. When tested over course materials at conclusion of study, over 40 percent of the participants will be able to explain the signs and symptoms of chlamydia, gonorrhea, and syphilis. Similarly, one year after completion of sexual health education course, at least half of participants will use a condom during every sexual encounter. At the end of the sexual education course, at least half of the participants will have improved confidence about condom negotiation skills.

**Outcome objectives.** Program planners aim to reduce the incident rates of STDs including HIV in youth and young adults residing in low-income areas of the southern portion of the United States by at least 25 percent in 5 years. In addition, the program seeks a reduction in the number of youth and young adults engaging in high risk sexual behaviors (drug use, alcohol use, multiple partners, and lack of condom use) by at least 25 percent in 5 years.
## Logic Model

### Inputs
- Personnel
- Funding
- Educational materials
- Space
- Participant recruitment strategy and materials
- Program training materials
- Stakeholder support

### Outputs

#### Activities
- Recruit participants
- Gain community and parental support of program
- Partnerships established among key stakeholders
- Educate target audience about STD/HIV through comprehensive sex education
- Develop regional sexual health plan
- Develop culturally appropriate education classes to inform public on STD/HIV

#### Participation
- Education of youth and young adults enrolled in program
- Participation in one hour sessions two times per week over 10 week period
- Free afterschool program for youth enrolled in program
- Life coaching sessions for young adults enrolled in program

### Outcomes -- Impact

#### Short
- Increased knowledge of HIV/STD transmission
- Increased knowledge of risk reduction strategies
- Enhanced perception of personal risk of STD/HIV
- Acquire skills on correct condom use
- Increased public exposure to STD/HIV awareness.

#### Medium
- Half of participants will use a condom during every sexual encounter.
- Improved condom negotiation skills.
- Increased public behavior toward STD/HIV education and prevention.

#### Long
- Reduce the incident rates of STDs/HIV in youth and young adults residing in low-income areas of the southern portion of the U.S. by at least 25 percent in 5 years.
- Reduce high risk sexual behaviors in youth and young adults.
- Increase in number of schools that provide comprehensive sexual education.

### Assumptions
People are more likely to adopt a behavior if given the opportunity to learn about the behavior.
Activities delivered to participants are evidence-based.
Activities are culturally sensitive.

### External Factors
Community attitudes toward sexual education and health.
School and parental support of comprehensive sexual education in school systems.
Access to personal health services and risk reduction materials/methods (condoms, dental dams, PrEP).
Due to the high incident rates of STD/HIV in the South a logic model was created to further address the need for comprehensive sexual education. The overall program goal is to reduce the incident rates of STDs and HIV by 25 percent in five years. Staff members followed the steps found in Kirby (2004) for designing, strengthening, and evaluating to reduce adolescent sexual risk taking. Kirby states that it is necessary to identify all the important behaviors that directly affect the overall program outcomes and health goal and select some or all of the behaviors to address in the health promotion program (2004). Therefore, increasing correct and consistent use of condoms, reducing the number of sex partners, and increasing medical help for treatment and testing of STDs are necessary to achieve the outcomes of the program. Comprehensive sexual education will be provided to youth and young adults in order to reduce incident rates of STD/HIV in the target population.

**Detail Program Objectives for Plan Implementation**

Over the past 20 years, many health promotion programs have been designed to “enhance adolescents’ STD/HIV-preventive knowledge, foster positive attitudes toward condom use, develop norms supportive of abstinence and condom use, teach skills to foster self-efficacy and motivate adolescents to adopt preventive behaviors, and to decrease risk behaviors” (DiClemente, Salazar, & Crosby, 2013, p. 889). The majority of these programs use small-scale educational formats to enhance STD preventive knowledge and have been effective in reducing risky sexual behaviors. However, DiClemente et al., stated that an individual’s environment may have an equal or even great effect on youth and young adults’ sexual risk behaviors (2007). Therefore taking an ecological approach to STD/HIV prevention by way of comprehensive sexual education has the potential to reduce transmission rates of STDs and HIV.
The Safe, Responsible Sexual Education Initiative will begin by raising awareness of comprehensive sexual education and STD/HIV prevention in low-income areas for youth and young adults (ages 14-25). Three study sites will be located in the South: one in Jackson, Mississippi, one in New Orleans, Louisiana, and one in Birmingham, Alabama. These cities were chosen due to the high rates of STD/HIV infection, neighborhoods of low-income and high ethnic diversity, and numerous college campus in the cities. In addition, regional messaging campaigns will be created via a mobile application to further increase awareness and knowledge levels of youth and young adults within the region on STDs/HIV and safe sex practices. Weekly text messages will remind participants on the importance of using condoms during sexual activities. In addition, web links will be provided if the participant wants more information. The webpage will included videos on STD/HIV prevention, correct condom use, condom negotiation skills, and other sexual health topics. Self-report surveys will be conducted on the website before enrolling in the messaging campaign and six months after. This data will be used to determine if a significant difference on STD/HIV prevention skills exists between participants receiving the messages and those who are not. In conjunction with the messaging campaign, mass media advertisements will be used to raise awareness, gain support, and increase participation.

The next phase of the promotion project is enrolling youth and young adults into free comprehensive sexual education classes. An estimated five hundred youth/young adults per year will be enrolled in the program each year. Participants enrolled in the program will partake in a 30-hour comprehensive sexual education course over a 15 week period. Youth (high school students) and young adults (over 18 years) will be enrolled in separate classes. Five 2-hour sessions will be conducted at each study site every week with no more than 20 participants each.
After completion of the 15 week course, new participants will start their course. The program director aims to conduct at least two sessions throughout the year at each study site.

To determine if the sexual education course has a significant effect on condom use, correct condom use, condom negotiation, and knowledge of STD/HIV each participant will take self-report surveys using Likert-type scales before and after completion of the course. These surveys will be similar to the ones received by participants in the messaging campaign. Moreover, participants will report information on likelihood of engaging in high-risk sexual behaviors (drinking, drug use, unprotected sex, and multiple sex partners) before and after the course. This data will be used to determine if participation in the comprehensive sexual education course reduces likelihood of engaging in high-risk sexual behaviors. Chi square tests will be conducted to determine if any significant differences occur between age groups and/or study sites. Follow-up surveys will be mailed to each participant six months and one year after completion of course to determine if the sexual education course promoted safe, responsible sexual choices. Baseline data will be needed from participants not enrolled in the study. Therefore, 500 surveys will be mailed to non-participant youth and young adults residing in low-income neighborhoods of the three study cities before the program starts and after the first session of sexual education courses end. This data in conjunction with the pre- and post-course surveys of participants will help program planners verify the effects of the program on STD/HIV prevention, condom use, condom negotiation skills, and attitudes toward sexual health.

Tasks, Timelines, Responsible Leads/Partners

To implement the Safe, Responsible Sexual Education Initiative, the Precede-Proceed model will be used. The program director will include the four Precede phases in the Gantt chart. Therefore, social, epidemiological, educational & ecological, and administrative & policy
assessments have been added to the tasks list. These assessments have been conducted before implementation of the program, so they have already been completed. Moreover, the comprehensive sexual education classes will be conducted throughout the school year by health education specialists. Thus, the lengthy time frame needed to complete two-15 week sessions of the course. Pre- and post-course data will need to be collected from each class session. On the Gantt chart data collection times are indicated for session 1 (fall) and session 2 (spring). The evaluation period of the program is expected to last approximately two months. Program staff will need time to collect and analyze all pre- and post-course survey data from each study site. Once the statistical analysis is conducted, the program director can begin to evaluate the effectiveness of the program and make any changes necessary.

**Program Pro Forma**

*Budgetary Needs*

According to a report on the cost analysis of school-based sexuality education programs in six countries, the cost per student can range from $7 to $160 (US dollars). The majority of these expenditures are the direct result of teacher salaries. However, newly implemented programs such as those found in Kenya and Indonesia are much more costly per student at $50 and $160 respectively (Kivela, Ketting, & Baltussen, 2013). Furthermore, four year costs of these sexual education programs including the development, adaptation, implementation, and updating the services were dependent on the number of total students receiving the education. Therefore, due to the newness and extracurricular nature of the Safe, Responsible Sexual Education Initiative costs per student will initially be high. These costs will be distributed unevenly due to the multifaceted approach of comprehensive sexual education classes and the mobile application. Without accounting for program staff salaries, the Safe, Responsible Sexual
Education Initiative will cost approximately $180 per participant for the first year for individuals enrolled in the sexual education classes.

Before the program can begin, the program director and other staff members will seek out grant money and donations in order to meet program needs. Approximately $240,000 is needed to pay for program expenditures. Over $230,000 will need to be obtained from grants while the remaining funds will be the result of contributions, gifts, and sale of program educational materials. Paying personnel will be the most costly expenditure of the program at $150,000 plus fringe benefits.

Other expenditures will include instructional and educational materials. Many of the lessons plans will be given to the program as gifts from supporters and consultations mentioned above. In addition, program planners are working diligently with contraceptive companies such as Trojan and Durex for discounted supplies and/or donations. Donations and discounted contraceptives will reduce overall program costs.

The Safe, Responsible Sexual Education Initiative will need at least $3,000 per year in order to pay for incentives. High school students that enroll in the education courses will receive discounted SAT/ACT prep classes upon completion of 30 course hours. Similarly, young adults (over 18) that complete the program will receive gift cards for participation or discounted tutoring services. Volunteers will be a large driving force of the program. As a means to thank them for their support and hard work, volunteers will be rewarded with gift cards and/or donated merchandise from area sponsors. Any remaining surplus toward the end of the year will be added to the incentive and unexpected costs funds.

Program Evaluation Plan

Outcome measurements and standards
The evaluation program design for the Safe, Responsible Sexual Education Initiative will incorporate elements of formative, process, and summative evaluation processes. Formative evaluations as found in Table 1 (Schlattmann, 2014) will focus on program content quality and program implementation (McKenzie, Neiger, & Thackeray, 2013). In order to justify the need for a health promotion program, program planners will conduct a needs assessment. In addition, program planners must provide evidence that comprehensive sexual education is effective in reducing STD rates and increasing overall sexual health in the target population by conducting literature reviews. Formative evaluation procedures will include self-report surveys, Gantt charts, and program and evaluation forms.

Process evaluations as seen in Table 2 (Schlattmann, 2014) are necessary for the Safe, Responsible Sexual Education Initiative to determine if the program activities were delivered as planned per Gantt chart and logic models. This type of evaluation ensures that “appropriate procedures are followed throughout implementation” (McKenzie et al., 2013, p. 393). Recruitment of participants, proportion of target audience given the opportunity to enroll in the program, and percentage of the priority population participating in the program may affect the results of the study, and thus, need to be carefully evaluated. Process evaluations allow for the determination of any confounding factors that may have affected the study results such as competing sexual education programs and conflicting messages.

Summative evaluation including impact and outcome evaluations will be conducted to determine the effectiveness of the program. Impact evaluations will determine if any significant differences occurred from baseline to post-program in awareness, attitudes, knowledge, skills, and behaviors related to comprehensive sexual education. In addition, outcome evaluations will determine STD incidents changed significantly due to the implementation of the Safe,
Responsible Sexual Education Initiative. This data will be collected via self-report surveys before and after completion of the sexual education course.

**Program Strategies Summary**

Lack of comprehensive age-appropriate sexual health education throughout the southern region of the United States has led to severe sexual health disparities for youth and young adults. Therefore, abstinence-only sex education alone will not address the sexual health status of all members of the target population, nor will it reduce the prevalence of STDs including HIV. The South needs an overhaul of the sexual education curriculum to eliminate these health disparities found throughout the region. A written regional plan will provide one cohesive voice to provide information on advocating for funds in an effective, efficient manner. The regional plan will help to identify and establish relationships with stakeholders and key community leaders which in turn will lead to action to continue making progress on comprehensive sexual education.

One of the biggest challenges that will be associated with implementing the Safe, Responsible Sexual Education Initiative is gaining community support. Due to the nature of the subject, many parents, educators, community leaders, and politicians may not support the cause due to religious beliefs and/or core values. Without support from the community, many high school students may not enroll in the program due to lack of parental permission. As a way to encourage parents in these low-income neighborhoods to grant permission to their students to partake in the comprehensive sexual education classes, program planners will be offering discounted ACT/SAT classes for all enrollees that complete the course. In addition, self-report surveys are not the most reliable source of data. Participants may give answers that they feel the researchers want to hear or answers to boost self-esteem. Due to this weakness of self-reporting surveys, the questionnaire will be administered at the end and beginning of the program. Lastly,
the mobile application to raise awareness and reduce high-risk sexual behaviors will be limited to participants that have smart phones. Therefore, implementing a comprehensive sexual education program will prove to be challenging.

Due to the nature of the program, randomization is not possible. Participants that agree to enroll in the comprehensive sexual education classes will receive the same education as all other participants for ethical reasons. Baseline data will be collected in order to make comparisons. Researchers will attempt to collect non-participant data by mailing self-report surveys to youth and young adults not enrolled in the program.
Table 1.
Elements of Comprehensive Formative Evaluation for the Safe, Responsible Sexual Education Initiative

<table>
<thead>
<tr>
<th>Element</th>
<th>How it will be assessed/evaluated in your program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Justification</td>
<td>In order to justify the need for a health promotion program, program planners will conduct a needs assessment prior to the start of the promotion.</td>
</tr>
<tr>
<td>Evidence</td>
<td>Evidence that comprehensive sexual education is effective in reducing STD rates and increasing overall sexual health in the target population is necessary. This element will be assessed by conducting a literature review on the benefits of comprehensive sexual education vs. absenteeism.</td>
</tr>
<tr>
<td>Capacity</td>
<td>All staff members will be assessed/evaluated on knowledge, skills, and ability to design/implement health promotion program prior to being hired. Health education specialists will be required to have at least 3 years of previous experience working on health promotion programs.</td>
</tr>
<tr>
<td>Resources</td>
<td>A budget will be created prior to implementation of the program in order to assess the needs of the program. In conjunction a logic model will be necessary to determine all inputs for the program.</td>
</tr>
<tr>
<td>Consumer Orientation</td>
<td>Tailoring the health promotion specifically to the needs of the priority population is key to the success and effectiveness of the program. All participants will be surveyed on their wants and needs for the program.</td>
</tr>
<tr>
<td>Multiplicity</td>
<td>The Safe, Responsible Sexual Education Initiative will take a multiple-component approach including mobile messaging campaign, mass media campaign, and educational classes. The implementation of each strategy will be evaluated upon completion of the program.</td>
</tr>
<tr>
<td>Support</td>
<td>The program will offer additional resources for persons not enrolled in the sexual education course and increase access to medical services for STD treatment.</td>
</tr>
<tr>
<td>Inclusion</td>
<td>All stakeholders involved in the program must have the same vision for the program: a nation free of STDs/HIV that emphasizes the importance of protecting all individuals’ sexual health via comprehensive sexual education.</td>
</tr>
<tr>
<td>Accountability</td>
<td>Gantt charts will be created to ensure that all staff members are fulfilling their responsibilities as planned. Staff meetings will be used to monitor progress.</td>
</tr>
<tr>
<td>Adjustment</td>
<td>At the end of every educational session, feedback from participants, staff members, and stakeholders will be used to adjust the program components as necessary.</td>
</tr>
<tr>
<td>Recruitment</td>
<td>Raise awareness in priority communities by holding awareness rallies. Youth and young adults will be able to enroll at these rallies or by contacting program staff. Recruitment will be evaluated basis on the number of participants that enroll at each rally.</td>
</tr>
</tbody>
</table>
Reach
All members of the priority population will have the opportunity to enroll in the program. No participant will be turned away because all youth and young adults have the right to comprehensive sexual education.

Response
Demographics and census information will be used to determine the percentage of the target audience that actually enrolled in the program.

Interaction
Feedback from participants will assess the interaction of staff members throughout the program.

Satisfaction
Feedback from participants using Likert-type scales will be used to evaluate participant program satisfaction.

Table 2.
Elements of Process Evaluation for the Safe, Responsible Sexual Education Initiative.

<table>
<thead>
<tr>
<th>Element</th>
<th>How it will be assessed/evaluated in your program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fidelity</td>
<td>Gantt charts and logic models will be used to determine if program activities were implemented as planned. Step-by-step protocols will be made prior to implementation to be followed by all program staff to ensure the activities are implemented as planned.</td>
</tr>
<tr>
<td>Dose</td>
<td>Each participant in the educational sessions will receive 30 hours of comprehensive sexual education logged by program staff. In addition, mobile message campaigns will deliver one message weekly for a calendar year (52 messages) as set by mobile application designer.</td>
</tr>
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<td>Recruitment</td>
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<td>Response</td>
<td>Demographics and census information will be used to determine the percentage of the target audience that actually enrolled in the program.</td>
</tr>
<tr>
<td>Context</td>
<td>The influence of competing programs and conflicting messages will be assessed by determining and identifying all factors effecting internal validity. Researchers cannot use random assignments to groups for the program and must rule out each threat to internal validity one by one (McKenzie et al., 2013). Baseline data will be collected in order to make comparisons. Researchers will attempt to collect non-participant data by mailing self-report surveys to youth and young adults not enrolled in the program.</td>
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References


