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Community Prevention Plan for the Reduction of Sexually Transmitted Infections in Bastrop County, Texas

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Prevention, Consultation, and Advocacy

**Community Prevention Plan for the Reduction of Sexually Transmitted Infections in
Bastrop County, Texas**

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OVERVIEW

Keywords: Sexually Transmitted Infections (STIs), STI Incidence and Prevalence, STI Prevention, Bastrop County, Texas

[Community Prevention Plan for the Reduction of Sexually Transmitted Infections in Bastrop County, Texas]

Goal Statement:

My goal is to increase community awareness of sexually transmitted infections (STI), increase community STI knowledge, and to identify a plan to reduce STI transmission through the use of prophylactic measures.

Significant Findings:

Sexually transmitted infections include infectious pathogens of bacterial, viral, or parasitic origin that are transmitted through anal, oral, and vaginal sexual contact. In the United States, from 2014-2018 there was a significant increase in reported STIs, nationwide. Within this time frame, there was a 19% increase in chlamydia cases, 63% in gonorrhea cases, and 71% in both primary and secondary stage syphilis cases (CDC, 2018). The significant increase in these three ubiquitous STIs of bacterial origin demonstrates a clear deficit in the utility of present STI educational and prevention programs. An increase in these relatively common STIs may also indicate a lockstep increase in other STIs. All sexually active individuals are at risk when it comes to the transmissibility of these infections. Alcohol and drug abuse, multiple concurrent sexual partners, and aversion to condom use and STI testing all confer an increased risk for STIs (Murali & Jayaraman, 2018; Lewis et al., 2020). Of those individuals sexually active, young

adults and adolescents represent the most at-risk group in the United States. Concerning all STIs, individuals aged 15-24 comprise more than half of the 20 million new STI cases each year in the United States (Saldanha, 2020). From the STI cases reported in Texas in 2019, 93,136 out of the total 145,874 cases were documented from individuals within the 15-24 age range (TDSHS, 2020). With this at risk population in mind, reformation of STI educational programs to include behavioral focused interventions may prove effective in reducing both STI incidence and prevalence.

Objectives/Strategies/Interventions/Next Steps:

For helping professionals, including but not limited to social workers, counselors, nurses, and physicians, behavioral focused psychoeducational STI programs appear to be the most effective intervention paradigms for reducing STI risk-associated behaviors and increasing use of effective preventative measures. The Health Belief Model (HBM) presents as a useful theory of prevention for identifying and reframing individual beliefs that dissuade people from utilizing and maintaining STI related preventative behaviors (NCI, 2005). Beliefs modulate how people perceive the risk and severity of STIs and the financial and social costs of both seeking treatment and maintaining preventative behaviors. Effective prevention must include concerted efforts at the community, institutional, and public policy levels. At the community level, psychoeducational programs are key. Training of respected community leaders in STI preventative practices, sexual health knowledge, and the effective delivery of information, as described in Young et al. (2011), will prove effective for bolstering community empowerment and disseminating risk-aversion practices. At the institutional level, psychoeducation programs in public school systems that emphasize prophylactic practices such as effective condom use, present as a useful tool for reducing risky behaviors and increasing safe sex practices. The *Be*

Proud! Be Responsible! program created by Jemmott et al. (1992) serves as a model for such interventions. At the public policy level there must be a redressment of policies such as Section 510 of Title V of the Social Security Act of 1996 that allocate funding only to those schools that teach abstinence-only-before-marriage curriculum (Jeffries et al., 2010). Such policies should be amended to include the preventative efficacy of condom usage in the reduction of STIs.

Knowledge of effective preventative practices and practical sexual health management will prove to be the most effective bulwark against the perceived barriers to STI prevention and treatment. The equitable dissemination of this information amongst the general public and at risk populations is the key to ameliorating the rising STI epidemic in the United States.

INTRODUCTION

[Community Prevention Plan for the Reduction of Sexually Transmitted Infections in Bastrop County, Texas]

Sexually transmitted infections (STIs) most commonly concern the transmission of bacteria, viruses, and parasitic pathogens through anal, oral, and vaginal sexual contact. The three most ubiquitous STIs in the United States are caused by the transmission of bacterial organisms, which foremost include chlamydia, gonorrhea, and syphilis (Kreisel et al., 2018; Seiler et al., 2020). Each of these three bacterial STIs are readily treatable with single-dose antibiotics, yet they often go undiagnosed due to asymptomatic cases, unavailable access to diagnostic, treatment, and prevention resources, and STI-related stigma (NASEM, 2021; Patricia et al., 2021). According to Feldstein Ewing and Bryan (2020), the reported rates of STIs declined in the latter half of the 20th century and reached a record low from 2001 to 2009. This significant reduction of diagnosed and reported STIs consequentially resulted in a reduction of federal and

state funding of STI behavioral prevention programs (CDC, 2018). This reduced funding in response to reduced STI incidence set the stage for a potential STI epidemic across the United States. This epidemic appears to have arrived in the surveilled years ranging from 2014 to 2018, where all three of the aforementioned primary bacterial STIs saw a significant increase in incidence, with a 19% increase in chlamydia cases, a 63% increase in gonorrhea cases, and a 71% increase in primary and secondary stage syphilis cases (CDC, 2018). In response to this epidemic, communities across the United States will likely benefit from behavioral focused preventions that increase awareness of the current STI epidemic and promote safe-sex practices that can be used to avoid STI transmission. My community of Bastrop County, in the state of Texas, is one such community that could benefit from an educational, targeted, STI prevention plan.

PART 1: SCOPE AND CONSEQUENCES

[Community Prevention Plan for the Reduction of Sexually Transmitted Infections in Bastrop County, Texas]

The national rise of STI prevalence and incidence has disproportionately affected rural communities that lack available access to diagnostic, treatment, and prevention resources. The state of Texas' Bastrop County is just one such community prone to such sensitive national increases in STI transmission. In 2007, Bastrop County cases of chlamydia were reported at 234 cases per 100,000 people, much fewer than the national and state reported cases, at that time (CHR&R, 2018). This record low level of cases for Bastrop County, reflects the national low STI prevalence as described by Feldstein Erwing and Bryan (2020). By 2018, however, the reported cases of chlamydia in Bastrop County more than quadrupled, with a reported 973.3 cases per 100,000 people (CHR&R, 2018). In comparison, Texas' reported cases in 2007 were 365 per

100,000 people, which increased to 518 per 100,000 people in 2018 (CHR&R, 2018). Likewise, the national increase in chlamydia cases was less significant than that of Bastrop County, with 370 cases per 100,000 people in 2007 and 540 cases per 100,000 in 2018 (CHR&R, 2018). This marked increase in the prevalence of chlamydia across the United States, significantly so in Bastrop County, represents an increased need for access to diagnostic, treatment, and prevention resources.

The allocation of available resources dedicated to prevention of STIs will serve as a potentially useful and effective intervention for reducing the community burden of STI cases. Prevention will be most effective in Bastrop if it can promote sex-positivity instead of promoting the STI related stigma that drives individuals away from seeking treatment and preventative aid from healthcare professionals. The stigma associated with STIs and sex in our predominantly rural community results in the creation of a growing invisible population afflicted with completely curable diseases. The subsequent promulgation of these STIs places a significant burden on the mental health and physical health of those infected. An individual's internalized cultural values associated with sex can result in a cycle of anxiety and depression associated with their infection, and how others, including healthcare professionals, might judge them. Furthermore, if these STIs are left untreated, they can result in serious bodily harm, affecting not only physical health, but one's ability to financially provide for themselves and their dependents. My goal is to increase community awareness of STI transmission, increase community STI knowledge, and to identify a plan to reduce STI transmission through the use of prophylactic measures.

PART 2: SOCIAL-ECOLOGICAL MODEL

[Community Prevention Plan for the Reduction of Sexually Transmitted Infections in Bastrop County, Texas]

The social-ecological model proposed by the CDC (n.d.) serves as an integral method for conceptualizing a prevention plan for STIs through analysis of both risk and protective factors at the individual level, the relationship level, the community level, and the societal level. The risk and protective factors delineated at each of these four levels indicates those factors that either increase risk of acquiring an STI or reduce the risk of acquiring an STI.

Individual

This level of the social-ecological model, as it pertains to STIs, includes personal and biological risk factors that increase the likelihood of acquiring an infection through sexual activity, and personal protective factors that reduce the likelihood of acquiring an infection through sexual activity (CDC, n.d.).

Risk Factors

Individual risk factors that may increase the likelihood of acquiring an STI include drug and alcohol abuse, loss of fertility, avoidance of condom use, low self-esteem, and mental health distress. Drug and alcohol abuse are a common risk factor that increase an individual's likelihood for contracting STIs. The abuse of drugs and alcohol typically signals other comorbid factors at higher levels in the social-ecological model that may increase STI risk, such as social deprivation, poor access to healthcare, and sexual activity with multiple partners (Murali & Jayaraman, 2018). While often a symptom of other related risk factors, drug and alcohol abuse can affect cognition, decision making, emotional control, and libido. The use of alcohol, crack-cocaine, and methamphetamine are specifically associated with decreased inhibitions, increased

libido, and elevated mood or euphoria, all of which increase one's proclivity for sexual activity at the cost of active risk assessment (Murali & Jayaraman, 2018). The loss of fertility in both men and women, due to such factors as menopause and sterilization, also results in a reduction of safe-sex practices (Lewis et al., 2020). This reduction in potential risk of pregnancy, associated with the loss of fertility, results in a perceived safety associated with sexual activity. This perceived safety leads to a decreased use of protective implements such as condoms that may otherwise aid in preventing the transmission of sexually acquired infections (Lewis et al., 2020). The use of oral contraceptives and intrauterine devices (IUDs) may also result in a similar increased perception of safety that predisposes individuals to engage in unprotected sex thereby increasing the risk of acquiring STIs. Furthermore, negative perceptions towards condoms present as another barrier towards STI prevention. Negative perceptions such as the belief that condoms reduce sexual pleasure, or that condoms are only for young people, promote the misuse or avoidance of condom usage (DiClemente et al., 2005; Lewis et al., 2020). Individuals that have low self-esteem and mental health distress also present at a higher risk for engaging in STI-related behavior (DiClemente et al., 2005).

Protective Factors

Individual protective factors that may reduce the likelihood of contracting an STI include abstinence, interaction with healthcare services, and condom/dental dam use. Abstinence is perhaps the only certifiable method of protecting against the risk of contracting and transmitting STIs. Both the CDC (2018) and the Mayo Clinic (2019) advocate for abstinence as a method for protecting oneself from STIs. Perception of healthcare services and active interaction with these services may also protect an individual from STIs. Active screening for STIs and adherence to educational practices advised by healthcare professionals decreases the likelihood of transmitting

or acquiring STIs. Prophylactic vaccinations through healthcare services are also effective at preventing against certain types of STIs, such as HPV (Mayo Clinic, 2019). Beyond abstinence, the correct utilization of preventative items such as condoms and dental dams, are the most effective methods for protecting oneself from acquiring or transmitting most STIs. These items are effective at preventing bacterial STIs but are ineffective at preventing the transmission of some viral STIs, such as HPV and herpes (Mayo Clinic, 2019). Individuals that feel confident in using condoms, confident in negotiating condom use with partners, and comfortable in discussing past sexual history with partners tend to present with lower rates of STIs (DiClemente et al., 2005). Knowledge of preventative measures is therefore not enough to confer protection from STI risk, alone. Individual perception and confidence associated with condom use play an impactful role in the effective prevention of STIs.

Relationships

This level of the social-ecological model pertains to the close relationships in an individual's life that may affect their interaction with STIs (CDC, n.d.). Relationships with friends, family and intimate partners may either increase the risk of acquiring an STI or act as preventative measures that reduce the risk of acquiring an STI.

Risk Factors

Relationship associated risk factors may include sexual activity with multiple partners, perception of a partner's sexual history, and social isolation. Perhaps the greatest risk factor associated with relationships, concerns sexual contact with multiple concurrent partners. Polyamorous relationships or those that emphasize casual sex, may increase one's exposure to STIs through the increased number of sexual contact with others (Murali & Jayaraman, 2018).

The CDC (2018) recommends that individuals reduce their active number of sexual partners, to subsequently reduce the risk of acquiring STIs. An individual's perception of their partners sexual history may also lead to an increased risk for STIs. Individuals who view themselves as being at a low risk for STIs typically also view their partners as low risk (Lewis et al., 2020). This perception of safety neglects the sexual history of new and long-term partners alike. The avoidance of testing or inquiry into a partner's sexual activity naturally predisposes people to an increased risk for STIs. Social isolation presents as another factor that increases risk for STIs. Isolation from friends and family can weaken an individual's resiliency through reduced social support and interaction with others. This type of isolation can predispose people to emotionally vulnerable states that lead to an increase in partner turnover, money-for-sex relationships, and casual sex acquaintances, all of which contribute to STI risk (Lewis et al., 2020).

Protective Factors

Relationship factors that protect against STIs may include mutual monogamy, commitment to mutual testing, adequate social stimulation, and the belief that contraception is a mutual responsibility. The CDC (2018) recommends both mutual monogamy and mutual testing as preventative measures that reduce the risk for contracting STIs. Mutual monogamy refers to the agreement between two partners to remain monogamous with each other in their sexual activity. Monogamy negates the STI risk associated with multiple partners, as an individual in a monogamous relationship need only concern themselves with the sexual health of one individual other than themselves. The commitment to mutual testing before engaging in sexual activity with a new partner also reduces the risk of contracting an STI. Many individuals with STIs may present with no symptoms, therefore it is essential to commit to testing for both oneself and any potential partners, to confirm sexual wellness before initiating sexual contact for the first time.

Regular testing may serve as a protective factor for those individuals with multiple concurrent sexual partners. As Lewis et al. (2020) indicates, social support serves as an integral factor in influencing one's sexual risk-taking behavior. The maintenance of healthy social relationships with friends, family, and peers that provide social stimulation and emotional support, may reduce the sexual risk-taking behavior associated with isolation. Other relationship protective factors include openness and willingness to talk about sexual history, condom use, and mutual responsibility for contraception (DiClemente et al., 2005).

Community

This level of the social-ecological model pertains to the settings in which social relationships occur and how those settings either predispose an individual to an increased risk of acquiring STIs, or how they aid in preventing the spread of STIs. The social settings that comprise this level include areas such as schools, workplaces, and neighborhoods (CDC, n.d.).

Risk Factors

Risk factors associated with this level may include inadequate access to sexual health services and sexual education programs that focus solely on abstinence. Sexual health services such as STI clinics and family planning programs both aid in reducing the transmission of STIs (Shlay et al., 2013). Rural communities and areas of socioeconomic disparity may have reduced access to these clinics. Those few clinics that may be accessible to these populations are likely to be overcrowded, understaffed, and lack the medical capability to address the STI burden of particularly high-prevalence communities. This barrier to healthcare access, in turn, increases the likelihood of STI transmission, especially in the case of asymptomatic individuals who may not

know they are infected. On the other hand, some sexual educational programs may also increase a community's STI burden. Community sexual education programs that focus solely on abstinence present as an STI risk factor, as they supply people with little knowledge of sexual health, STIs, and preventative measures (Seiler-Ramadas et al, 2021).

Protective Factors

Protective factors associated with this level may include the integration of family planning services with STI clinics and the implementation of comprehensive sex education programs. The integration of family planning services with STI clinics may be effective in reducing the STI burden of a community by offering combined services that are cost-effective and tailored to the needs of at-risk individuals (Shlay et al., 2013). In coordination with STI testing and treatment, family planning services also provides individuals at-risk with preconception counseling, contraceptive counseling, and pregnancy prevention counseling (Shlay et al., 2013). The addition of family planning services to standard STI clinics may serve as a sexual wellness educational bulwark against the transmission of STIs. Outside of the clinic, community driven sexual educational programs that focus on STI knowledge, healthy relationships, and communication may serve to reduce community STI transmission (Seiler-Ramadas et al., 2021).

Societal

This level of the social-ecological model concerns those broad factors that influence the spread of STIs in a society (CDC, n.d.). These broad factors may include government policies as they relate to healthcare, economic, educational, and social conditions, along with the predominant cultural norms of a society.

Risk Factors

A primary risk factor associated with this level pertains to the social stigma associated with STIs, the cultural perception of sex, and media and entertainment exposure unprotected intercourse. According to Garcia et al. (2021), modern medicine's ability to effectively treat STIs is outweighed by the deeply ingrained social stigma against STIs. This stigma against STIs avoidance of healthcare treatment and sexual health communication avoidance between partners, both of which lead to an increase STI transmission. The cultural perception of STIs and casual sex in the United States deters afflicted people from actively maintaining their sexual health, due to fear of discrimination, marginalization, and hostility from healthcare professionals (Garcia et al., 2021). Media and entertainment presentation of STI and STI prevention also plays a significant role in predisposing individuals towards STI risk. Scenes in music videos, movies, and pornography that depict unprotected intercourse model risky behaviors while promoting the perception that protective measures are unnecessary or undesirable (DiClemente et al., 2005). Exposure to this kind of media and entertainment may unconsciously promote risk-taking behavior in adults and implicitly encourage adolescents to disregard protective measures.

Protective Factors

A primary protective factor at this level includes the implementation of federal and state policies that promote family planning and STI health related services. These services present as the primary institutional bulwark against the spread of STIs. They aid in identifying and treating symptomatic cases, while also providing educational services to those population that are at-risk. Increased availability of these services across the nation will likely aid in reducing the nation-wide STI burden. The Affordable Care Act (ACA) represents a federal policy-level protective factor, against the spread of STIs. The ACA acts as a protective factor, as it has increased access

to healthcare services and family planning services for those with Medicaid coverage (Montgomery et al., 2017).

PART 3: THEORIES OF PREVENTION

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Theories of prevention provide different frameworks for understanding how people make health related decisions and identifying intrinsic and extrinsic factors that affect behavior, attitude, and perception of health conditions. The social-ecological theory represents one such framework for identifying factors that affect the probability of acquiring a disease and classifying how those factors operate at the individual, relational, and communal levels. The factors that protect people from disease and the factors that increase the risk of disease, at each level of the social-ecological model, provide areas of concentration where further theories of prevention may be utilized to explain health decisions. The interconnectedness of each level of the social-ecological theory ensures that the interventions applied at one level reciprocally affect the other levels of the model. The salience of the impact of these interventions across levels may differ in effectiveness based on the theoretical model used and the health task in question. Matching the correct theory to the health task at hand is therefore essential in implementing an effective prevention plan.

The Health Belief Model

The Health Belief Model (HBM) presents as an effective theory for identifying and understanding the factors that impact individual probability of acquiring and spreading sexually transmitted infections. This model focuses specifically on the individual level of the

socioecological perspective of health and posits that health is influenced by an individual's beliefs associated with the health task at hand. The HBM outlines six constructs that influence people's beliefs and their health decision making process. These constructs include perceived susceptibility to the condition, perceived severity of the condition, perceived benefits in taking action to avoid the condition, perceived barriers towards acting, factors that prompt action, and self-efficacy to maintain action (NCI, 2005). By breaking down an individual's health decision making process into these six categories, the HBM provides an effective method of conceptualizing the risk and protective factors that may lead to the transmission of sexually acquired infections.

The HBM suggests that people will engage in the prevention of STIs if they believe they are at an undesirable degree of risk for acquiring an STI that is severe enough to warrant medical intervention, and if the perceived benefits of prevention are greater than the perceived financial, individual, and social costs of taking prevention. The beliefs and perceptions of people, therefore, play an important role in health promotion and prevention of STIs. The perceptions of individuals towards STIs, their susceptibility, their severity, and the benefits of preventing them, impact behavior associated with condom use and STI testing (Huang et al., 2020; Neuberger & Pabian, 2019). Both condom usage and STI testing are primary prophylactic methods for preventing the spread of STIs (CDC, 2018). Focusing on these aspects through the conceptual lens of the HBM will aid in better understanding factors that motivate action towards prevention and avoidance of preventative actions.

A study conducted by Huang et al. (2020), utilized the HBM to classify the psychological factors that promote or prevent the use of condoms among Chinese men-who-have-sex-with-men (MSM). This study outlined the perceived threats of STIs, perceived benefits of condom use,

perceived barriers toward condom use, self-efficacy towards condom use, and cues to action from a surveyed population of 313 men who had anal sex with regular partners and 429 men who had anal sex with non-regular partners. Of this population, 57.8% of men who had anal sex with a regular partner, and 73.4% of men who had anal sex with a non-regular partner, acknowledged the risk of developing AIDS from HIV, if they engaged in condomless sex within the next six months (Huang et al., 2020). Perceived benefits of condom use, agreed upon by greater than 50% of the surveyed population, include the belief that condoms reduce risk of infection by HIV and other STIs, and the belief that condom use would make them feel at ease and reduce regret (Huang et al., 2020). Less than 40% of both groups agreed with the barriers to condom use, such as the belief that condoms would reduce sexual pleasure, or that condom use would damage their intimate relationship (Huang et al., 2020). Greater than 60% of both groups identified that they were confident in their self-efficacy to use condoms consistently during anal sex, confident in persuading partners to use condoms, and that they were confident in refusing to have condomless intercourse (Huang et al., 2020). Furthermore, greater than 80% of both groups believed that their prompt to action came from people around them that remind them to use condoms, and that condoms are not just for contraception, but also protection (Huang et al., 2020).

A study conducted by Neuberger and Pabian (2019) produced a similar survey centered on the motivations for STI testing in a college-age population at the University of North Florida. This study applied the HBM to categorize the underlying beliefs that affect completion of STI testing. They surveyed 389 individuals ranging in age from 18-44, split into those who presented to STI testing (n=124) and those who did not present to STI testing (n=265). In this study, Neuberger and Pabian (2019) found that those who presented to STI testing had more positive attitudes towards testing than non-presenters, that those who had previous STI tests were more

likely to engage in testing in the future, and that people generally presented to testing because they regularly received checkups, believed testing was a good idea, or had recently engaged in risky sexual activity. The common barriers towards testing in this population were found to be cost concerns, scheduling, transportation issues, and the potentiality of parents finding out (Neuberger and Pabian, 2019).

The studies conducted by Huang et al. (2020) and Neuberger and Pabian (2019) address common health beliefs associated with condom use and STI testing, respectively, in two highly specific populations. The populations in each case may not directly reflect the broad demographics of my community, yet the health beliefs identified in both may prove as effective targets in the construction of a tailored prevention program. The barriers presented from both cases for avoiding preventative measures represent common areas of concern that can be targeted by evidence-based programs focused on psychoeducation and behavioral health counseling interventions. Likewise, factors that promote engagement in preventative measures represent areas of positive reinforcement for targeted evidenced-based programs.

Evidence Based Program

Evidence based programs are programs that have demonstrated, through peer-reviewed clinical trials, to be effective in their specific function and purpose. The behavioral health program *Be Proud! Be Responsible!* is an applicable evidence-based tool for providing educational knowledge of STIs, knowledge of preventative techniques, and for reducing risk-associated behaviors (Jemmott et al., 1992). This interventional program has a wide demographic application and can be used in community settings, outpatient clinics, and schools. The original *Be Proud! Be Responsible!* study sample primarily included heterosexual, black, male, adolescents in Philadelphia, Pennsylvania. Application of *Be Proud! Be Responsible!* in

Philadelphia resulted in a significant reduction in risky sex, number of sex partners, unprotected sex, anal sex, and increased condom use, with a 3% attrition rate at three months (Jemmot et al., 1992).

With the success of this program in mind, I believe that it can be molded to suit the needs of my community, and effectively aid in preventing STI transmission. This program has proven specifically useful for decreasing those behavioral factors that present as barriers to action by engaging participants with knowledge concerning the risk and severity of infection with HIV and other STIs. This program therefore fits well within the HBM conceptualization of STI prevention, with its focus on increasing preventative behaviors at the intrapersonal and interpersonal levels. In my community, this program could be utilized on a rotating basis in schools, clinics, and other community settings. Community leaders would be educated in the supportive program evidence and program function. They would also be taught and how to facilitate each of the six 50-minute modules of the program, using exercises, games, group discussions, lectures, practice, and role-play, as outlined by Jemmot et al. (1996).

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

[Community Prevention Plan for the Reduction of Sexually Transmitted Infections in Bastrop County, Texas]

The Health Belief Model (HBM) is a useful application for understanding those intrinsic factors that people utilize in their interaction with healthcare decisions which either confer risk to disease or confer protection from disease. The HBM is naturally useful in identifying how people interact with healthcare decisions, in this case, interaction with the prevention of STIs through condom use and STI testing. Beliefs and perceptions about disease are motivated by cognitions

extrapolated from observations and experiences, which ultimately shape an individual's action. While effective, this narrow approach to sexual health does not adequately approach the disproportionate incidence of STIs amongst ethnicity and age. Beliefs may shape action, yet there are certain socioecological factors that confer risk to populations that inherently operate from an external locus of control. This prevention plan is directed towards addressing the collective STI burden on my community across all socioeconomic statuses, ethnicities, and age groups. In the construction of such an inclusive program, it is important to consider initiative efforts that address the most community stakeholders as possible. A wide-reaching approach is useful but ineffective if utilized alone. In the case of STIs, adolescents and young adults ages 15-24 have a much greater incidence in infections than all other age ranges (TDSHS, 2020). This incidence of STIs is increased for adolescents across majority and minority ethnicities alike (TDSHS, 2020). A well-rounded STI prevention plan must therefore generate mechanisms for addressing this sub-population specifically with targeted and relevant initiatives.

Disproportionate Presentation in Adolescents

In the current United States STI epidemic, adolescents, and young adults ages 15-24 are disproportionately at risk for contracting STIs, in comparison to all other age groups (Saldanha, 2020). Furthermore, approximately 25% of all new cases of HIV in the United States each year, occur in people aged 13-24 (Cordova et al., 2018). From Texas STI surveillance data alone, people aged 15-24 represent the most effected community at risk for acquiring an STI.

According to the Texas Department of State Health Services (2020) people in this range made up for 93,168 cases out of a total of 145,229 cases in 2017 and 93,136 cases out of a total of 145,874 total cases in 2018. This representation is also matched nationwide, with people aged 15-24 comprising over half of the 20 million new cases of STIs diagnosed each year in the

United States (Saldanha, 2020). With these data in mind, there must be environmental, cultural, psychological, and social factors that predispose this population to a greater STI risk than other groups. Indeed, individuals aged 15-24 face several factors at the individual, family, community, and societal levels of the socioecological model that confer risk (DiClemente et al., 2005). Analysis of the risk factors at these levels will aid in generating relevant prevention mechanisms for increasing cultural relevance for this age group.

Mechanisms to Increase Cultural Relevance

Characteristics at the community and society level of the social-ecological model must be analyzed to increase cultural relevance and prevention salience amongst individuals aged 15-24. At the community level, factors such as peer relationships, involvement in social organizations, and social capital affect adolescents' risk of acquiring an STI (DiClemente et al., 2005). Peer pressure is a major contributor in increasing the risk of STIs while involvement in organizations and greater social capital derived from trusting, cooperative, and reciprocal social relationships prove to reduce STI risk (DiClemente et al., 2005). At the societal level, media presentation of unprotected sex predisposes adolescents to a greater STI risk, while cultural perception of figures in authority positions as judgmental, such as physicians, results in an unwillingness to seek healthcare services and sexual education (DiClemente et al., 2005; Cordova et al., 2018).

Just as the Health Belief Model must be utilized to better conceptualize the thoughts and perceptions that affect interaction with STI prevention, cultural considerations directed at people aged 15-24 must be included in this prevention effort to increase the salience of prevention across the cumulative population of Bastrop County. According to SAMSHA (n.d.) two ways to make initiatives more culturally relevant are to request individuals of the targeted population to serve on the working group and to enlist champions from the community. At the community

level, one way to make this program more culturally relevant, would be to run a specialized prevention education program to local school staff. The school staff may then recruit interested students to serve as community ambassadors. At the societal level, one way to make this more culturally relevant would be to acquire advertising space on content created by media icons on YouTube and Twitch, whose audiences primarily include individuals aged 15-24. Such advertisements would provide essential STI statistics regarding incidence in this age group. The advertisements themselves would hotlink to the intervention website where evidence based preventative information would be provided in an easy to digest manner. Media exposure on this level will further aid in disseminating prevention practices.

Core Ethical Considerations

As counseling pertains to the construction and implementation of this prevention plan, two ethical concerns must be addressed, namely the acquisition of informed consent and the avoidance of imposing personal values on to subsequent clients. According to A.2.a of the ACA Code of Ethics (2014), the client must have detailed information of the counseling process, boundaries of practice, how their information may be used, and how mandated reporting impacts the counseling relationship. In a school or community setting where the counselor may be hosting a psychoeducational group, the acquisition of secure informed consent may be more difficult. This must be addressed by adequately outlining this aspect of the counseling process regardless of the community setting the prevention program is utilized in. Furthermore, some individuals may be unable to give informed consent due to age. Adequate measures must be taken to acquire parental consent in such cases. Another ethical concern that must be addressed is the exclusion of the counselor's personal values related to sex and sexual education. According to code A.4.b (ACA, 2014) counselors must ensure that their values, attitudes, beliefs, and

behaviors are not imposed on the client, especially when they are inconsistent with the client's goals. In this case, the counselor must understand how their own values and perceptions interact with this prevention plan and approach the program in a manner that excludes the imposition of those potentially discordant values.

PART 5: ADVOCACY

[Community Prevention Plan for the Reduction of Sexually Transmitted Infections in Bastrop County, Texas]

The topic of sexually transmitted infections and their prevention remains a far reaching epidemiological and public health issue that extends beyond the application of individual or small-group counseling initiatives. Interventional models such as the *Be Proud! Be Responsible!* evidence-based program have proven useful for increasing sexual-health knowledge, increasing safe-sex practices, and reducing risk-associated behaviors that promote unprotected sex, especially in adolescents (Jemmot & Jemmot, 1996). Programs such as this are useful and effective for instilling knowledge of sexual health and connecting individuals with medical and psychosocial resources to increase the salience of effective, integrated, health practices. Psychoeducational programs, in this vein, benefit from utilizing the Health Belief Model axiom of projecting the benefits of prevention as outweighing the costs of infection. By their nature however, these psychoeducational programs operate most effectively on the interpersonal and intrapersonal levels of the social-ecological model. The factors that have created and promoted an environment conducive to the emergent STI epidemic extend beyond the interpersonal and intrapersonal levels, and are systemically encouraged through factors at the community, institutional, and public policy levels of the social-ecological model.

The application of the social-ecological model to the prevention of STI transmission demonstrates that there are risk and protective factors at each level that respectively either increase or decrease the probability of contracting an STI. These risk and protective factors represent areas at the community, institutional, and public policy levels that present as barriers to prevention and as focus points for advocacy efforts.

Barriers

In the context of STI prevention, barriers can be considered as those factors that limit the efficacy of preventative initiatives to reduce risk probability of acquiring or spreading STIs. Barriers serve a similar ontological threat to preventative efforts as the risk factors that predispose people towards sexually transmitted infections. In contrast to risk factors, however, barriers to prevention represent ingrained psychosocial and sociopolitical constructs that hamper the effectiveness of positive change. These barriers, particularly at the community, institutional, and public policy level, shape the ways in which individuals interact with sexual health.

Community Level

Barriers at the community level of intervention include social stigma associated with STIs and the lack of adequate access to healthcare resources (Amenta et al., 2021; Watkins & Lee, 2014). Community social stigma extends far beyond the individual's negative perceptions and cognitions of STI prevention. Rather, these individual perceptions merge in a contributive fashion to the community perception of STIs, STI treatment, and STI prevention. This transition from the individual to the collective whole of a community serves to intensify the cumulative effect of those negative perception thereby increasing the barrier to care for those individuals that desire to seek treatment. This fear of social stigma and ostracization is especially present in rural

communities where individuals are more likely to encounter community members at the local clinics (Amenta et al., 2020). Loss of privacy and autonomy regarding one's health therefore presents as one collective barrier towards interaction with healthcare services at the community level. People also avoid clinics out of fear of stigmatization due to past personal or vicarious experiences of discrimination, apathy, and hostility in healthcare settings (Garcia et al., 2021). Community availability to adequate healthcare resources presents as another major barrier towards STI prevention. Lack of transportation to clinics, deficit of clinics near home and workplace environments, and long wait times all present as factors that dissuade people from engaging with STI testing and treatment services (Watkins & Lee, 2014).

Institutional Level

Barriers at the institutional level comprise sexual-education programs offered in schools that do not incorporate information regarding contraception use and healthcare provider ability to address STIs. Abstinence only education refers to sexual education offered in public schools that is required by federal law to teach abstinence outside of marriage as the only effective preventative measure against pregnancy and STIs (Jeffries et al., 2010). These federally funded programs are restricted from teaching the efficacy of other preventative measures, such as the use and implementation of condoms, except to solely emphasize their failure rate (Jeffries et al., 2010). Those programs that function to teach abstinence only present little to no information regarding effective and practical preventative measures. These programs are unsuccessful in preventing sexual activity and fail to actively provide useful information regarding protective measures against STIs (Seiler-Ramadas, 2019). The healthcare provider component of care presents as another critical point in the institutional level of intervention. At the institutional level, healthcare providers present as the primary institutional force against the spread of STIs

through treatment and testing services. These providers must therefore be comfortable and competent in addressing STI related issues, especially for at-risk patients. Watkins and Lee (2014) indicate that many providers cite lack of time, comfortability discussing STIs, perception of patient risk, and perception of patient comfort in discussion of STIs as barriers to addressing sexual health concerns. Certainly, these barriers may not apply to all providers, yet the inability to effectively broach such sensitive issues presents as a systemic barrier to STI prevention.

Public Policy Level

Barriers at the public policy level present as perhaps both the most influential and mercurial of all factors that impede STI prevention. These barriers may be drawn along political, religious, ideological, or financial lines. A prime example of a barrier at this level concerns Section 510 of Title V of the Social Security Act of 1996 which mandated that federal funding for sexual education programs at the state-level be allocated solely to those programs which teach abstinence-only-until-marriage sexual education (Jeffries et al., 2010). Abstinence is a useful and effective method of preventing STIs when taught in conjunction with other preventative measures (Seiler-Ramdas, 2019). The policy level barrier with such a mandate as Section 510, stems not from the teaching of abstinence, but rather from the exclusionary education of abstinence at the cost of all other preventative measures. Abstinence-only education, by federal mandate, is not allowed to teach the efficacy of condoms in preventing STIs (Jeffries et al., 2010). Furthermore, these types of programs center primarily on preventing out-of-wedlock pregnancies and STIs; little to no concern is generated for the transmission of STIs in marital relationships (Jeffries et al., 2010). Programs that function solely along ideological lines rather than consideration of verifiable health practices present as the most deleterious public policy initiatives because they deprive entire generations of adolescents from

access to effective and safe sexual education that recognizes sexual activity outside of marriage as a reality rather than a behavior to be stigmatized.

Advocacy

In the context of STI prevention, advocacy concerns the application of interventions that address the barriers to prevention at the community, institutional, and public policy levels. Advocacy seeks to address those factors that predispose populations to marginalization. These factors may include the inequitable access to socioeconomic resources and perpetuated systemic discrimination through institutions and organizations that provide aid, and which enact inequitable laws and policies. In the case of STI prevention, advocacy efforts may be targeted specifically towards at-risk populations such as adolescents and ethnic minorities. These efforts may also be targeted at dismantling the cultural stigmatization associated with sexual health and the utilization of sexual health services.

Community Level

At the direct community level, social stigma and access to healthcare services present as primary barriers to STI prevention. An advocacy effort at this level to target both barriers, might include a community-involved sexual-wellness program that provides both sexual education and access to healthcare examination services. The training of nominated or elected community opinion leaders to disseminate preventative sexual health information presents as a potentially effective advocacy intervention. A study conducted by Young et al. (2011) found that the training of nominated community leaders from high-risk populations in Peru significantly decreased community stigma associated with HIV/STI prevention. These trained community leaders possessed social trust and integrity, as designated by their peers. Through training, they

were equipped with the knowledge of STI preventative practices, educated in sexual health and wellness, and taught how to effectively deliver information to their communities. This style of intervention looks promising and should be replicated in the United States to determine its translational efficacy.

Institutional Level

Identifiable barriers at the institutional level include the exclusionary and selective curriculum of sexual education programs in public schools and the capability of healthcare providers to broach STI related concerns. Ideally, medical professionals should have a pronounced place in providing sexual education programs with evidence-based practices that reduce STI risk. This provision of statistically relevant information contributes to only one part of an effective advocacy initiative at this level. Medical professionals may provide the grounded health information to the public, yet they too should be taught how to effectively broach issues on an individual basis. Medical mistrust, perception of provider discrimination, and the perception of provider hostility represent a confluence of factors that further dissuade people from seeking health services (Armenta et al., 2021; Watkins & Lee, 2014). These perceptions are further perpetuated by lack of effective public health education in adolescence. An effective advocacy intervention at the institutional level may therefore concern the training of medical professionals in culturally competent practices that provide them not only with information concerning the disproportionate STI incidence amongst high-risk populations but also with the strategies and confidence to initiate conversations regarding sexual health. Such a training program must be interdisciplinary by design, including educational, sociological, psychological, and policy maker experts. This training approach, by design, should target environments and populations at high-risk for STIs. Special emphasis must also be given to the training of

primary/secondary school nurses. Training of healthcare professionals unilaterally will aid in providing them with the ability to broach uncomfortable and sensitive sexual health concerns with their patients. Ideally this will make waves in reducing public perception of potential provider discrimination and apathy. Furthermore, inclusion of school nurses in this program will aid in ensuring that educated and effective ambassadors for sexual wellness and STI prevention are available at schools, where they are most needed. Even if schools are unable to provide comprehensive preventative sexual education, they will ideally have a professional capable of championing evidence-based wellness and preventative care.

Public Policy Level

A primary barrier at the public policy level concerns the lack of STI preventative education in public schools, other than abstinence-only-until-marriage curriculum. This type of policy perpetuated through the Social Security Act of 1996 represents a potential stonewall for effective and timely advocacy efforts (Jeffries et al., 2010). Undoubtedly such a policy is intrinsically motivated by strongly held ideological beliefs ingrained in the cultural perception of sexual health and STIs. Rather than address this pillar of inefficacy directly, advocacy efforts should be made to increase public access to family planning services that are independent of public education. Increased access to family planning services would ensure that those that may benefit most from sexual wellness and STI preventative practices may access them while ensuring that detractors need not partake in initiatives that they do not align with. Access to STI testing and treatment through family planning services presents as a useful intervention for reaching individuals that may not normally access STI health services (Shlay et al., 2013). Furthermore, STI services conjoined with family planning services will serve as a sufficient method for targeting those populations at high risk of contracting STIs (Seiler et al., 2020).

According to Seiler et al. (2020), there is a significant overlap between high-risk individuals, particularly low-income women, and those on Medicaid. Therefore, increasing availability of STI related services by incorporating them into existing family planning services covered by Medicaid will directly provide the most at-risk individuals with access to affordable and quality care. Additionally, the combination of these services will provide facilities to communities that are specially targeted at addressing issues of reproductive health, STIs, and family planning. Ideally, such specialized facilities would have competent and confident healthcare professionals that are familiar with broaching the sensitive topic of sexual wellness and STI related concerns. Access to such an integrated facility of competent professionals may also make strides in reducing public hesitance towards seeking healthcare services from more generalized healthcare practitioners.

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