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REVIEW, APPROVAL AND ACCEPTANCE

The document mentioned above has been reviewed and accepted by the student's advisor, on behalf of the advisory committee, and by the Director of Graduate Studies (DGS), on behalf of the program; we verify that this is the final, approved version of the student's capstone including all changes required by the advisory committee. The undersigned agree to abide by the statements above.

Kayla M. Storrs, Student

Richard Crosby, PhD, Committee Chair

Corrine Williams, ScD, MS, Director of Graduate Studies

HIV/STI AND TEEN PREGNANCY PREVENTION WITHIN MCLENNAN COUNTY TEXAS

CAPSTONE PROJECT PAPER

A paper submitted in partial fulfillment of the
requirements for the degree of
Master of Public Health
in the
University of Kentucky College of Public Health
By
Kayla M. Storrs
Amarillo, Texas

Lexington, Kentucky
April 14, 2014

Richard Crosby

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In response to the Center for Disease Control and Prevention (CDC) funding announcement, the McLennan County Health Department proposes to implement Be Proud! Be Responsible!, an evidence-based HIV/STI and teen pregnancy prevention program into the pre-existing health curriculum of the sixth grade classes within the county. With the highest rates of chlamydia and gonorrhea within the state of Texas, and $7 million per year of teen pregnancy related costs spent in Waco, Texas alone, this intervention aims to increase HIV/STI knowledge, increase positive perceptions of safe sexual behaviors, increase parent-student communication about safe sexual behaviors, prolong first sexual initiation, and reduce frequency of risky sexual behaviors, thus contributing to a decrease in the incidence of STI rates and teen pregnancy within the county. In implementing the curriculum in to the health classes for sixth graders, we hope to educate the participating students before they have initiated sexual activity. Under the leadership of Program Director Kayla Storrs, Director of the Sexual and Reproductive Health Department within the McLennan County Health Department, and Program Coordinator, Cynthia Estrada, Associate Director of the Sexual and Reproductive Health Department, the program will be integrated into the pre-exiting curriculum of six intervention schools within the county and six control schools will be used to help evaluate the program effectiveness. Upon completion of program implementation, based on evaluation results, the program will then be implemented across the county.

TARGET POPULATION AND NEED

In the United States, teens and young adults aged 15-24 only make up about 25% of our population, yet they account for roughly half of all newly diagnosed cases of sexually transmitted infections (STIs) each year. (Weinstock, Berman, & Cates, 2004). Based on this, an estimated ten million new cases of STIs will be diagnosed solely amongst young people in the 15-24-age range each year. (Center for Disease Control and Prevention, 2013). While the projected STI and teen pregnancy rates continue to grow, the state of Texas seems to carry a large burden of the overall rates.

According the U.S Census Bureau in 2013, Texas is home to approximately 27.5 million people and the population is continually growing. Of that population, 26.4% are under the age of 18 (United States Census Bureau, 2015). Texas ranks 3rd in the nation in HIV diagnoses rates, 5th in Primary and Secondary Syphilis rates, and 13th in both Chlamydia and Gonorrhea rates (Texas, 2015 State Health Profile, n.d). Further, in 2011, Texas ranked 5th in the nation in teen birth rates among females aged 15-19, and has an overall birth rate of 46.5 per 1,000 compared to the national average of 31.3 per 1,000 (Texas Adolescents Reproductive Health Facts, 2014). Though there are a variety of factors that contribute to STI acquisition and teen pregnancy, research has shown that by focusing on reducing risky sexual behaviors one can hope to see a direct decrease in the rates of sexually transmitted infections and teen pregnancies. (DiClemente, Santelli, & Crosby, 2009). For the purposes of this project, risky sexual behaviors are defined as any of the following: early age of sexual initiation, frequent sexual intercourse, infrequent condom use or use of a contraceptive method, and multiple sex partners. When looking at rates in Texas and averages across the United

States as a whole, Texas appears to have worse sexual and reproductive health outcomes compared to the rest of the United States. As reported by the Office of Adolescent Health (See Table 1), Texas is doing poorly with respect to risky sexual behaviors: 52% of teens in Texas have engaged in sexual intercourse, compared to the national average of 42%(Texas Adolescents Reproductive Health Facts, 2014). Unfortunately, Texas also has a lower condom use rate compared to the national average (54% vs.60%), a lower rate of reported birth control pill use (11% vs. 18%) and a higher rate of high school students who reported not using any type of contraceptive during their last intercourse (20% vs.vs. 13%) (Texas Adolescents Reproductive Health Facts, 2014).

Table 1. Risky Sexual Behaviors Reported by High School Students in Texas and the United States, Youth Risk Behavioral Factor Surveillance System, 2013.

Risky Sexual Behavior	Texas	U.S.
Percent of high school students who have ever had sexual intercourse	52%	47%
Percent of high school students who have had sexual intercourse with 4 or more persons	17%	15%
Percent of high school students who used a condom during last sexual intercourse	54%	60%
Percent of high school students who used birth control pills before last sexual intercourse	11%	18%
Percent of high school students who did not use any method of contraceptive during last intercourse	20%	13%

With an exist ent large popu latio n, and one that is steadily growing, it is important to make sure that teens in Texas as a whole

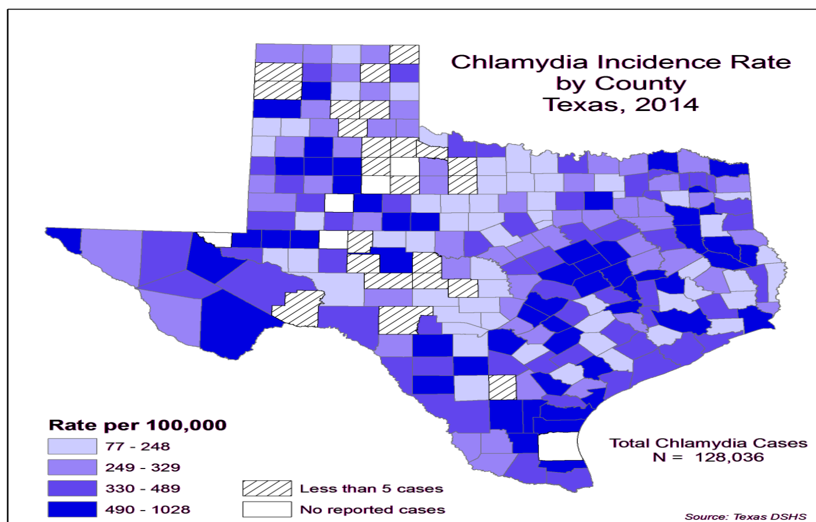
are equipped with the necessary resources to prevent sexually transmitted infections and unintended pregnancy. Though rates are high in the state, smaller cities, towns, and counties are experiencing even higher rates of sexually transmitted infections and teen pregnancies, which supports the need for intervention on a smaller, more local level.

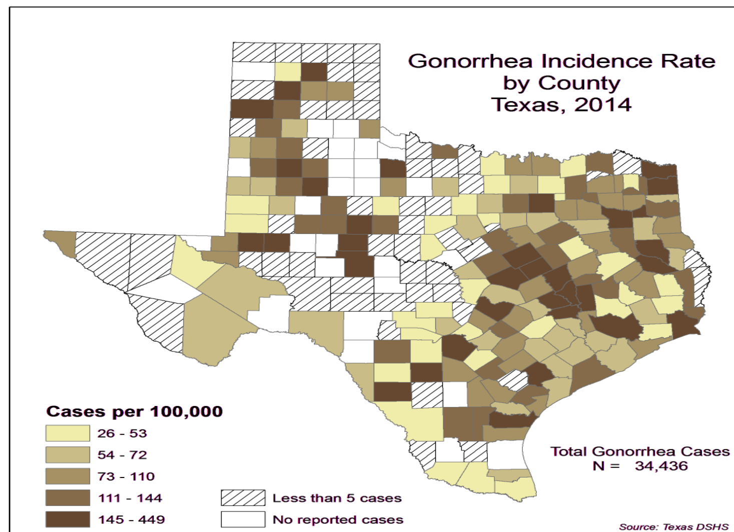
McLennan County is home to approximately 243,441 people, as reported by the U.S. Census Bureau in 2014. McLennan County also encompasses 21 towns, the most populous of which include Waco and Hewitt (United States Census Bureau, 2015). Unfortunately, McLennan County is also responsible for the highest rates of both chlamydia and gonorrhea (see Figures 1 and 2) in the entire state of Texas, with between 145-449 cases of chlamydia per 100,000 and between 490-1028 cases of gonorrhea per 100,000 (Texas Department of State Health Services, 2014). Additionally, the totally population of females ages 13-17 is roughly 8,100, with a birth rate of 22.7 per 1,000 (Texas Adolescents Reproductive Health Facts, 2014). Waco is the largest town in McLennan County, and every year, almost $7 million is spent on health and social services for the teen parents and their children (Dennis, 2014).

In the state of Texas, sexual education is not mandated but previously, the state required the schools who provided the curriculum to teach abstinence only education. There was no teaching about any types of contraceptives, no parental communication skills taught, and the information that was presented did not have to be medically accurate. In 2011, the state shifted to include Abstinence Plus as an option for those choosing to integrate sexual health education into their curriculum, meaning that curriculum can now include information about HIV/AIDS and contraceptive use, but

must still stress abstinence as the main and best option (Texas Freedom Network, 2011).

Considering the updated mandates in the state of Texas, the burden of disease of sexually transmitted infections, the elevated rates of teen pregnancy, and the overall financial burden that comes as a result, the information provided makes it clear that there is a definite need for a more comprehensive sexual health education program, starting in McLennan County.





When considering a sexual health program that is to be implemented within the public school systems, key criteria for selection included modules that can be implemented within the classroom setting, a training guide that is easy to follow and administer to those who will be facilitating the curriculum, and a well-established structure that increases sustainability within the setting in which it will be administered. Because of the presence of these factors, the evidence-based intervention that will be the best fit for the state of Texas is Be Proud! Be Responsible! (BPBR), a program that aims to help participants evaluate and change behaviors that can potentially put them at risk for pregnancy, sexually transmitted infections and HIV/AIDS. The intervention also aims to delay the initiation of sex among those who have yet to initiate, reduce the

prevalence of unprotected sex among those who are sexually active, and help participants make proud and responsible decisions about their sexual behaviors.

This program is fit to be administered in a school or after school program setting, but integration into the curriculum varies based on the setting in which it is going to be implemented. In this project, BPBR will be implemented in six Middle Schools. We anticipate that the curriculum should be able to be given as intended. The curriculum will be adapted and integrated into the existing health class, as indicated by the training provided by the national program. Because of this, the intervention will be implemented as an "opt-out" program, so those participants choosing not to participate will be assigned to a non-participating health class that doesn't present the curriculum. In using this mechanism, we hope to see higher participation rates. Trained health teachers will present the curriculum, and because the modules can be integrated into the already existing health curriculum, the likelihood of sustainability increases, because the information can be permanently integrated after a few years of implementation and positive results. Also, considering that the largest town in the county currently spends almost $7 million a year solely on services for teen mothers and their children, if we are able to reduce the rates of teen pregnancy alone, we can allocate $1 million of the funds saved from prevention to continuous funding and possible expansion of the program.

According to U.S Census data, as of 2015, the total population of McLennan County was 243,441 with 24.8% percent of the population being under the age of 18, and 17.7% of the population falling in the 6-18 year old range, leaving us with an estimated 10,686 adolescents within twenty independent school districts that could potentially be reached each year by this program in the long run (United States Census

Bureau, 2015). Considering not all parents will allow students to participate, we can estimate that at least one of two adolescents will participate, leaving us with a minimum of roughly 500 students reached by the program per semester. If this program is implemented across *six* of the twelve middle schools in the county, we can estimate that a rough total of students reached by this program by the end of the three-year grant-funding period would around 2,500 students.

PROGRAM APPROACH

Be Proud! Be Responsible! is designed to decrease the frequency of risky sexual behavior and related HIV/STD infection among minority (African American, Latino) adolescents. Based on the Cognitive-Behavior theory, the program uses group discussions, videos, games, brainstorming, experiential exercises, and skill-building activities to improve teens' knowledge about HIV and STIs, and to increase self-efficacy and skills that might help to avoid risky sexual behavior (e.g., abstinence, condom use). The intervention includes six sessions, of 60-minute length, led by trained facilitators, but can also be implemented within a school setting as part of the curriculum of a required health education class. The program can be implemented in a six-day, two-day, or one-day format, but varies when integrated into school curriculum.

The program originated in the early 1990's in a sample population of 157 inner city African-American males ages 12-19. All participants were administered the program and 96% of program participants returned to complete the 3-month follow-up evaluation. Follow-up measures included HIV risk-associated sexual behavior, intentions to engage in risky sexual behaviors, attitudes toward risky sexual behaviors, and AIDS and STI knowledge. Results found that participants having received the intervention program

had higher HIV/AIDS knowledge, less favorable attitudes towards risky sexual behaviors, and lower intentions to engage in risky sexual behavior than those participants in the control group. Follow-up data found that those having received the intervention had fewer occasions of sexual intercourse, fewer sexual partners, greater use of condoms and lower incidence of heterosexual anal intercourse than those who did not receive the intervention (Jemmott, Jemmott & Fong 1992).

Multiple studies since the origination of the program have taken the intervention and tailored it to different populations and different settings, and findings show an increase in HIV/STI and condom knowledge, safer sex related skills (impulse control, condom negotiation, condom use), favorable beliefs about condoms, decrease in unprotected sexual intercourse, increase in condom use, and decrease in multiple sex partners (Jemmott, Jemmott & Fong 1992; Jemmott & Jemmott 1992; Jemmott, Jemmott, Fong 1998; Jemmott et al. 1999).

Further studies have proven outcomes in number of sexual partners, recent sexual activity, frequency of sexual activity, and contraceptive use and consistency. Among the population of participants having in engaged in sexual intercourse, results from previous implementation show a decrease in the number of female sexual partners among the males administered the program, decrease in the frequency of vaginal intercourse in the past three months, increased frequency and consistency of condom use during the sexual encounters in the past three months, and decrease in the number of anal intercourse encounters by participants (Jemmott, Jemmott, & McCaffree, 1996; Jemmott et al. 2005; Borawski et al. 2009).

The program can be generalized to African American and Latino populations aged 11-19 and have been shown effective for implementation in a mixed-gender population, male-only, and female-only populations. This information is important considering all of the middle schools in Waco alone have student bodies that are made of up more than 84% African American and Hispanic students. (Waco Independent School District, n.d).

Because the average age of sexual initiation in the Unites States is 17.2 years old (with minority populations debuting sooner than the national average), utilizing this specific prevention program before our target population reaches the predicted age allows them to be well equipped with all of the necessary information needed to make smart, health conscious decisions when it comes to sexual activity, resulting in later initiation of sexual intercourse, and safer sexual practices upon sexual initiation (Cavazos-Rehg et al. 2009). Therefore, for the purposes of this proposal, we will be administering the program in sixth grade health classes in six of the twelve willing middle schools across McLennan County.

BPBR is a six-session program that focuses on the following topics:

Module 1: Introduction to HIV and AIDS
Module 2**:** Building Knowledge about HIV and AIDS
Module 3**:** Understanding Vulnerability to HIV Infection
Module 4**:** Attitudes and Beliefs about HIV, AIDS, and Safer Sex
Module 5**:** Building Condom Use Skills
Module 6**:** Building Negotiation and Refusal Skills

Within these modules that encompass the program curriculum, information about HIV, etiology, transmission, and prevention, sexually transmitted infections, etiology, types,

transmission and prevention, pregnancy and prevention, and various prevention strategies including negotiation, condom use, and problem solving are all covered. With twelve schools willing to participate, in order to account for potential bias within the study we will be randomizing the schools that will be receiving the curriculum, so six will be implementing Be Proud! Be Responsible! and the other six will be used a the control groups with data collected from the standard health class.

Because this is a national program, we anticipate the curriculum being age and culturally appropriate, as well as medically accurate, but to ensure it meets those requirements, our Community Advisory Group will review all of the curriculum before live implementation.

During the first six months of the grant, as part of the planning period, all teachers administering the program in their classrooms will undergo an 8-hour training course specific to BPBR packaged training manuals and facilitated by Ms. Estrada, the Program Coordinator, to ensure they are properly prepared to implement the program within their curriculum. In order to account for potential bias, teachers who do not agree with the curriculum will not be considered for the program. In taking action here, we can ensure that the curriculum is presented the way that it is intended without any personal biases from those not in agreement. The training will take place on a Saturday in order to allow for all teachers to be trained together. Training will include an overview of the program, the goals and expectations for those administering the program, and ways teachers can help optimize effectiveness of the program through their classroom administration. We will also conduct focus groups with these teachers in order to allow time for brainstorming ways to integrate the six-module program into the full 16-week

CAG Member	Role in CAG

semester. Information and ideas from these focus groups will be compiled and shared in the form of final suggestions for implementation to the teachers at a kickoff meeting upon completion of the planning phase. At this point, the proposed implementation will be piloted in classes in one of the participating schools. Upon completion of pilot implementation, feedback from teachers and students in the form of satisfaction surveys with open-ended response options will contribute to the final tailoring and adapting of the program in the implementation phase of the program.

During the planning phase we will also form a Community Advisory Group (CAG) made up of individuals that aren't part of the program implementation, but have a genuine

Parent Leaders in the community	These are parents who are invested in the success of the program and are able to communicate with parents who may disagree with the purpose and goals. These parents will be recruited through information sessions at PTA meetings and online school board postings. They will be able to better the explain rationale in a way that opposing parents might understand.
Faculty and administrators of participating schools	We need these individuals to help us navigate the details of educational politics to give insight on policies and procedures of the school system. This will help ensure that we are able navigate the process in the most effective way possible without breaking any rules.
Community Center staff/administrators	These individuals will be included in order to offer insight on how things learned from the school program can be reinforced outside of a school setting. They also give insight into the interactions of students outside of the classroom, and can bring feedback and hearsay from the students themselves into the meetings so we can do somewhat of a program evaluation throughout the program.
Former or current teen parent	This individual offers firsthand insight into the experiences of teen pregnancy and will help determine what could work and what may not work so well, based on their own personal history with sexual health education and things they wish they knew when they were younger/before they got pregnant.
Parent of a teen parent	This individual will be able to offer insight into the experiences of being a parent of a teen parent, discuss communication about sexual health in the home, and help the program to balance topics that should be discussed in class, and those that should be briefly touched on in the class but left for in depth discussions with caregivers in the home. They will also be an advocate for the program, discussing potential benefits of preventing teen pregnancy through wholesome education.
Representatives from partner organizations	We will be including places like Planned Parenthood and/or other organizations that have a genuine interest in preventing teen pregnancy and STI transmission. Not only will they offer insight into best practices, but they will also be used as referrals, so that any services that we are unable to provide through the program are still made available to participants.

interest in the program goals and offer valuable insight. CAG members will serve as advisors for the overall implementation of the program, meeting quarterly to discuss program progress and ways to keep not only the schools and parents engaged, but the community as a whole. Below is a detailed list of potential community advocacy group members, what they bring to the table, and why they are important to the success of our program.

Once implementation of the program is live in our target schools, fidelity will be monitored by random bi-weekly check-ups from program staff. We will be using the dual-assurance methodology, therefore the students will rate the teachers administering the curriculum based on the criteria that is supported to be presented and our program staff will rate the teachers on a more detailed scale, making sure that they are adhering the to curriculum guideline as outlined by the national training manual. Staff will also take note of any questions and/or concerns that teachers may be experiencing. If for some reason teachers are straying away from the program curriculum and goals, as noted by program staff during their monthly check-ups and the one-on-one meetings with teachers, a re-evaluation meeting will be scheduled immediately to get back on track and make sure that information of being disseminated is as outlined in the program.

Because the program is being implemented in a middle school setting and is being integrated into the already existing health curriculum, during program implementation, students will be presented with information and resources that will encourage safe and health conscious sexual behaviors, including referral information to local sexual health clinics offering free or low cost birth control options and screenings for sexually

transmitted infections. Below is a list of available resources for participants and program administrators, all of which offer services for sexually transmitted infections and/or pregnancy. This information will also be disseminated to parents in the initial program bulletin as a "Resources and Referrals" page.

- Sexually Transmitted Disease Clinic
    - $30 Gonorrhea and Chlamydia tests
    - $10-15 pregnancy tests
- McLennan County Clinic
    - Free HIV and Syphilis testing
    - All other STD screenings/tests for a small fee
- Planned Parenthood of Waco
    - STI/HIV Screenings
    - Birth control options
    - Pregnancy tests
    - Contraceptive Counseling
    - Nobody's Fool Sex Ed program offered year around for groups requesting the program
- Free Texas District Clinics
    - Offer free STD screenings/tests
    - Small fee for HIV test

These programs/organizations will be used on a linkage basis, meaning that students will have access to information about services, but because we are not doing any actual testing, we will not be making any official referrals. Partnerships can be formed so that they offer things like free condoms and sexual health information and we refer students and parents to them for STI testing and treatment, pregnancy tests and contraceptive counseling. All organizations will be contacted by the program director to organize a brief meeting, detailing the program purpose and objectives, the need for the program,

and overview of responsibilities of partner organizations, and how they can be of assistance in success to the program. In taking the personal approach with these organizations, we hope to have everyone on board, in order to have a thorough list of linkage organizations that will offer the care and services necessary for those participants who may be in need. These services should include but are not limited to STI screening and treatment, HIV tests and counseling, pregnancy tests, contraceptive options, and contraceptive counseling. They should also offer information regarding HPV and have the ability to administer the vaccines. Information about our partner organizations and their clinic and counseling services will be integrated into the program curriculum so that participants are aware of the available resources that they are able to take advantage of if necessary. Students and parents will also be given information regarding the Texas states laws and the partner organizations. An adolescent under the age of 18 does not have to have permission or consent from a parent or guardian to received STI testing and services. Physicians are not legally required to inform the parents, but they may choose to do so anyway. Minors can buy condoms without a problem, but unless they are married, a minor cannot receive birth control services without their parent’s permission.

In order to maintain those partnerships and linkages with the referral organizations, we will serve as a partner to them, publicizing their events and services, and providing their information to the general population through the health department website and office bulletins.

Program administration will continue with new cohorts every semester for the duration of the grant funded time period, with quarterly CAG meetings to focus on

sustainability and assess resources needed to do support long term integration, of the program after the grant funded period has ended. At this time, Ms. Estrada will also work with the program staff to make additional refinements and final adjustments to the program as needed to support continued implementation using process and outcome evaluation results. Meanwhile, Ms. Storrs will use information from the overall analysis to construct an evidence-based manuscript of the program results, and will engage in other dissemination activities, including presenting at national and regional conferences. She will also take results and feedback from conference presentations to present to the Texas Board Education to push for widespread implementation of BPBR into health curriculum across the state.

In order to compensate teachers for their time during the training and the time put in during the school year for the program, they will be receiving $100 for the full Saturday training, and $100 per year of extra school supplies. We will also offer three scholarships each year for teachers participating in the program to attend the National Sex Ed Conference. For students, we will have program t-shirts as completion gifts once they have submitted their post-test survey.

For more in-depth information regarding the three-year plan, the specific goals of the program, and measures of sustainability, please refer to the Appendix for the Work Plan and Logic Model.

PERFORMANCE MEASURES AND EVALUATION

Performance Measures

Upon live implementation of BPBR within our participating schools, our program staff will be in charge of visiting all schools and conducting the pre-test data collection. They will also visit the six non-participating schools to collect pre-test data that will be used as control information. Measures used to collect this information will include but is not limited to the following variables, as outlined in the original BPBR program, pulled from the Theory of Reasoned Action, Theory of Planned Behavior, and Social Cognitive Theory, all of which were measured with 5 point Likert scales:

- Intention to use condoms (3 items, alpha=.86)
- Condom use hedonistic beliefs (7 items; alpha=.84)
- Beliefs regarding partner's approval of using condoms (1 item)
- Condom use technical skills beliefs (3 items, alpha=.65)
- Condom use impulse control beliefs (2 items; alpha=.61)
- Condom use negotiation beliefs (3 items; alpha=.82)
- HIV/STD risk-reduction knowledge (48 true-false items)
- Knowledge specific to condom use (6 true-false items)

Process Evaluation

Once this data is collected, teachers will begin administering the curriculum as designated with the adapted program. During this period, program staff will conduct bi-weekly classroom observations and meetings with teachers to monitor fidelity. We want to make sure that the curriculum being presented is in the structure as outlined in the program manual in order to ensure best possible results therefore we will be using the dual assurance method (Crosby, DiClemente, & Salazar, 2006). With this method of monitoring fidelity, students will rate their teachers based on the information presented and method of dissemination and the program staff will rate the teachers based on more detailed information specific tot the program curriculum. Program staff will also gather feedback, and notate obstacles experienced by teachers. Information will then be

communicated back to Ms. Estrada for further tailoring as necessary. Below are sample fidelity surveys that will be filled out by program staff to monitor fidelity.

FIDELITY CHECKLIST

Facilitator(s)____________________ Dates for this cycle ___/___/___ - ___/___/___

Site Location:

____In School classroom ____In-School after school program ____Foster Care Facility ____Other Residential Facility

____Community Center /CB O ____Faith Based Institution ____Clinical Setting ____Other:____________

Module 1: Introduction to HIV and AIDS

Activity	**Date Activity Was Carried Out** (MM/DD/YY) if not carried out write"O"	**Was Activity Carried Out According to Directions in the Facilitator's Curriculum?** Y=YES N=NO (describe changes in next column)	**If Changed, WHAT was changed and WHY? Please be specific: describe things you left out, added, or changed and WHY.**	**Were Changes (if any) Pre-Approved?** Y=YES N=NO
Warm Up Introduction & Overview		Y / N		Y / N
Activity A: Group Introduction		Y / N		Y / N
Activity B: Creating Group Rules		Y / N		Y / N
Activity C: Discussing HIV and AIDS		Y / N		Y / N
Activity D: What I Think About HIV, AIDS and Safer Sex		Y / N		Y / N

Please use this space if you have comments on Module 1 or any of its activities:

EVALUATION PACKET FOR BE PROUD! BE RESPONSIBLE!

Module 2: Building Knowledge About HIV and AIDS

Activity	**Date Activity Was Carried Out** (MM/DD/YY) if not carried out write"O"	**Was Activity Carried Out According to Directions in the Facilitator's Curriculum?** Y=YES N=NO (describe changes in next column)	**If Changed, WHAT was changed and WHY? Please be specific: describe things you left out, added, or changed and WHY.**	**Were Changes (if any) Pre-Approved?** Y=YES N=NO
Activity A: The Subject is HIV		Y / N		Y / N
Activity B: Myths & Facts About HIOV and AIDS		Y / N		Y / N

Please use this space if you have comments on Module 2 or any of its activities:

Mid-program data collection will be administered at the mid-semester mark through electronic surveys that will be taken on the student issued iPads, and post-test data will be collected upon completion of the program at the end of the semester from both participating schools and out control schools. At this time, the 6-month follow-up

evaluation will also take place for those students having participated in the pilot program to conduct our first round of long-term analysis.

For ease of data collection and analysis, we will be utilizing Qualtrics to administer the pre, mid, and post tests to students. McLennan county schools issue students iPads at the beginning of each school year to use as educational resources, therefore when conducting the data collection, program staff will walk students through accessing the pre-constructed surveys on their iPads. In order to keep each student's pre, mid, and post test information together and their information will be identified by a random number that will be associated with their student identification numbers. Information will then go straight to the Qualtrics system and will be available for analysis when the time comes. These data collections will take place before implementation, at the mid-program mark, and when the program has been completed.

Follow-up surveys will also be administered to participants at six months (at the end of the semester following program completion) and one year (at the end of the following academic year) after the program finish to measure the intermediate effectiveness of the program. These surveys will solicit information regarding behaviors participants have engaged in since introduction into the program. Behaviors and perceptions measured include but are not limited to sexual initiation intention to use condoms, beliefs regarding partner's approval of using condoms, condom use technical skills beliefs, condom use negotiation beliefs, HIV/STD risk-reduction knowledge, and knowledge specific to condom use. We understand that not all students will have engaged in sexual activity, and we are actually assuming that they have yet to initiate sexual activity. But we must also provide a measure of evaluation for those who may

have already initiated any type of sexual activity. For those purposes, specific questions regarding sexual intercourse and sexual activity to be included in the survey and answered by students include the following:

- Have you engaged in sexual intercourse?
- If so, how often do you engage in sexual intercourse?
- How many times in the past six months have you engaged in unprotected sexual intercourse?
- How many times in the past six months have you avoided sexual intercourse because you did not have a condom?
- Do you carry condoms or have quick access to them?

Because we are asking about sexual activity and behaviors, the main obstacle that we foresee facing will be false reporting of sexual behaviors by participants due to negative perceptions of sexual reporting. We also foresee a loss to follow-up and inability to collect data from participants at the six-month and one year based on students moving schools or school districts, parents not authorizing students to participate in follow-up surveys, and student absence. There is also the potential for study contamination if there are students that move from one school participating in the program to another school that may be a control school. This should be noted as a limitation to the study results, but should not interfere with the continued program implementation.

In terms of the program itself, we do foresee political pushback, considering the taboo nature of the topic and the overall political state of Texas. We understand that there will be people within the community that will oppose the implementation of the program and parents with significant influence that will be opposed. As this comes with the territory of proposing sexual health education in Texas, through Parent Teacher Association meetings and town hall meetings, we will identify influential parents who

support the program and will partner with them to help increase buy-in from other parents and community members. We will also stress that fact that the program is opt-out, so for those who are strongly opposed, they can refuse to have their students participate. This too, should not affect the overall implementation of the program and the goals that we have set.

Outcome Evaluation

Upon program completion, data collected from the pre, mid, and post-test surveys will then be analyzed to measure the actual effectiveness of the program. For knowledge and perceptions regarding condom use, HIV/STIs, pre-test data will be compared to mid-program, post-test, and follow-up surveys using a simple t-test and a change score will be calculated. For sexual activity and behaviors, pre-test data will be compared to the mid-program, post-test, and follow-up surveys using a chi-squared test, and a change score will also be indicated here. The information from the change scores of the intervention group will then be compared to the change scores of the control group to indicate whether or not the intervention was actually effective and reached the goals set out during the planning phase.

This information will then be translated into infographics, including graphs and photo representations and constructed into newsletters and pamphlets in order to ensure ease of interpretation by a broader audience. These dissemination materials will also outline the previous rates of STIs and teen pregnancy within the county for comparison purposes and to highlight the importance of comprehensive sexual health education. In order to make sure that there is proper communication within the community about the program, bulletins will be posted on each of the independent

school districts websites outlining the overall objectives of the program and what schools are participating. Because the program is ongoing, periodic updates will also be posted to the bulletins with information regarding the number of students participating, outcomes of the programs, and information about how to request to have the program implemented in other schools. There will also be information sent out in the school newsletter. An email list serve will be constructed to keep parents and stakeholders aware of updates and progress with the implementation of the program. Performance and evaluation measures will also be disseminated back to the funder on a semi-annual basis via a brief status report constructed by the Program Director. For the purposes of continually improving the implementation process for both teachers and students, satisfaction surveys will be administered upon program completion. Information from these surveys will be used for continuous quality improvement.

For funding, the program will be covered for three years by the grant money allocated specifically for the program. Through evaluation measures every year, we hope to see positive results and an overall decrease in the rates of STIs and teen pregnancy in the county. Assuming the program evaluation finds positive outcomes within the target population, funds can then be reallocated from that spent on teen pregnancy every year to reinvest in the program for future years.

Capacity and Experience of the Applicant Organization

Since the inception of the McLennan County Health department in 1917, our mission has been to promote the health of the people of McLennan County through the prevention and control of disease and injury. We serve an estimated population of

243,441 men, women, and children within the county and cover a 1,060 square mile service area. With a staff of 173 full time employees, 89 part time employees, and numerous contracted partners, our ability to service the health and wellness needs of our community is of the highest degree. Current projects and programs that are underway at the HD include but are not limited to Walk Across Texas- a diabetes prevention program, Live Well Waco- a health and wellbeing promotion program, Healthy Babies Coalition- an infant mortality improvement program, multiple smoking cessation programs and efforts, as well as Healthwise- a monthly television broadcast on the local networks outlining the health needs of our community and discussing options for improvement on the individual and community level.

Though this will be the first teen pregnancy and STI prevention program that will be implemented on a grand scale, McLennan County Health Department has experience successfully implementing evidence based public health programs within the youth population. In 2012 a childhood obesity program was integrated into the curriculum in our public schools. Over the course of 18 months with our first cohort of participants, results showed significant decrease in the number of obese and overweight youths grades 1-6. Subsequent cohorts are currently in different phases of the program and we expect to see similar results as the data continues to be collected. The program has served an estimated 2,400 children, not including students that have transferred to other school districts and those who did not fully complete the program.

In 2013 a violence intervention program was made available in our middle and high schools across the county, due to an elevated rate of violence among young males ages 10-17 within the public school system. The program is a 6-week intervention

program and had resulted in a 25% decrease in the amount of violent interactions between participants in the program over the course of 12 months. Currently, the violence interventions program has served approximately 1,100 young males.

As the regional health department, we have a very diverse staff with expertise in sexual and reproductive health that will be overseeing the program implementation. They have experience in working with diverse populations, youth included and they will offer insight about best practices and ways to make the program as effective and efficient as possible. Our staff will reach out to previous contacts (program coordinators, policy makers, community organizations, etc.) from sexual health programs that they have worked on in the past to contribute their insight by being a part of our Community Advisory Group. We will also use a County town hall meeting to gauge the interest of community members interesting in being a part of the work being done, and recruit those with valuable insight and resources to be a part of the Community Advisory Group as well.

Housed within the main HD, we have a Sexual and Reproductive Health Department that is responsible for all of the sexual and reproductive health services, education, and programming within the county. The head of our department has an MPH with a concentration in health behavior and 10 years of experience with sexual health on an individual, community, and societal level, and all others on staff within the department are Certified Health Education Specialists, 80% of whom specialize in sexual and reproductive health, bringing a diverse background of previous work experience and skills to the table. Because of this, we have the resources, people, and the infrastructure to support the implementation of this program. We also are familiar

with all of the different funding sources that offer aid specifically for teen pregnancy and STI prevention and treatment.

Due to the vast number of programs, interventions, and educational events that have been put on through our sexual and reproductive health department, we have established an extensive network with different partner organizations that contribute to our programming. We use different partners for different programs, but at the start of every new project, partner lunches are arranged in order to give our partners an overview of the new project, what the goals and objectives of the program are, and how they can be of assistance. After follow-up, different partners step up and determine what they are able to contribute. Because not everyone can always contribute, we maintain contact for future projects and programs. Holiday cards are sent out to all of our partners, and we provide informational resources that our partners are able to use for their organizations as well.

Previous partners include but are not limited to:

- Planned Parenthood of Waco
- Baylor University
- Waco Family Health Center Bells Hill Community Clinic
- South Waco Community Center
- Bledsoe-Miller Community Center
- Dewey Community Center
- 12 of the 20 independent school districts
- City of Waco
- Waco Non-Denominational Worship Center

In the past, we have partnered with these organizations to hold a multitude of events and programs for the community. Every year, we partner with Planned Parenthood to hold an HIV test drive at local supermarkets and community centers on World AIDS Day (December 1) and National HIV Testing Day (June 27). We have also worked with the surrounding community centers to host parent/child "Let's Talk About It" classes providing sexual health education to the familial pairs in a group setting, "Step 1" classes specifically for parents, teaching them how to approach the topic of safe sex with their children, contraceptive classes outlining the different contraceptive methods and their uses, and other sexual health classes and event available to the community for free or for a small fee depending on the program. We have also previously worked with the public school districts to implement a childhood obesity program as well as a violence prevention program, as mentioned in the text above.

All of the data collected from our programs is analyzed and put into a final summary of goals and results by our Health Department statistician. This information is then made into a report and presented to the lead staff on the program. An exit meeting is then held for the entire department in which the results are presented, feedback is given, and programs are tailored for future implementation.

All of our programming is made to benefit those in need of the information being provided. When working in public schools, the programs are offered to all students, regardless of race, ethnicity, gender, color, national origin, sexual orientation, disability, or religion. Our programs are age appropriate, so as long as students are within the specified age range, they are all offered access to the programming.

Partnerships and Collaboration

In order for our program implementation to be effective, we understand that partnerships with local organizations and community members are vital. Because we will be integrating program information into the public school curriculum, the academic institutions are going to be our most important partnership. Fortunately, we have implemented previous programs within the different schools districts in the county and the relationship that we have with them is strong. This will be the 12th program that has been implemented within the schools in the past five years, and the administrators and our staff are on a first name basis. All twelve school districts that we have previously worked with are on board with the program and there have already been brief discussions on the planned integration of the program into their current curriculum. Our other partners come from diverse backgrounds, but all are stakeholders and will either benefit directly from program outcomes, or have a genuine interest in the sexual health and well being of the community. The graph below indicates the seven main partners outside of our public schools that will contribute to the planned success of implementing Be Proud, Be Responsible! There are also letters of support and memorandums of understanding attached for each of these partner organizations and personnel.

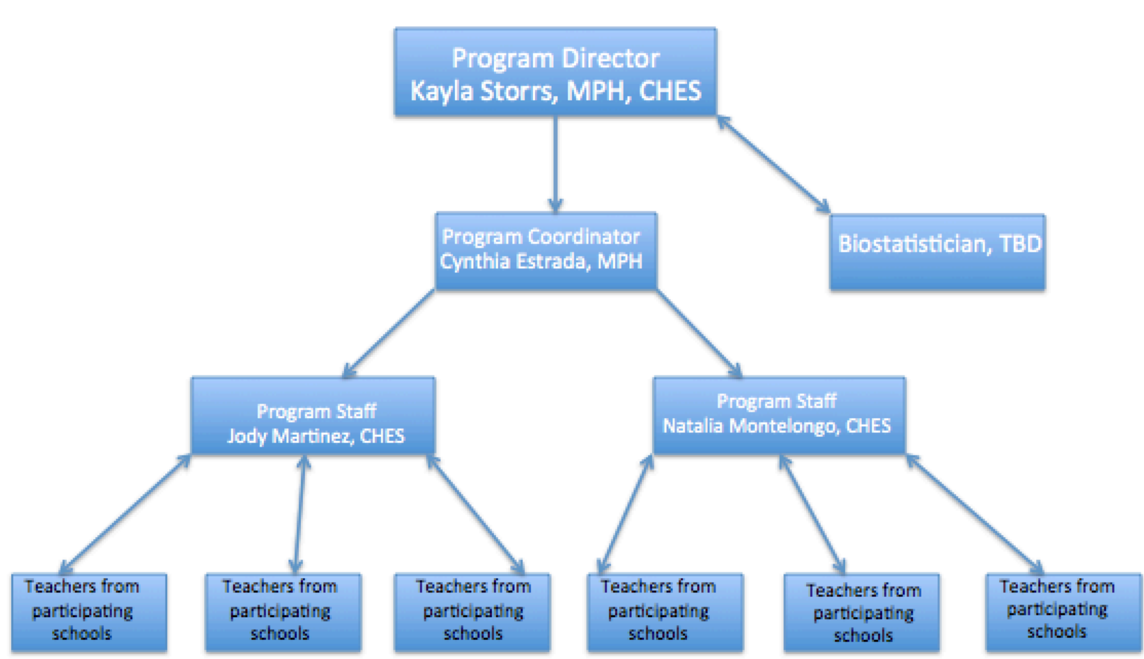
Partner	Organization Type	Partner Role
Wendy Davis	Political Advocate	Will be a voice, advocating for the program and speaking to the benefits
State Department of Health and Human Services	Governmental Organization	Will provide supplemental funding for sustainability
Planned Parenthood of Waco	Healthcare Center	Will be a linkage site, offering testing and

		services to participants in the program who may need them
Sexually Transmitted Disease Clinic	Healthcare Center	Will be a linkage site, offering testing and services to participants in the program who may need them
Waco Family Health Center Bells Hill Community Clinic	Healthcare Center	Will be a linkage site, offering testing and services to participants in the program who may need them
South Waco, Bledsoe-Miller, and Dewey Community Center	Non Profit Organizations	Will disseminate information and supplemental information about sexual health to the community
Parent Teacher Associations	Home/School Organizations	Will present a cost/benefit analysis to help rally support from parents not in PTA

Because this is an opt-out program, we are able to ensure that the largest possible number of youth will be reached. The schools have also worked with us in the past and have experience in implementing evidence based prevention programs at the public school level, and because the faculty and staff work with these youth five days a week, they have vast knowledge and experience in working with out specific target population. The curriculum will be integrated into the health courses that are required for all students, and because there are multiple health courses with multiple trained teachers, we can ensure that the largest possible number of students is reached.

Project Management

Shown below is the organizational structure of those who will be involved in the program implementation.



Because the core information will be disseminated through health education classes within the independent school districts, teachers are going to be our program facilitators, and staff within the Sexual and Reproductive department of the McLennan County Health Department will prepare documentation to secure IRB approval, manage fiscal matters, oversee the training of the teachers, and will perform the data collection and analysis, provide consultations for schools needing to tailor the program, and prepare all reports and documents to support success of the program.

Kayla Storrs MPH, CHES, is the Director of the Sexual and Reproductive Health Department at the Waco-McLennan County Health Department and a part time Sexual Health Education Specialist with Planned Parenthood of Greater Texas. She has worked with the health department for 7 years now, and has been in her current role as

director for the past 4 years. She has extensive background and experience in sexual and reproductive health, working for and providing sexual health education consultations for previous organizations like Planned Parenthood Federation of America, AIDS Volunteers of Lexington, The University of Kentucky College of Public Health, and the University of Illinois, Chicago, College of Public Health. She has provided education, resources and counseling to college students in large numbers, adults of all ages going required to take HIV/AIDS education courses as part of their drug sentences, and middle and high school students in a variety of settings including, but not limited to after school programs, community centers, religious organizations, and college student groups.

She is highly educated and knowledgeable in all things sexual and reproductive health related, and is able to disseminate information to a wide variety of high risk population groups including the LGBTQ community, injection drug users, single and teenage parents, and youth. She has previously implemented sexual health education programs across a number of populations, on an individual level with individual-centered goals and objectives, as well as group specific education. With now 17 published articles documenting the benefits of comprehensive sexual health education across a range of subpopulations, and a network of sexual health researchers and educators, national advocates for comprehensive sexual health, the former education Commissioner of the State of Texas, Michael L. Williams, the President of Planned Parenthood Federation of America, Cecile Richards, as well as the Vice President of Education, and education coordinators at affiliates across the country, community health center staff across the county, and multiple members of a number of school districts

within the county, there is no one better to head the implementation of this program within our public schools.

Ms. Storrs will serve as the Program Director, and will manage and oversee all of the activities involved in the planning and implementation of the proposed Be Proud, Be Responsible! grant. Ms. Storrs will serve as the liaison between the Health Department, the participating school districts faculty and staff included, the Program Coordinator and the two community health educators representing the health department, our community partners who will be used as linkage resources, and the Community Advocacy Group established to guide the objectives and principles of the program. She will also monitor all data collection activities; ensuring adherence to best practices and required funding requirements; and monitoring overall project progress and fiscal matters.

Cynthia Estrada, MPH, Program Coordinator, is the Manager of the Sexual Health and Reproductive Department of the McLennan County Health Department. She has been with the Health Department for 5 years, and is responsible for all of the education materials, seminars, trainings, and programs that come out of the HD. Her job duties include overseeing the construction of new education materials to be used within the county, coordinating sexual health education and inclusion seminars for schools, community centers, corporate companies, and other organizations seeking such services, and working as the in-house trainer for all of our incoming staff and conducting the mandatory annual sexual health education trainings for all staff employed at the HD. All final education materials are reviewed, edited, critiqued, and approved by Ms. Estrada before they are trademarked and used for dissemination. With an MPH concentrating in Health Communication, Ms. Estrada is trained and fully equipped to not

only education and implement health education on many levels including individual and group, but to also evaluate implementation and tailor programs to fit the needs of the population that is being served, to ensure maximum fidelity and desired results.

Ms. Estrada will serve as the Program Coordinator and will be in charge of administering the program overview for faculty and staff of the participating schools and the 8-hour curriculum training for the teachers that will be integrating the program into their curriculum, consulting for tailoring as need be, overseeing the two community health educators on the ground interacting first-hand with the teachers, and will aide in data collection, and analysis.

Jody Martinez, CHES, is a Sexual and Reproductive Health Specialist with the Waco-McLennan County Health Department. He has been with the HD for 8 years and has served in the Sexual and Reproductive Health Department for the past 3 years. Mr. Martinez is involved with all of the educational programming that has and is currently coming out of the HD and is the liaison between the local organizations offering testing, treatment, and other resources to the community and our specific department. He coordinates quarterly meetings with these organizations to evaluate the services being offered and ways the health department can collaborate with them to make sure the community has the best possible access to affordable, confidential, and effective sexual and reproductive health services. He is also involved with the carrying out of these collaborations, allowing him to form meaningful relationships with staff and stakeholders of those organizations.

Natalia Montelongo, CHES, is also a Sexual and Reproductive Health Specialist with the Waco-McLennan County Health Department. She has been with the HD for 3

years and works alongside Mr. Martinez in education dissemination efforts. She is also our community liaison, visiting community and town hall meetings, schools, community centers, health centers and primary care physicians, gauging the sexual health needs of the community and using such information to contribute to the construction of new educational materials and educational programming planning.

Jody Martinez and Natalia Montelongo, will serve as our hands in the field, working first-hand with the participating schools. They will be responsible for conducting bi-weekly classroom observations and meetings with teachers, communicating tailoring needs and fidelity conflicts to the program coordinator, and working with partner organizations to establish a smooth linkage process. They will also aide in the data collection and analysis aspect of the program implementation. Monthly meetings with the program director, program coordinator, and community health educators will allow for monitoring and tracing the progress of participating schools.

Our biostatistician will be contracted out from Baylor University and will compose all data, run statistical analysis, and compose reports and documents to support the results found through implementation of the program. Our data collection will consist of a pre-test measuring risky sexual behaviors that will be administered before the implementation of the program, a mid-program assessment administered half-way through the program, a post test to be administered upon completion of the program, and two follow-up surveys administered at the 6-month post completion point, and at the one year post completion point.

Budget

Please see appendix for budget and budget justification.

Appendix

Budget

Allocation of Funds	Year 1	Year 2	Year 3
A. Personnel	$79,338	$79,338	$79,338
B. Fringe	$11,901	$11,901	$11,901
C. Curriculum	$22,500	$45,000	$45,000
D. Travel	$864	$1,728	$1,728
E. Incentives	$8,000	$13,000	$13,000
F. CAG Meeting Lunches	$1,200	$1,200	$1,200
G. Dissemination Materials	$1,000	$1,000	$1,000
H. Conference Costs for HD Staff	$6,000	$6,000	$6,000
I. Conference Scholarships for Teachers	$9,000	$9,000	$9,000
Total	**$139,803**	**$168,167**	**$168,167**
Overall Total	**$476,137**		

Budget Justification

Kayla Storrs, MPH, CHES, Program Director- will devote 15% effort annually to executing the proposed grant. She will assume responsibility and accountability for all aspects of the project throughout the duration of the 3-year grant period and will manage and oversee all of the activities involved in the planning and implementation of the proposed Be Proud, Be Responsible! grant. She will serve as the liaison between the Waco-McLennan County Health Department, the 6 school districts participating including staff and faculty, the staff from the health department on the ground monitoring and evaluating the implementation, the surrounding health centers providing

testing and treatment as necessary for students in the program, and the Community Advocacy Group established to guide the objectives and principles of the program. She will also be responsible for supervising the Project Coordinator; monitoring all data collection activities; ensuring adherence to best practices and required funding requirements; securing IRB approval; and monitoring overall project progress and fiscal matters. She will then be held responsible for conducting/overseeing the data analysis and manuscript / policy brief / white paper preparation from the study.

$80,000 * .15 = $12,000

Fringe- $12,000 * .15 = $1,800

$13,800 * 3 = $41,400

Total: $41,400

Cynthia Estrada, MPH, Program Coordinator- will be responsible for training all department staff on the program curriculum, conducting the program overview and details meeting for the staff and administrators of our participating schools, and the training for all teachers that will be administering the program. She will oversee the tailoring of our program as need be, and will lead the team in the measurement and evaluation process, conducting pre-program data collection and ensuring the rest of the HD staff working on this program are capable and confident in conducting mid program, final, and follow-up data collection assessments. Ms. Estrada will dedicate 30% effort towards the implementation of this program.

$60,458 * .30 = $18,138

Fringe- $18,138 *.15 = $2720.70

$20,858.70 * 3 = $62,576.10

Total: $62,576.10

Jody Martinez, CHES, Program Staff - will be on the ground working with the schools and teachers, conducting the bi-weekly observations, meetings with teachers, and communicating back to Ms. Estrada if/when tailoring needs to be done or fidelity is being compromised. He will also be a part of the measurement and evaluation process, conducting the mid-program, final, and follow-up data collection assessments. Mr. Martinez will dedicate 50% efforts towards the implementation of this program.

$42,000 * .50 = $21,000

Fringe- $21,000 * .15 = $3,150

$24,150 * 3 = $72,450

Total: $72,450

Natalia Montelongo, CHES, Program Staff- will be alongside Mr. Martinez on the ground working with the schools and teachers, conducting the bi-weekly observations, meetings with teachers, and communicating back to Ms. Estrada if/when tailoring needs to be done or fidelity is being compromised. She will also be a part of the measurement and evaluation process, conducting the mid-program, final, and follow-up data collection assessments. Ms. Montelongo will dedicate 50% effort towards the implementation of this program.

$42,000 * .50 = $21,000

Fringe- $21,000 * .15 = $3,150

$24,150 * 3 = $72,450

Total: $72,450

Biostatistician, TBN, will be contracted out to an individual (to be named) from the Robbins College of Health and Human Sciences at Baylor University. TBN will work with Ms. Storrs on all aspects of analyzing the data collected from all phases of the program. TBN will assist in conducting progress and final reports of all information, indicating the impact made by the program implementation, noting trends in sexual behavior and/or lack of sexual behavior, comparing rates of risky sexual behaviors, age of sexual initiation, reported sexually transmitted infections diagnoses, and pregnancies pre-implementation and post implementation, and evaluation of the same information within our control groups. TBN will dedicate 10% efforts towards the analysis of information from the implementation of this program.

$72,000 * .10 = $7,200

Fringe- $7,200 * .15 = $1,080

$8,280 * 3 = $24,840

Total = $24,840

Program Curriculum: $500 per work kit (for 30 students), with an estimated 225 students per seventh grade group per middle school, totaling roughly 1350 students to be administered the program across the county, a total of 45 curriculum kits will be necessary for successful implementation of the program.

$22,500 * 5 = $112,500

Total: $112,500

Travel: 54 cents per mile, for staff visiting schools across the county bi-weekly, with an estimated 100 miles per week for 16 weeks. Total mileage to be reimbursed equals out to 1,600 miles.

.54 * 1,600 = $864

$864 * 5 = $4,320

Total: $4,320

Incentives: $100 paid training for all teachers administering the program, with an estimated 15 teachers.

$100 * 15 = $1,500

An additional $100 gift card will be allocated to each teacher at the end of implementation for each cohort completing the program.

$100 * 15 = $1,500

$100 * 15 * 5 = $7,500

Conference Scholarships for participating teachers to attend the National Sex Ed Conference- three will be awarded each year. All travel and lodging will be covered by the scholarship, as well as the registration fees.

$3000* 3 = $9,000

$9,000 * 3 = $27,000

Program t-shirts for students completing the program- $10 per shirt, with an estimated 500 students being administered the program every semester

$10 * 500 = $5,000

$5,000*5 = $25,000

<u>Total: $61,000</u>

Conference Costs: for HD staff- $3000 per person, with two staff members attending a year

$3,000*2 = $6000

$6,000 *3 = $18,000

<u>Total: $18,000</u>

CAG Meeting Lunches: $300 per lunch meeting with four lunch meetings per year

$300 * 4 =$1,200

$1,200 * 3 = $3,600

<u>Total: $3,600</u>

Dissemination Materials: Printing of pamphlets, newsletters, etc. for dissemination of program progress and results

$1,000 per year
$1,000 * 3 = $3,000

<u>Total: $3,000</u>

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Program: Be Proud Be Responsible! in McLennan County Texas Logic Model
Situation: Reducing Teen Pregnancy and STI Rates Through Early Youth Development

Inputs	Outputs: *Activities*	Outputs: *Outputs*	Outcomes -- Impact: *Short*	Outcomes -- Impact: *Medium*	Outcomes -- Impact: *Long*
• Funding • Staff • Partnerships-schools, parents • Equipment and needed materials • Primary and secondary data • Time	• Staff training • Instructor trainings • School visits • Focus groups • Adaptations if necessary • Data collection	• Number of participants in the program • Positive attitudes about the program, amongst parents, teachers and students • Education dissemination	• Increase in positive perception about safe sexual activities • Increased parent-student communication about sexual safety • Increased self efficacy in sexual negotiations	• Reduction in the number of sexual partners had • Increase in education about sexual health • Increase on overall communication about sexual health and safe sex practices • Increase in birth control uptake • Increase screening habits among sexually active youth • Increase in partner communication	• 15% decrease in sexually transmitted infections • 10% decrease in teen pregnancy rates • Integrate comprehensive sexual health education into routine health curriculum

Assumptions

- Program is well accepted and implemented with fidelity by teachers administrating the program

External Factors

- Time allocated in the school day for the curriculum
- Instructors bias when disseminating information

Three Year Action Plan for Be Proud, Be Reponsible! In McLennan County, Texas

Project Period Goal: Be Proud, Be Responsible! curriculum will be tailored to the semester long health class to ensure smooth implementation

Long-term Impact or Outcome: Permanent adoption of BPBR program into health class curriculum

Long-term Measure (s) of Success: Continued long term integration of BPBR into health curriculum

Annual Objective: Perform annual focus groups in order to collect feedback about best practices and potential alterations/adaptations that need to be implemented, adjusting for relevant and up to date sexual health information and science

Activities:	Team Member Responsible	Completion Date
1.1 Conduct focus groups with teachers to discuss best ways to extend the six module program into a semester long health class	Ms. Storrs and Ms. Estrada will be responsible for conducting and facilitating the focus groups, collecting information and suggestions, analyzing and interpreting qualitative findings and subsequently tailoring the program to reflect those suggestions.	This activity will be completed by January 1, 2017
1.2 Pilot the newly adapted program into a one semester class	Teachers from one of the participating schools will administer the pilot program with their students.	This activity will be completed by June 1, 2017
1.3 Upon completion of the pilot program, a project summary will be conducted in order to make final tailoring adjustments as advised by teacher and student feedback.	Ms. Estrada, with the help of the teachers, will be responsible for final tailoring and adjustments before live implementation.	This activity will be completed by July 1, 2017.

Project Period Goal: Administer BPBR curriculum to 1,000 students during the first year (two semesters) of program implementation

Long-term Impact or Outcome: Increase in knowledge of safe and health conscious decisions regarding sexual activity, and an increase in actual health conscious sexual behaviors amongst all program participants. Additionally, among those students having already engaged in sexual activities, we hope to see a decrease in risky sexual behaviors.

Long-term Measure (s) of Success: Later age of sexual initiation, decrease in rate of teen pregnancy, and decrease in diagnoses of sexually transmitted infections

Annual Objective: Bi-annual analysis of number of participants administered and successfully completed the program

Activities:	**Team Member Responsible**	**Completion Date**
1.1 Collect pre-test data from students, measuring sexual perceptions, sexual initiation, and risky sexual behaviors*	Mr. Martinez and Ms. Montelongo will visit participating schools to administer pre-test data collection for those receiving the program. They will so visit control schools to collect pre-test data for those not receiving the program.	This activity will be completed no later than August 31st, 2017.
1.2 Trained teachers begin administration of BPBR program in Fall health class curriculum*	Teachers administering the program will teach the program to students throughout the semester as part of their existing health class.	This activity will be completed by December 20, 2017.
1.3 Fidelity to the program will be monitored through bi-weekly observations, to ensure the proper implementation of program curriculum*	Mr. Martinez and Ms. Montelongo will conduct bi-weekly observations and check-in meetings with teachers to ensure fidelity.	This activity is ongoing throughout the school semester and will be repeated in subsequent semesters of program implementation.

1.4 Post-test data will be collected from students upon completion of the program in order to analyze effectiveness of BPBR on sexual health perceptions and behaviors	Mr. Martinez and Ms. Montelongo will visit schools to collect data after program implementation from both those receiving the program, and our control schools not receiving it	This activity will be completed no later than June 1, 2017.
1.5 – Convene Community Advisory Group to keep up to date with results	Ms. Storrs and Ms. Estrada will conduct quarterly lunch meetings with the CAG to keep interest and investment in the continued program implementation	

***This activity will be repeated every semester**

Project Period Goal: Integrate curriculum into routine health classes to ensure sustainability after completion of grant-funded program		
Long-term Impact or Outcome: Increase capacity of teachers to teach sexual health education in an existing health curriculum and create a culture of positive sexual health education within schools		
Long-term Measure (s) of Success: sustainability of the program after grant funded portion of the program has ended and continued implementation after 5 years		
Annual Objective. Annual check-in meetings with schools to evaluate continued implementation		
Activities:	**Team Member Responsible**	**Completion Date**
1.1 Convene CAG to review progress and discuss ways to ensure sustainability.	Ms. Storrs and Ms. Estrada will conduct quarterly lunch meetings with the CAG to presents obstacles encountered, results of implementation, and gear supporters in the directions of continued program implementation	This activity will be ongoing throughout the three-year grant funded program dates.

1.2 Using process and outcome evaluation results, make additional refinements and adjustments as needed to support continued implementation	Ms. Estrada, with the help of Mr. Martinez and Ms. Montelongo, will analyze evaluation information to make any adjustments that may need to be made to the program curriculum to ensure teachers are equipped with up-to-date information for successful program continuation.	This activity will be completed no later than 3 months before grant funded program completion
1.3 Engage in dissemination activities including but not limited to conference presentations, peer-reviewed manuscript, and white paper construction	Ms. Storrs will be responsible to compiling all relevant information into an evidence-based manuscript, submitting to a peer-reviewed journal of public health, and presenting findings at the APHA conference and other regional and/or national conferences.	This activity will be ongoing throughout the last year of grant funded program completion
1.4 Present findings to Texas Board of Education and/or other policy makers to push for widespread implementation among Texas schools	Ms. Storrs will be responsible for presenting results to the Texas Board of Education in an attempt to support the push for comprehensive sexual health education	This activity will be completed no later than 3 months before grant funded program completion