

T h e M a l e A d v o c a c y N e t w o r k

and

Chivers-Grant (Morehouse College)

COMPONENTS THAT WORK IN MALE
REPRODUCTIVE HEALTH AND EDUCATION
PROGRAMS

*143 Kennedy Street, N.W., Suite 6 ❖ Washington, D.C. 20011
P: (202) 722-8870 ❖ F: (202) 722-8871*

COMPONENTS THAT WORK IN MALE
REPRODUCTIVE HEALTH AND EDUCATION
PROGRAMS

JULY 2002

143 Kennedy Street, N.W., Suite 6 ❖ Washington, D.C. 20011
P: (202) 722-8870 ❖ F: (202) 722-8871

The Male Advocacy Network

PREFACE

As early as the 1970s there was a growing recognition of male reproductive health problems and sexual health care needs. While there was a tacit assumption shared by public health professionals that promoting male sexual and reproductive health services can lead to healthier lifestyles, preventing disease transmission and reducing unplanned pregnancies and births, there had been few opportunities for males to receive counseling about reproductive health care from service providers. Males appear to have only received family planning counseling as part of maternal and child health care services, which were designed to serve women.

By the mid to late 1970s, the Office of Family Planning (OFP) of the Department of Health Education and Welfare (DHEW) had already begun to fund demonstration projects to encourage male involvement in family planning services. However, compared to OFP's regular clinical service programs, the demonstration projects exhibited only limited success and were subsequently discontinued in 1982.

The recent interest in encouraging male involvement in family planning, reproductive and sexual health is driven not only by the current epidemic of sexually transmitted diseases (STD), including HIV/AIDS, and high rates of unplanned pregnancies, but also by shifts in public health policies, new information, greater understanding, and new approaches to helping males become full partners in reproductive health activities.

Increasingly males are fathering children outside of marriage, and children growing up without meaningful contacts with their fathers are at a greater risk for poor health outcomes. Fighting the fatherless epidemic has been a major concern for the nation's lawmakers. Promoting responsible fatherhood has formed a critical component of the Welfare Reform Act of 1996: Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Improving the nation's health by promoting responsible sexual behavior was more recently articulated in the health goals of the Healthy People 2010 initiative.

New family planning, sexual and reproductive health paradigms appear to be more inclusive of male participation. Increasing male participation, and encouraging them to adopt a range of positive reproductive health and social behaviors, helps to ensure the well being of men, women and children. From this new perspective, males are viewed as potential partners and advocates for good reproductive health rather than bystanders, barriers, or adversaries. A more comprehensive understanding of the impact of culture, gender and sex roles, power dynamics, socialization, and communication strategies on sexual behavior, reproductive decision-making, and reproductive health appear to have regenerated the movement to include men in reproductive health programs. Newer perspectives on males that recognize men's distinct reproductive health needs and innovative strategies to address these gender-specific reproductive needs are now emerging.

Finally, there appears to be a shift in thinking among males that reflects a more positive attitude and behavior regarding healthy life choices. Confronted by increasing morbidity and high mortality rates, males are beginning to pay more attention to their own health concerns and needs. Increasingly, males are now more likely to seek services for their own health concerns

and needs and, at the same time, they are becoming more receptive to participating in health promotion programs.

In 1997, the Department of Health and Human Services (DHHS), Office of Population Affairs (OPA), Office of Family Planning (OFP), renewed its commitment to fund programs that address family planning and reproductive health information and services for males. These projects were intended to integrate family planning service and education into programs where young males were already receiving other health, education, and social services. The OPA/OFP initiative involved community-based health and social service organizations in developing, implementing and testing approaches for delivering family planning /reproductive health education and services to males.¹

Components That Work in Male Reproductive Health and Education Programs builds on previous and current efforts by the Office of Family Planning (OFP), Office of Population Affairs (OPA), Department of Health and Human Services (DHHS) to define a national strategy for addressing male sexual and reproductive health, and extends these efforts toward improving the quality of male health care in general. It is a compilation of insights and experience, derived from the implementation of community-based programs. This paper is intended to be a resource of model program components that contribute to the success of these programs. While it is expected to be of use to most Community and Faith Based Organizations (CBO/FBO) that offer male health programs, it is expected to be particularly useful to CBOs/FBOs with little or no experience in providing male services. It will also be useful as a guide to funding sources considering support of male health programs.²

¹ Synopsis: The Evolution and Current State of Sexual and Reproductive Health Programs for Men: The 1997 Office of Population Affairs, Office of Family Planning Initiative (Unpublished paper) R. Ashok Shankar, Ph.D., Evaluation Consultant.

² *Components That Work in Male Reproductive Health and Education Programs*, The Male Advocacy Network, Inc. Washington, D.C., 2002.

MESSAGE FROM MAN

Components that Work in Male Health and Education Programs is one in a series of papers developed by The Male Advocacy Network (MAN) for community and faith based organizations (CBO/FBO.) While it will be useful to most CBOs/FBOs that offer male services, it will be especially useful to organizations/programs with little or no experience in providing reproductive health services to males.

The information provided will serve as a resource guide in developing the infrastructure necessary to deliver health care services in various community settings. It is organized around educational programming with a focus on operational issues, program content, planning and evaluation. The paper represents a compilation of information from academicians, researchers, program providers and others.

MAN's challenge is to continue to develop technical and other resources to facilitate the development of effective male health programs and to educate and motivate males to use these services for the improvement of their health.

Staff Editors: Jo-Ann Wells
 Sam Taylor
Project Assistant: Karen Guzman

MESSAGE FROM MOREHOUSE

This paper, *Components that Work in Male Reproductive Health and Education Programs*, is the first in a series of papers resulting from the collaboration between the Male Advocacy Network and the Chivers-Grant Institute for Family and Community Studies of Morehouse College.

Although the United States achieved great strides in the area of public health during the 20th century, we are still plagued by high rates of sexually transmitted diseases (STD), Human Immuno-deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and unplanned pregnancies. Our challenge is to combine research findings with the experience and insight of community and faith based organizations (CBO/FBO) to improve health care services to males, their families and the community.

The purpose of this paper is to provide CBOs and FBOs with information regarding the basic components that are essential to the development of effective male health programs.

Obie Clayton, Ph.D.
Chair, Department of Sociology
Executive Director, Chivers-Grant Institute
Morehouse College, Atlanta, GA

ACKNOWLEDGMENTS

This paper was prepared with support from the Office of Population Affairs (OPA), Office of Family Planning (OFP), U.S. Department of Health and Human Services (DHHS), and the Chivers-Grant Institute for Family and Community Studies of Morehouse College. *Components that Work in Male Reproductive Health and Education Programs* is a product of the Male Advocacy Network's Models Committee and represents research and insights of its members on the basic components of community-based programs. The committee would like to acknowledge the able research and guidance of William Gruchow, Ph.D. who served as the Chairperson of the Models Committee and the lead author in the development of the document. In addition, MAN's members and others attending various meetings and workshops provided valuable comments and suggestions that are reflected in both the content and presentation of this paper.

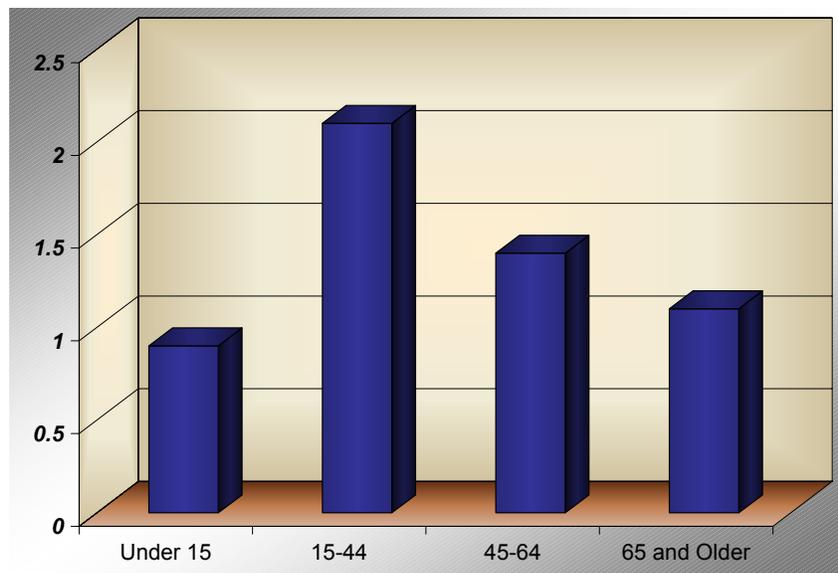
MODELS COMMITTEE

<p>H. William Gruchow, Ph.D. Chairperson, Lead Author The Institute of Health, Science & Society The University of N.C. at Greensboro Greensboro, NC</p>		
<p>Rick Brown, BA Wise Guys Coordinator The Family Life Council Greensboro, NC</p>	<p>Ron Peters, PhD Faculty Associate UT Houston Center for Health Promotion & Prevention Research Houston, TX</p>	<p>Robert Simon, III, MA Director Early Intervention Program Metropolitan Police Boys & Girls Club Washington, DC</p>
<p>George L. Garrow, Jr., Esq Executive Director Concerned Black Men Washington, DC</p>	<p>Sheila E. Pierce, RN President/CEO Walker/Pierce Associates South Hampton, PA</p>	<p>Peggy B. Smith, PhD Professor & Director Department of OB/GYN Baylor College of Medicine Houston, TX</p>
<p>Shawn Gibson, MHS Director of Adolescent Programs Family Planning Council Philadelphia, PA</p>	<p>Rafael Rangel, MD Director of Programs Pike County Health Department Pikeville, KY</p>	<p>Freya Sonenstein, PhD Director of Population Studies Center The Urban Institute Washington, DC</p>
<p>Susan Moskosky, MS, RNC Director Office of Family Planning U.S. DHHS Bethesda, MD</p>	<p>Ada Rodriguez, BSW Clinic Coordinator Bienvenidos Children's Center Los Angeles, CA</p>	<p>Sam Taylor, MSPH Male advocacy Network Washington, DC</p>
<p>Travis Patton, MA Director Chivers-Grant Institute for Family & Community Studies Morehouse College Atlanta, GA</p>	<p>Richard Shankar, MA, PhD Professor Stonehill College Easton, MA</p>	<p>Jo-Ann Wells, MBA Executive Director Male Advocacy Network Washington, DC</p>

1. INTRODUCTION

Despite the apparent advantages males enjoy compared with females in most spheres of life, males still experience higher mortality (16 percent higher in the United States in 1998), and shorter life expectancy (by 5.5 years in the United States in 1998) than women.¹ Overall, men have a life expectancy that is less than that of women, and have higher death rates for each of the 10 leading causes of death.² While males engage in more risky behavior, they report less disability and make fewer clinician visits than women (figure 1).³ This lack of participation in health care may be a contributing factor to men's higher risks of morbidity and mortality. Not only are men less likely to visit a clinician, they are also less likely to embrace health promotion and prevention services, which could lead to longer, healthier lives. Men are also more reluctant than women to bring problems of a reproductive or sexual nature to their clinician's attention.

Figure 1. Female to male ratio of physician and hospital outpatient visits in the US, 1998



Source: U.S. Census Bureau 2000.1

This behavior is rooted in male socialization and peer relationships, which often portray health care or help seeking behavior as unmanly.⁴ Unlike females, males do not have salient trigger events early in their adult lives that bring them into contact with health care. For females, the onset of menstruation and the desire for assistance in pregnancy prevention, or perhaps pregnancy itself, lead to more encounters with health care professionals. These events in female development create the opportunity for them to receive preventive services and health promotion along with treatment. Males seldom experience the same need for the services of health professionals, except for perfunctory physical exams to participate in sports, obtain a job, or get married. While clinician visits are a part of expected behavior for females, the same is not true for males.

Despite their lack of participation in health care, males are not without significant health concerns and problems. The list of concerns varies with age. Elementary and middle school-age males, although still dependent on their parents for managing their health care, are laying the groundwork for lifestyle habits and attitudes that will strongly influence their health behavior as

adults. During adolescence and young adulthood, sexual and reproductive behavior is a primary focus of male's lives. Sexual activity introduces a special set of health concerns, including Sexually Transmitted Diseases (STDs), Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), pregnancy, and the emotional risks from interpersonal and intimate relationships. These concerns, however, are usually not an adequate impetus to bring males into the health care system.

Among middle age and older adult males, health concerns regarding sexual and reproductive behavior continue, though the nature of the concerns may differ from that of younger males. As divorce rates rise, older males may find themselves facing many of the same challenges as adolescents. Pregnancy and STDs are generally of less concern to this age group, but sexual performance issues (such as erectile dysfunction) may become a concern. Emotional problems from relationships with a spouse or other family members can be a factor as well in the health of older males. In conjunction with these health concerns, the onset of other health problems may occur, including risk factors for heart disease, cancer, and other potential causes of mortality and long-term morbidity. Among adult men of all ages, health concerns do not readily translate into health care-seeking behavior. Given the different attitudes and expectations that men and women have toward health care, it is apparent that involving men in their own care requires a different approach from that which has been successful with women. More than twenty-five (25) years of family planning clinic experience, in which males comprise only 2-3% of clients served, demonstrates that simply offering clinical services will not motivate males to use the services.⁵

Until recently, few attempts have been made to understand why males fail to access health care, and how this resistance exhibited by men can be overcome. Men do not value health or health care less than women.⁶ More likely it is because our current clinic centered delivery of care is not as attractive to men as it is to women. Greater efforts need to be exerted to communicate with men where they congregate or places they frequent in the community in order to provide them with information and motivation to participate in health care. This approach is probably most effective when health promotion and prevention services are the core elements of the outreach activities, and complement the treatment services provided in clinics.

Community and Faith based organizations (CBO/FBO) can augment clinics as partners in the delivery of health care to males by focusing on health promotion and prevention services, and by contributing their outreach capabilities to increase health care seeking behavior among males. Key factors in the success of this complementary arrangement between CBOs/FBOs and clinics are that CBOs/FBOs take on health care as part of their activity, and that directors of health care programs reinforce the partnership role of the CBOs/FBOs.

This paper builds on previous and current efforts by the Office of Family Planning (OFP), Office of Population Affairs (OPA), Department of Health and Human Services (DHHS) to define a national strategy for addressing male sexual and reproductive health, and extends these efforts toward improving the quality of male health care in general. It is a compilation of insights and experience, derived from the implementation of community-based programs. This paper is intended to be a resource of model program components that contribute to the success of these programs. While it is expected to be of use to most CBOs/FBOs that offer male health programs, it is expected to be particularly useful to CBOs/FBOs with little or no experience in providing male services. It will also be useful as a guide to funding sources considering support of male health programs.⁷

The information provided cannot be used without careful consideration. The challenge is to configure and adapt the components in this paper to the particular needs and target population of a CBOs/FBOs program. This can only be done by individuals who are experienced in delivering programs to their particular target groups, with the help of professionals who have a working knowledge of the theoretical bases of the implementation models employed, and who can assist in the development of assessment tools to help monitor and guide their implementation.

2. NEED AND BASIS FOR EDUCATIONAL PROGRAMMING

The goal in developing male health programs is to provide a service needed in the community that is not already provided by other agencies. This requires a combination of needs assessment and asset mapping. The needs assessment determines the existence of problems for which programming is needed, and asset mapping identifies resources and programming available to meet those needs. If a need is known or suspected, the assessment can focus on the degree and location of the need in the community. This will enable the program to have maximum benefit while conserving resources.

Methods of needs assessments are variable. While assessments are often associated with large community-based surveys, there are more efficient ways to gather the same and sometimes better information. Table 1 offers suggestions on how to accomplish needs assessments other than through a community-based survey. The suggestions are keyed to likely sites of contact with males.

When conducting needs assessment surveys, interviews, focus groups, and listening groups, the assessment process must not lead responses toward a predetermined outcome (Glossary of Terms, 30). This problem is most likely to occur when the organization's assessment instruments are designed internally. Enlisting the help of an outside expert to design the instruments used in assessment can help avoid this pitfall.

Asset mapping entails taking an inventory of resources presently available and complements the needs assessments. However, information about assets is not always readily available, and asset mapping can actually be more challenging than needs assessment. Though we assume that the staff of a CBO/FBO active in the delivery of health services would be knowledgeable about what services are available elsewhere to their clients and potential clients, this is seldom the case.

An excellent way to find out about available services is to ask the target groups about the community services they utilize. This can be accomplished by incorporating asset identification as part of the needs assessment process. Questions can be included in surveys and interviews about services used, and focus group discussions can be scripted to include consideration of strengths and weaknesses in service availability.

Once there is an understanding of the needs programming must address, planning can begin. The specific nature of the programming will depend on the needs identified, the mission and expertise of the organization, and the available resources. A universal component of male health programming is education to inform, raise awareness, and motivate males to action. Health concerns among males do not readily translate into health care seeking behavior. This places a greater cost and effort burden of male-directed intervention programs to motivate them to actively participate in their own care.

Table 1. Conducting Needs Assessments

<i>Site of Contact</i>	<i>Method of Needs Assessment</i>
Barber shops, building supply, and other retail places where men congregate	Key informant interviews, informal focus groups and listening sessions, with convenience samples of men at these places.
Clubs and youth groups	Key informant interviews and listening groups with staff members of clubs and youth groups who may be willing to talk about the needs they see; listening groups with youth members.
Community-based location	Key informant interviews with community leaders; probability surveys of general population; focus groups with selected population segments.
Criminal justice system	Key informant interviews and listening groups with probation officers, court counselors, and other correctional personnel.
Faith communities	Key informant interviews with clergy and lay leaders; listening groups with community members.
Family	Interviews with spouses and children; focus groups and listening sessions with neighborhood or faith-based groups composed of family members.
Health care-based	Inpatient and outpatient discharge data; convenience sample interviews of patients.
School-based location: elementary through college	Key informant interviews with educators willing to give insight into the knowledge levels and needs of students; listening groups with students; probability sample interviews with parents and students.
Social clubs and fraternal organizations	Interviews with organization leaders; focus groups and listening sessions with members.
Sports-based location	Adolescents who play sports need physicals; key informant interviews with the physicians in practices that provide them; listening groups with adolescents and parents.
Workplace	Focus groups and listening sessions with workers who routinely work in group settings, such as office workers, teachers, police, fire-fighters, construction crews; key informant interviews and probability sample interviews with workers who routinely work independently, such as administrators, consultants, sales representatives, artists, and writers.

Source: Models Work Group, Washington, D.C., November 2001 –June 2002. ⁷

Often it is decided that an educational program is needed before there is a clear sense of what is to be accomplished. Implementing a program in these circumstances can result in disappointment, and may drain limited resources that could be better utilized. The first step in deciding on an educational program should be to determine that a program is needed, what the specific objectives of the program will be, and how these objectives will be measured. If there is difficulty in identifying measurable indicators of objectives, this is a sign that the objectives may

be too broad, may not be appropriate, or should be reconsidered. The remedy for this is to simplify the objectives and make them more specific; expert help may be beneficial in this situation.

The organization and delivery of educational programming for male health is at least as critical to its success as its content. Most effective educational programs share the following eight characteristics:

- ▶ ***Identify the needs of the target group; differentiate what they want from what they need.*** Often males are reluctant to express their needs regarding sexuality and relationships, and getting men to verbalize their needs requires skill and patience.
- ▶ ***Employ age-appropriate materials and teaching methods.*** Males, even of the same age, vary in their knowledge and experiences with sexuality, as well as what sexuality means to them. This affects their ability to deal with issues regarding sexual relationships, and their receptivity to different teaching methods. Identifying appropriate teaching methods requires an in-depth understanding of the target group. However, there are some general guidelines to follow in order to maximize the impact of educational programs. First, arrange for adequate time and effort in the education program. Short one-time programs may be useful to help raise the awareness of the target group, but are not as useful for bringing about long-term changes. Long-term contacts that extend over a period of weeks are usually more productive and allow for a learning relationship to develop between the teacher and the individuals in the target group.⁸ This arrangement also allows for discussion and reflection of the material being presented. Second, booster sessions at intervals after the delivery of the original program reinforce what was learned. Third, teaching methods that involve the participants in activities are usually more effective than those that do not. Fourth, selecting teachers and peer leaders who connect with the target group audience and believe in the program enhances the success of the program.
- ▶ ***Use curricular material that has been proven effective.*** Strictly adhere to the curriculum or program script. Assert the benefits of the actions advocated, but avoid overstatements and threats. They are counter-productive and can lead to loss of the audience. The best materials are those based on theoretical approaches that have been demonstrated to influence health behaviors. Talking with others who have addressed similar issues may be useful, as is consulting with experts.
- ▶ ***Incorporate the target group's values and norms into the educational program.*** This will better enable the participants to relate to the lessons presented and will increase the likelihood of success in changing behavior. The group's values and norms are largely derived from their culture and community, mediated by peer groups and family. However, regional and geographic variations may alter a target group's perspective from that of other groups with similar cultural backgrounds.⁹
- ▶ ***Maintain a positive orientation in the content and delivery of the educational program.*** Although there is a natural tendency to talk about the downside of health issues i.e. What can happen to a person if the rules of positive health behavior are not followed, this approach is usually counter-productive. Instead, positive health should be portrayed as an asset that makes individuals better prepared to achieve their aspirations in life.

- ▶ ***Use all available avenues of access to target populations.*** Not everyone in a target population can be reached through a single group or activity. When multiple avenues are used, coverage of the target population is expanded. Any overlap in audience should be viewed as an opportunity to reinforce educational objectives. Access to younger age groups (9–17 years) is usually through captive-audience locations such as schools, Boys’ Clubs, faith-based groups, community organizations, particularly sports-based activities, and the juvenile justice system. Access to older age groups (18 years and older) can be more challenging, and requires greater creativity (Further discussion of access issues is in the age-specific topic guidelines in Chapter 5).
- ▶ ***Involve gatekeepers in the planning and delivery of educational programs.*** Gatekeepers are club and group organizers, clergy, social workers, justice system officials, and, for younger males, school officials and parents. Other persons who function as gatekeepers are individuals who can determine for the group they represent whether an educational program can be delivered. Gatekeeper involvement will require expending additional time tailoring programs to the different expectations of the various groups. Time expended developing the support of the gatekeepers will be more than offset by the advantages that can be gained if the gatekeepers support and facilitate the programs.
- ▶ ***Construct a two-way linkage between educational programming and clinical activity, so that both sets of activities support and reinforce each other.*** Generally this has not happened. Clinics provide screening, diagnostic and treatment services, and referrals to medical specialists, when appropriate. Health promotion counseling and education services are not clinics’ primary activities. Effective outreach for males entails effectively integrating health promotion outreach with the clinical services.

3. THEORETICAL SUPPORTS

Background

The idea that changing an individual’s behavior can lead to improved health is fundamental to the study of health behavior and underlies all health promotion and education programs.¹⁰ The theoretical supports for health behavior interventions are based on cumulative evidence of research from the social and health sciences.¹¹ Most of this research has focused on identifying determinants of health behavior and on bringing about changes in health behavior by altering one or more of its determinants. Theory-based health promotion and education programs use this information to increase their likelihood of success.

Rational Models

Much of health behavior theory is based on rational models of behavior. These models follow an intuitive line of reasoning, which specifies that acquiring appropriate knowledge and attitudes precede the desired behavior.¹¹ Refinements to these models add skills development and the belief by the individual that he or she can successfully execute the new behavior as a prerequisite to behavior change.¹²

A generalized pathway of associations incorporating these model components is:

Knowledge + attitudes + skills + self-efficacy → behavior change → improved health

Essentially, the pathway states that with sufficient and appropriate knowledge, attitudes, and skills to do the alternative behavior, and the perceived ability to perform the behavior, an individual will be more likely to implement behavior change that will lead to improved health.

Theory-based models are organizing frameworks that provide us with reasons to expect certain outcomes from health promotion and education programs. The research behind the models provides us with methods that are most likely to give us the outcomes we expect. This is why programs that have a theoretical base are more effective. If a planned program is not supported by theory-based research, there is no basis for expecting that the desired outcomes will be attained.¹³

The major theory-based models, or organizing frameworks, used today for health behavior research and programming are derived from the Health Belief Model. There are also several motivational, cognitive, and behavior change models, including Social Cognitive Theory and the Theory of Reasoned Action. In addition, the Stages of Change model is frequently used in conjunction with the above models to further assess the readiness of target populations for health promotion and education interventions.¹¹

The Health Belief Model

The Health Belief Model originated several decades ago in an effort to understand why individuals did not participate in disease prevention and screening programs.¹⁴ According to this model, as described by M. H. Becker, whether individuals will take action to treat or prevent a health problem depends on the following:¹⁵

- ▶ How serious a threat they perceive the problem to be, and their level of confidence in being able to effectively cope with it. The more severe the health problem is perceived to be, and the more susceptible a person perceives himself or herself to be to the problem, the more likely they are to take action
- ▶ Whether the individual sees such action to be beneficial.
- ▶ Any barriers to the action, such as cost in time, money, or effort, diminish the likelihood of action.
- ▶ Whether there are “cues to action;” that is, something that happens within a person, such as soreness or pain, or in a person’s environment, such as the illness or death of a friend or relative to increase the likelihood of a health behavior.
- ▶ Whether an individual sees himself or herself successfully performing the action.

Substantial parts of the Health Belief Model have been tested and supported by research, although the entire model has not been rigorously tested.¹⁶ Nevertheless, it is useful in helping us understand the wide range of factors that influence our health behavior and the complexity of interactions between these factors.

Social Cognitive Theory

Social Cognitive Theory incorporates a number of concepts from psychology that give insights into health behavior. The core concept of this theory is that behavior, personal factors, and environmental influences all interact. Among the components of this theory are *behavioral capability* (the knowledge and skill to perform a behavior), *expectancies* (the values that the person places on a given outcome), *observational learning* (learning from watching others), and *self-efficacy* (confidence to perform a certain behavior), among others. By appropriately influencing an individual's underlying cognitive variables, behavioral change is more likely to occur.¹⁷

The Theory of Reasoned Action

The Theory of Reasoned Action is distinguished by its focus on beliefs and attitudes as they relate to motivational factors as determinants of an individual's specific behaviors.¹⁸ A health behavior example of how this theory is used would be to identify beliefs and attitudes toward *smoking cessation*, then to trace how these beliefs and attitudes affect motivation to quit smoking. Smoking cessation programs using this theory would be based on altering beliefs and attitudes so that they would facilitate motivation to quit.

In their current stages of development, the most prominent theories of health behavior do not yet provide the level of specificity needed for planning and implementing all aspects of health promotion and education outreach programs, especially for males. Nevertheless, they provide conceptual frameworks that have been empirically tested, and the knowledge gained from these tests can be used to improve the chances for success of community-based health promotion and education programs.

Stages of Change Model

A concept now widely applied to health promotion and education programs is the Stages of Change Model. This model does not predict health behavior in the way that health behavior theories do, but it provides a framework for studying and understanding the timing of health behavior change. The focus of the Stages of Change Model, which is also called the Trans-Theoretical Model, is on the level of readiness (or un-readiness) of the individual to make a behavior change, and provides a scheme for progression of the individual through successive stages, from a "more ready" to a "less ready" state.¹⁹ It does not specify behavior, but provides a template for tracking a person's movement between low and high probability states of making changes.

Applying the Models

In applying theoretical constructs, no one model is necessarily appropriate to a particular health promotion and education program. Instead, a combination of models and personal knowledge tailored to the content of the program and the intended audience may provide the best template for planning and evaluating a program. However, the need for a model cannot be overemphasized. As stated in *Healthy People 2010*, "Identifying the use of established health promotion planning and identification models provides more information on strategically

planned and implemented programs as opposed to [a] single method of noncomprehensive approaches considered less productive.”²⁰

In other words, to the extent that theory-based constructs can be incorporated into health promotion and education programs, the programs will be strengthened, not only with regard to their content, but also with regard to the ability to measure how well program objectives are met. This latter aspect is essential if a program is to be constructively modified to improve its impact, or if it is to be replicated at other sites. Knowing what really works, and what does not, is a necessary part of implementing and maintaining effective community-based health promotion and education programs.

4. OPERATIONAL ISSUES

Community-based educational programs have unique challenges to overcome to be successful. Unlike other types of training and educational programs that take place in environments such as schools, corporations, or specialized training facilities, community-based programs are developed, marketed, and delivered in the public arena, often with a good deal of public scrutiny. Thus resources beyond those required for the development and delivery of the program are needed to attend to issues associated with operating in this arena. These issues include determining who the participants and stakeholders in the programming are; what barriers to effective programming exist; how staffing and training are to be achieved and maintained; and what cost expectations are associated with delivering community-based educational programs.

Participants

Participants are those individuals who are actively engaged by the educational programs and likely to receive the most benefit from them. Participants in educational programs run a continuum from those actively engaged in longer-term education programs to those receiving brief contact interaction with the program. Education programs are usually long term, dispensing information over a greater time interval, that allows for learning reinforcement. They are more costly, but ultimately, more effective.

The distinction between participants and contacts is important when resources and costs of programming are considered, since participants require considerably more of each. It is also an important distinction in marketing efforts. Depending on the nature of the educational program and its objectives, participants and contacts may be targeted differently.

Stakeholders

Stakeholders are people and organizations that are affected by the CBOs/FBOs program, for better or for worse. Participants are obvious stakeholders, as are those who deliver the program and those who fund it. There are also those who do not benefit, but whom the program may disadvantage, however well intended the program.

Often educational programs offered by CBOs/FBOs affect other entities in the community, who then become stakeholders. For example, families and partners of those participating can become stakeholders, as can elements in the larger community. Faith-based groups, the justice system,

and schools can individually or collectively become stakeholders in programs that are directed at reducing crime, abuse, HIV/AIDS and other STDs, and unintended pregnancies.

Stakeholders who do not benefit from CBOs/FBOs educational programs will view them from a self-interest perspective. Some opposition can be expected from other CBOs/FBOs, organizations, political bodies, special interest groups, and the general public because of real or perceived resource competition. Overlapping services and interest areas will intensify the resistance from these other entities.

A variety of techniques can be used to increase the level of successful participation from disinterested or opposing stakeholders. Including representatives of potentially reluctant entities in the planning and development of the educational program, and perhaps even in its delivery, is one method. Regardless of whether this is possible or desirable, three other strategies that can reduce resistance to a program include:

- ▶ Demonstrating a need that is either not being met by existing programs, or that requires greater effort than is currently being given.
- ▶ Proposing a novel approach to a problem that has not been effectively resolved by existing programs.
- ▶ Engaging in complementary activities with another organization, such as linking programming with an advocacy group on the same topic.

Barriers

Barriers to a successful program can arise internally as well as externally. However, the effects of barriers are seldom confined to only internal or external matters. Rather, barriers from whatever source often have rippling effects on all of an organization's activity, if left unresolved. For this reason, barriers should be addressed early and aggressively if they are to be successfully managed and overcome. Some major internal and external barriers are described below.

Mission Incompatibility

Perhaps no internal factor is more important to the success of a program than that it be consistent with the mission of the organization offering it. Conversely, attempting to initiate a program that is not consistent with that mission raises a host of barriers that can threaten not only the success of the program, but also the organization itself. For a program to be effective, both staff and administration must have the required expertise, program vision, and goals and objectives needed to implement the program. Board members must be comfortable with the program's content and direction. Other players in the community must perceive the program to be within the organization's purview. Without these prerequisites in place, barriers might arise including a lack of support from the organization's own staff, administrators, and board members. Opposition to the program may also emanate from other community players, including other CBOs/FBOs and the community's political, religious, and social leadership.

Threats to Organizational Identity: Partnership Pitfalls

Partnering with other entities can be advantageous for an organization. It can lead to more efficient use of limited resources, greater impact from combined strengths, and increased attractiveness to funding sources. However, partnerships can have downsides. The most common problem is related to sustaining the individual identities of each partner (turf issues). The viability of most CBOs/FBOs is tied to their visibility in the community and perceived effectiveness. The costs to a CBO/FBO of submerging its identity in a collaborative effort are real and threatening. Tangible assurances that a collaborative effort is a real partnership, and not an exploitation of one or more CBOs/FBOs by others, include shared and equal governance of the collaboration, equitable distribution of resources to support the collaboration, and equal responsibility and credit for the successes and failures of the effort. Written contractual agreements to these points should be viewed as evidence that all partners are committed to sharing the risks of the collaborative effort.

Compliance and Reporting Requirements for Funding

With funding comes responsibilities that extend beyond accomplishing the goals of the funded program. The recipient program's organization, procedures for policy development and protocols for services, are elements that directly impact the funding program. The most comprehensive of these requirements are associated with funding from federal government agencies. Assurances of compliance with federal and state laws governing nondiscrimination and safety in the workplace are required. Additional safeguards designed for the protection of human participants in organizational programming is a funding requirement. Further assurances that the organization is eligible for federal funding, including a statement of lobbying activities, and guarantees that a drug-free and environmentally safe smoke-free workplace will be maintained, are mandatory requirements. Specific agencies may have additional requirements for assurances, and each funded grant may have specific performance and reporting conditions attached to it.

Private sources of funding usually have fewer requirements, but there may be other conditions, such as limitations on the geographic areas in which programming may be offered, or restrictions on the type or content of programs.

The most challenging funding condition for most organizations is compliance with the required protection of human participants. The intent of the rules governing the participation of humans is to guarantee that every program participant understands what their involvement entails, that no participant is unknowingly exposed to any risk, and that risks associated with involvement are acceptable to the participant exposed to them. These conditions impose added cost and personnel burdens on the organization. To satisfy the required conditions, the organization offering the programming must take steps to fully explain to all participants the nature of the program and what their participation entails, inform participants that their participation is entirely voluntary, and allow participants to withdraw from the program at any time without penalty or sanction. These activities must all be documented. In addition, all federal and many non-federal funding sources require signed consent forms to document participant understanding of these safeguards.

The very nature of male reproductive health programs raises some important administrative issues concerning the need to protect human subjects from exposure to risk. Though it is unlikely that most program designs would subject participants to bodily harm, other forms of risk do occur. These forms of risk generally arise because programs need personal, and often sensitive,

information. Administrative staffs need to develop protocols that maintain, at a minimum, the confidentiality of such information. It should be standard practice to obtain informed consent from all program participants. As part of the consent, subjects should be apprised of any risks of participation in services, and informed of specific benefits to be gained through participation. If participants are under 18 years of age, parental or guardian consent should also be obtained when possible and practical. Subjects should also be aware that in general there are no negative sanctions associated with refusal to participate in any activity with which they feel uncomfortable.

Specific procedures for protecting human subjects vary among funders. Determination of required standards should be discussed with grantors early in the program development stage. The organization's advisory board should also be an active participant in establishing standards and protocols for protecting human subjects. Program directors should familiarize themselves with federal guidelines concerning human subject protection. Though a project may not formally be required to meet the federal standards, they provide a solid basis for designing protocols to meet any situation. The Federal Standards are found in the Code of Federal Regulations (CFR), Title 45, Part 46.

Staffing and Training

Staff is critical to the success of educational programming. Without competent staff even excellent educational programs may fail. Exceptional staff can make a worthy program succeed, even if the format and content are not ideal. Despite the enormous importance of staff, recruitment, training, and retention of staff are chronic challenges for CBOs/FBOs.

The special nature of community-based health education programming limits the pool of potential staff. In many instances, several organizations in a community may be recruiting the same small group of individuals. Added to this is the costly training of staff in the delivery of educational programming, work intensity, low pay and job insecurity. Given this combination of factors, it is no mystery why there are high turnover rates among CBO/FBO staff.

Since these conditions are unlikely to change in the foreseeable future, what can CBOs/FBOs do to cope and remain viable, while taking on health education programs? While each CBOs/FBOs situation is unique, the following four general suggestions should be considered:⁷

- ▶ ***Recognize the unique aspects of your organization that relate to staff recruitment and retention.*** Include staff in the review of the programs offered, the target audiences, and what delivery of the programs requires of staff. Identify where the difficulties lie for staff, and jointly consider possible solutions. By doing so, staff will participate in the implementation of programs.
- ▶ ***Consider creative, alternative approaches to the training and organization of staff.*** The most important determinant of success is to meaningfully involve staff. By including them in not only implementation, but also planning, they will be able to claim ownership and feel committed to the program's success. Their incentive is that a more efficient and effective organization will make their jobs less demanding and more rewarding. It is also important for administrators to offer training that is consistent with staff career goals. An example of a creative approach might be to offer an accelerated training protocol to bring new staff up-

to-speed faster. This will result in less program down time. The training should include components that prepare staff to anticipate and cope with the difficult circumstances they are likely to experience on the job.

- ▶ ***Provide strong administrative support and encourage staff visibility.*** The commitment and support of the administration to staff should be constant and visible. Recognizing staff contributions publicly and allowing them to share in the organization's successes will go a long way to motivate staff, even when monetary compensation is modest. Providing perks that reflect a caring attitude on the part of administrators, combined with incentives (such as travel to conferences), will increase the real participation of staff in the organization's activities and help avoid the development of internal barriers to accomplishing the goals of the organization.
- ▶ ***Maintain a grassroots administrative style.*** The leadership should maintain close ties to the target population and involve members of that audience in policy making. While this is usually done through an advisory board, other strategies such as periodic key informant interviews and focus group sessions should be used to achieve this objective. Like staff, the target population should always share in the organization's successes.

Staffing Issues for CBOs/FBOs Offering Male Sexual and Reproductive Health Programs.

Male reproductive health programs introduce staffing issues that a CBO/FBO might not otherwise encounter. The most effective programs are based on knowing the target audience and meeting them on their terms, while remaining empathetic and nonjudgmental toward their view of reproductive health.²¹

In educational programming, similarities that create compatibility between the provider and the audience relating to gender, ethnicity, sexuality, and geographic background is generally preferred. With compatibility, there are fewer communication barriers to overcome and there is a higher level of audience comfort when the provider and the audience share similar cultural backgrounds and worldviews, regardless of the topic of their interaction.²² This is particularly true when the topic is sexual and reproductive health, and the audience is composed of males.⁹

However, a difference in program staff's cultural background does not constitute an insurmountable barrier to a program's success. Skilled educators can overcome gender, ethnicity, sexuality, and geographic differences, though the dissimilarity generally requires a longer time to break down barriers. The most crucial element to successfully breaking down barriers and establishing an environment conducive to open communication between the staff and the target population is for the staff to remain empathetic and nonjudgmental.

General Commentary

All organizations seek to attract individuals to their staff who have a mixture of skills and other attributes. Examples of such attributes include a caring and flexible attitude, having empathy toward the target audience and its culture, and demonstrating role-model behavior to provide translation of their ideals into the real world. The ability to communicate effectively with the target audience and to connect with the individuals who use the organization's services are essential skills for a health educator.

Given the importance of effective communication skills, trial presentations to groups similar to those the educator will be working with should be a key screening component before hiring, regardless of an educator's origins, sexual orientation, and other skills. The trial presentations will alert potential employers to any characteristics of the individual, including nonverbal communication that might compromise his or her effectiveness in delivering the organization's programs.

The demand for individuals who meet all of these requirements is far greater than the supply, and CBOs/FBOs compete with each other for the same small pool of highly qualified potential staff members. Seldom will all of an organization's needs and preferences be met in the process. Hiring and effectively using staff is a process of achieving the best approximation of the ideal with the resources available. This requires careful prioritization of needs to guide recruitment and staffing decisions.

Coalition Building

Sometimes agencies and organizations recognize that a community health issue is so challenging that the best way to effectively address it is by pooling their resources and forming a coalition. In a coalition, each member retains its identity and agenda, but there is agreement to cooperate on the specific part of their respective agendas that they have in common. The coalition's impact can be achieved either through more intense activities within a target area shared by the participants, or through coordinated activities over a larger geographic area. A coalition can develop and demonstrate a critical mass of support behind a community effort.

Forming a Coalition

The coalition agreement is usually formal to protect the financial and programming interests of all parties. The coalition may even have its own administrative structure. This more flexible organizational arrangement is usually seen as less threatening to individual agencies, and presents less of a barrier to their participation.

The most common way coalitions are formed is when an umbrella organization sees a need for concerted action to address a health problem and solicits the participation of interested agencies, organizations, and individuals to join together in meeting the challenge. Another way coalitions form is when an agency, faced with responsibility for a challenge it cannot meet alone, solicits the participation of other stakeholders.

The motivations for joining coalitions are wide-ranging and varied among participants. Some organizations participate in coalitions simply because the activities are consistent with their own missions. Others see participation in a coalition as a way to raise community awareness about their programs. A less common but particularly strong motivation is the potential for additional financial resources that may be available to participants in some coalitions.

Barriers to the Success of Coalitions

Despite the evident advantages, there are barriers to coalition participation. A major barrier for many agencies and organizations is the loss, however small, of administrative and program autonomy that participation in a coalition entails. Decision-making on priorities and the use of resources no longer rests solely within the organization. Another barrier is the investment of additional staff time required in coalition participation.

Finally, the success of a coalition rests on explicit and realistic goals, and on the accountability of each member to every other member pertaining to the activities of the coalition. The heightened interest in activities that inevitably occurs when a new coalition is formed can dissipate quickly if its goals are unclear or ambiguous. Similarly, members can lose interest quickly if they perceive that other participants are not as committed as they are to its success or if they perceive that their efforts are not central to the work of the coalition.

Avoiding the Pitfalls

Despite these pitfalls, coalitions can be powerful forces for change in a community when properly organized and maintained. The following five guidelines are intended to help avoid the major pitfalls in developing coalitions:

- ▶ Establish a clearly defined lead agency to take responsibility for providing direction, oversight, and administrative support to the coalition.
- ▶ Base the goals of the coalition on a clearly identified need and well-defined method of attack.
- ▶ Ensure competent leadership and obtain any needed technical assistance to properly implement and evaluate the coalition's activities.
- ▶ Focus the coalition's activities on bringing about positive change in the system.
- ▶ Recognize that it will take a lot of work on the part of coalition initiators for the coalition to succeed, and that for most participating individuals the coalition represents an addition to their already heavy workload with their employing organization.

If males are going to be successfully brought into the health care system, and provided with the modes of health care appropriate to their situation in life, changes will have to be brought about in the current system of health care delivery. Coalition building is a prominent strategy that will be instrumental in bringing about the needed changes.

Guidelines for Costs of Male Sexual and Reproductive Health Care

Costs in the traditional model of health care delivery are determined on a fee-for-service basis. This method works best when the services are delivered within a health care facility such as a clinic, where they can be efficiently delivered and their costs can be tracked. With this method of payment, health care costs (reimbursements) are not linked to the outcome or success of the service, only to whether the service is deemed appropriate, and provides a best practice approach.

In this model, client-initiated clinic visits are the defining points of contact with the health care system, and the focus of that care is on delivery of treatment. While health promotion and prevention services are also delivered in clinics, best practices for these modes of care, including follow-up to determine outcomes and effectiveness, are seldom used because they are not reimbursable. As a result, the effectiveness of clinic-based health promotion and prevention services is largely untracked and therefore undetermined.

This model works reasonably well for the female half of the population. Females have compelling reasons for entering health care at a young age, i.e. the onset of menstruation, pregnancy prevention, or prenatal care, and for repeat encounters during their adult lives. Unlike females, males do not have the same compelling reasons for interacting with the health care system. They are not as easily reached for delivery of any mode of health care, especially health promotion and prevention services. This situation persists for most of their adult lives. To effectively reach the male population with health care services, a departure from the current models of health care delivery and methods of determining and paying for health care costs is required.

16

For male-targeted intervention programs to be successful, the primary location of health care activities needs to shift from the clinic to the community. The focus of these activities needs to shift from client-initiated treatment or prevention to provider-initiated risk and needs assessment, health promotion, prevention services and treatment appropriate to the individual's risks and needs.²³ An advantage of this approach is that by identifying risks early, health promotion and prevention services can be emphasized so that the need for treatment is reduced.

Higher initial costs and the need for more health professionals trained in the community-based model are the most significant barriers to these changes. While the supply of appropriately trained health professionals will respond to market demands, the cost barrier is not easily overcome. Proponents of health promotion and prevention services often argue that effective delivery of these modes of health care reduces treatment costs and yields net savings. While the unit costs of health promotion and prevention services are almost always less than the unit costs of treatment, the lower unit costs of health promotion and prevention services can easily be offset by the larger number of people, i.e. more units, to whom the services need to be delivered to be effective. This will produce higher overall costs. In addition, these health promotion and prevention services costs are paid up-front, and are "add-ons" to the continuing costs of clinic-based treatment programs. The community-based model may cost less in the long run because of its emphasis on health promotion and prevention services, but there is no guarantee of this, and third-party payers are reluctant to assume that risk. Thus effective male sexual and reproductive health programs not only cost more to implement than sexual and reproductive health programs for females, they also require alternative sources of funding.

When attempting to set cost guidelines for male sexual and reproductive health care services, experiences with female services of this type are of only limited use for two reasons. First, the types of health care services required by males are different from those required by females, except for physical exams, screening, and testing for HIV/AIDS and other STDs. Second, greater efforts are required to engage males before effective health care can be provided to them.

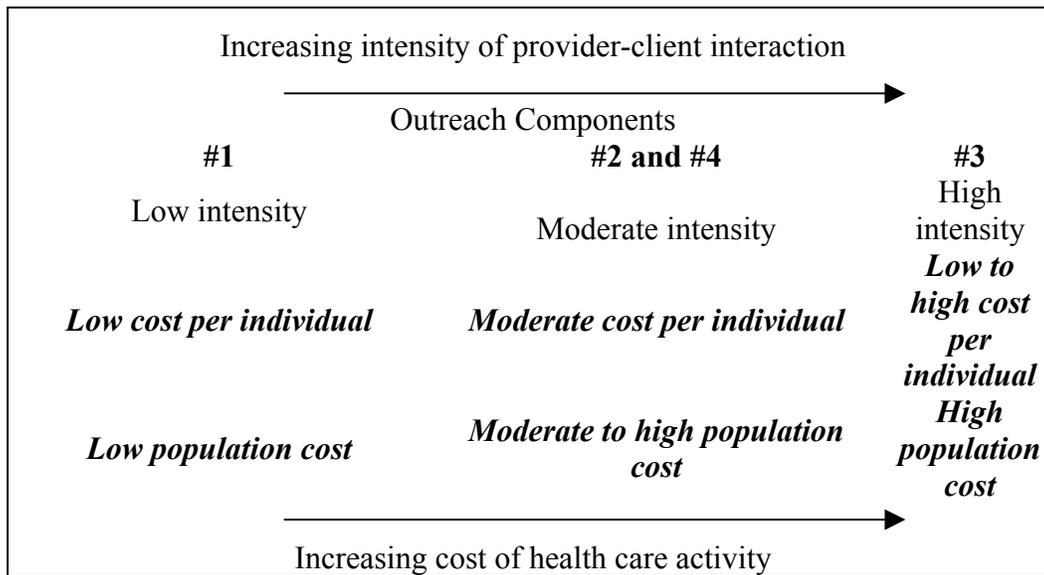
There are additional health care needs for males that are seldom considered as part of sexual and reproductive health care. These include conditions that result from age-related physiological changes (arteriosclerosis), are secondary to illnesses and health conditions (diabetes, alcoholism,

drug abuse, hypothyroidism), or are attributable to pharmacological agents (anti-hypertensives, tranquilizers, sedatives) that can have serious impacts on male sexual and reproductive health.²⁴ However, the biggest cost differences in providing sexual and reproductive health care to men are those of the outreach programs necessary to make them effective.

The content of outreach programs is unique for each group of men targeted. However, all models have common components, which can be used to make general estimates of the costs of outreach programs for males. These are:

- ▶ ***Outreach component 1: Activities that provide information to members of the target group.*** The purpose of these encounters is to attract the attention and raise the awareness of males in the target group of their health risks and health problems. This is a *low-intensity* activity that may involve media campaigns but most often entails more grass-roots activities, including brochure distributions and presentations to groups in the target population. The per person cost of this activity is low, and since the size of the target population segment is not a factor in the cost, the total cost to serve the population is also low.
- ▶ ***Outreach component 2: Activities with individuals for assessments of risk and impairment, followed by linking them with the appropriate care, and providing motivational interventions to encourage them to participate in that care.*** The purpose of these activities is to stimulate action by males in the target group to seek health care appropriate to their level of risk or degree of health impairment. This is a *moderate-intensity* activity, involving person-to-person contact. The per person cost of this activity is moderate because it involves more intense interactions between client and provider than component 1, though not as intense as those of component 3. The population cost can be moderate to high, depending on how large a population segment, i.e. the number of individuals, is selected for this intervention activity.
- ▶ ***Outreach component 3: Activities that support the participation of individuals in modes of health care, i.e. health promotion, prevention, treatment, and functional support, appropriate to their level of risk or degree of impairment.*** The purpose of this is to ensure that males in the target group receive appropriate health care. This is a *high-intensity* activity involving the most extensive interactions between client and provider. The per person cost of this activity can vary from low to high, depending on the mode of health care. Health promotion and prevention services are usually low-to-moderate cost interventions, while treatment and functional support are usually high-cost interventions. The population cost is generally high because treatment and functional support tend to be the predominant forms of care.
 - ▶ ***Outreach component 4: Follow-up on the effectiveness of health care provided to males in the target group and on their need for further care.*** This is a *moderate-intensity* activity involving periodic contacts with individuals in the target group. These can be group contacts by a field worker trained to gather this information. The per person cost of this activity is moderate, as is the population cost. Figure 2 depicts the general relationship between intensity of provider-client interaction and health care costs.

Figure 2. Schematic showing direct relationship between intensity of provider-client interaction and outreach component costs



Source: Author's compilation.

Covering the costs of provider-initiated outreach components, which are generally not reimbursable by third party payers, requires either new sources of funding, or the assignment of these activities as added responsibilities to clinic personnel already supported by reimbursements. General guidelines for what outreach components should cost can be derived from the intensity level of provider-client interaction: the greater the intensity, the higher the costs. Intensity level is a function of both the quality and quantity of contact time with individual clients, ranging from less intense group meetings, used mainly for information exchange, to more intense interactions, used to bring about change in client behavior.²⁵ More intense contacts are usually more effective and costly.⁷

Despite higher up-front costs, the community-based approach can provide long-term cost savings. These can be realized when the community-based approach is applied to any target population of men or women, regardless of age. First, the need for treatment may be reduced by addressing the total health care needs of the population, including health promotion and prevention.

Second, when the array of health care services provided in a community is organized and coordinated to better match the needs of the population for health care, there will be fewer duplicated services and wasted effort in seeking appropriate care. The mix of health promotion, prevention, treatment, and functional support services should be consistent with the needs of the community for each of these activities.

Third, with trained professionals who are knowledgeable about both the needs of the population and available community resources, clients can be more effectively linked with providers of the mode of health care most appropriate to their needs. This may reduce unnecessary treatment and minimize delays in receiving appropriate care.

There is another unique advantage realized when the community-based model of health care is applied to males. By successfully involving men more directly in health care, especially in health

promotion and prevention, they will participate in programs that complement and enhance programs in place for women, such as those aimed at preventing STDs, unintended pregnancies, and violent and abusive behaviors.

5. EDUCATIONAL PROGRAM CONTENT

The goal of any male health education program is related to the mission of the organization providing the program. What these programs have in common is the intent to provide individual males health care, broadly defined as health promotion, prevention services, treatment, and support services. The organization's message must be consistent with the personal goals and priorities of their male audience. Goals and priorities are different for males than for females, and vary by age. In this section we provide guidelines for selecting and preparing program content for males with these differences in mind. Both general and age specific guidelines are included.

General Guidelines

- ▶ ***Identify the real needs of the target group, differentiating what they want from what they need.*** This requires detailed knowledge of the needs and assets of the target group, their demographic and epidemiological make up, and their health risks.
- ▶ ***Incorporate the values and norms of the target group's culture and community into the content of the message.*** A message will not resonate with members of the target group unless they are comfortable with its content and delivery. Consideration of the different languages, dialects, and customs of ethnic and racial groups and subgroups are intended by this guideline.
- ▶ ***Account for regional and geographic variations in values and norms in preparing educational programs.*** This guideline is based on the point above, but is included separately to emphasize that urban-rural differences, as well as differences between parts of a city, county, or state, or between states, are often as important as ethnic and racially cultural differences.
- ▶ ***Create an inviting and culturally sensitive service environment that celebrates male involvement, reflects the program's mission, and matches the racial and ethnic composition and needs of the target group.*** The physical, structural, social, and emotional climate of a program can communicate a cogent message that help-seeking is normal and consistent with healthy and competent male behavior. Efficient service provision by skilled and knowledgeable staff is the most basic ingredient of a male-friendly service environment. Photographs and other visual images of men who reflect the target audience's racial and ethnic composition and who endorse the program or the program's health message enhance program ambiance. The availability of health and entertainment videos, printed materials, and other media that make "down time" at the service site more comfortable. "Teachable moments" in waiting rooms and other agency venues can be crafted so that men have opportunities to learn about health issues and community resources, discuss health beliefs and attitudes, and practice skills that enable them to engage in health-promoting behaviors.
- ▶ ***Employ developmentally appropriate material, especially as it relates to the knowledge of sexual and intimate relationships.*** Age, experience, and

environment contribute to an individual's responsiveness to an educational intervention. This is very important when approaching males about matters of sexual and reproductive health. Over or underestimating the level at which a group is ready to deal with an issue can result in an unsuccessful educational effort, misunderstandings and uncertainties among members of the target group. Activities that help the participants gain communication, negotiation, and decision-making skills are recommended (Table 2).

- ▶ ***Maintain a positive orientation toward sexual relations, intimate relationships, and health.*** The natural curiosity and interest of males of all ages in sexual and intimate relationships should be used to engage them in consideration of how sexual and intimate relationships can help bring fulfillment to their lives. Sexual health and the activities that prevent risk can both affect and be affected by how they manage sexual and intimate relationships.
- ▶ ***Use credible sources in preparing and delivering educational programs.*** This guideline has two aspects. The first pertains to the integrity of the content and delivery of the educational program; the second pertains to the acceptability of the educational intervention to the target group. Both are necessary for successful educational programs. Credible sources pertaining to the integrity of the program means that the material and the way it is delivered have been proved effective in field tests with target groups similar to the one for which it is intended to be used, and that documentation of this effectiveness is available, either in the scientific literature or from the author of the material. Credible sources pertaining to target group acceptability means that the target group considers the organization or individuals delivering the program as a legitimate source.
- ▶ ***Employ role modeling mentors to reinforce educational messages.*** One of the strongest methods of engendering acceptability in male audiences is through role modeling, especially by the persons delivering the program. In the absence of role models, or to augment existing role models, further acceptability can be achieved through endorsement of the program by an opinion leader within the target group, or by someone outside the target group who is held in high esteem by members of the group.

Table 2. Overview of Sexual and Reproductive Health Educational Programs for Males

	<i>Goal 1</i>	<i>Goal 2</i>	<i>Goal 3</i>	<i>Goal 4</i>	<i>Goal 5</i>
Educational intervention	Promote sexual health and development	Promote healthy intimate relationships	Prevent and control STDs and HIV/AIDS	Prevent unintended pregnancy	Promote responsible fatherhood
Information	Normal anatomy and pubertal development Social and emotional development Hygiene STDs and HIV/AIDS Where and how to access services Physical activity	Stages in romantic relationships Readiness for sexual involvement Forms of sexual expression Sexual coercion and violence	STD and HIV/AIDS symptoms and transmission Diagnosing and treating STDs and HIV/AIDS Prevention strategies Prevalence of diseases Short- and long-term consequences of STDs and HIV/AIDS Where to get condoms	Contraception and its effectiveness Reproductive biology and how pregnancy occurs Where to obtain contraceptives Consequences/costs (of pregnancy/contraception) Forms of sexual expression	Responsibilities of parents Prenatal health and childbirth Child development Child health and well-child care Paternity establishment, child support, and visitation
Skills	Resisting peer pressure Communication Decision making Self-advocacy Risk assessment and avoidance Setting and achieving goals	Communication and listening Partner selection and avoiding unhealthy relationships Negotiating safe sexual activity Recognizing difference between consent and coercion Violence prevention	Negotiating sexual activity and setting limits Negotiating condom use How to use condoms properly Communication (with partner about sexual activity) How to recognize STD and HIV/AIDS symptoms How to access services How to ask for more information	Negotiating sexual activity and setting limits Communication (with partners, providers) Decision making How to access services/resources Resisting peer pressure How to be intimate with partners How to use contraceptives properly How to use condoms properly	Parenting skills Life skills (obtaining job, housing, medical care) Training and opportunities for financial self-sufficiency Communication (child and child's mother)
Positive self-concept	Self-esteem Self-respect Sexual identity/orientation Gender roles Personal potential	Self-esteem Self-respect Sexual identity/orientation Gender roles	Self-esteem Self-respect Awareness of vulnerability Self-efficacy Sexual identity/orientation	Self-esteem Self-respect Confidence in the future Sense of control over one's life and decisions	Self-esteem Self-respect Nurturance Sense of control over one's life and decisions
Values and motivation	Respect for others Spirituality Family expectations Healthy lifestyles Value of education Social responsibility and contribution Cultural appreciation Value of healthy sexuality	Healthy relationships Role expectations Mutual fidelity	Health as a priority Concern for partner's health	Women's/men's role in contraception Women's/men's role in pregnancy Setting and achieving life goals Parenting as a life goal	Values regarding parenthood/fatherhood Values regarding manhood

Source: Adapted from Young Men's Sexual & Reproductive Health, Sonenstein 2000b.²⁶

Topic Guidelines: Pre-Adolescent Young Males, Ages 9–11

Access to males in this age group for health education programming is usually through captive-audience situations, such as schools, churches and other faith-based groups, community organizations such as Boy Scouts, Boys' Clubs, sports groups, and the juvenile justice system. Males in this age group are relatively easy to locate and address. However, there are topics that cannot be covered, especially in schools and faith-based groups, and others that have restrictions on how they can be presented. There is a greater number of community-based health education programs for adolescent males than for any other male age group.

Success with adolescents and teens requires an educator who is sensitive to their concerns and misconceptions, who is skilled in maintaining their attention, and who is able to effectively deal with the wide range of knowledge and experience in sexual matters among boys of these ages. A positive orientation toward sexual and intimate relationships and health should be maintained, from a perspective that recognizes the value and challenges of teens.

Sexual and reproductive health topics appropriate to this young pre-adolescent male group include:

- ◆ Hygiene and anatomy.
- ◆ Puberty education.
- ◆ The concept of manhood within the contexts of relationships and roles.
- ◆ Gender identity.
- ◆ Etiquette training, in relationships.
- ◆ Peer relations.
- ◆ Life skills that contribute to health and quality of life.
- ◆ Health literacy.
- ◆ Attitudes of respect and consideration for others, and how to translate these into behavior.

Topic Guidelines: Adolescent Young Males, Ages 11–13

In addition to the topics in the previous age-group listing, sexual and reproductive health topics appropriate for discussion with this older adolescent male group include:

Values in the context of value-conflict and clarification.
Peer pressure management.
Responsible behavior and healthy relationships.
Crushes and attraction.
Abstinence, decision-making, and risk-taking avoidance.
Parenthood: consequences and responsibilities of paternity.

Topic Guidelines: Teen-Age Young Males, Ages 14–17

In addition to the topics in the previous age group listings, sexual and reproductive health topics appropriate for discussion with this teen-age male group include:

- ◆ Physical and verbal assault.
- ◆ Gender identity development.
- ◆ Contraception, ethical and practical considerations.

- ◆ STDs, HIV/AIDS, testicular cancer, and other reproductive health issues.
- ◆ Risk-taking avoidance.
- ◆ Relationships and sexual intimacy.

Topic Guidelines: Young Adult Males, Ages 18–29

Access to adult males, is substantially more challenging than access to adolescent and teen-age males. While most adult males have jobs, the jobs of young adult males are less stable. This translates into greater mobility and less insurance coverage for health care and less likelihood of continuity of health care, if care is obtained or sought at all. Furthermore, access to cars, the availability of street drugs, feelings of invincibility, and high denial of risk and responsibility can all combine in this age group to create high resistance to health education interventions. Nevertheless, there are a number of successful community-based health education programs across the country for males in this age group.

Places to access young adult males for health education programming include clinic referrals, especially for physical exams for jobs and other reasons; STD and HIV/AIDS clinics; faith-based groups and churches, colleges and community colleges; barber shops; sports clubs; military barracks and reservist training facilities; and prisons. These access efforts are more costly and require more resources than those effective for younger age groups. Adult males of all ages need confidentiality and assurances in their encounters with health care.

In addition to the topics in the previous age group listings, sexual and reproductive health topics appropriate for discussion with this young adult male group include:

- ◆ Lifestyle and environment.
- ◆ Depression.
- ◆ Psychological and interpersonal factors that can impact sexual and reproductive functioning.
- ◆ Sexual activity, risk of HIV/AIDS and other STDs, and unintended pregnancies.

Topic Guidelines: Middle-Age Males, Ages 30–60

Men in middle age tend to be less mobile than younger men, but access to them for health education programming is still challenging since even these men generally do not interact with health care unless acute treatment is required. Some avenues of access to men in these ages are contacts with spouses and children, social clubs, fraternal and civic organizations and faith-based groups. Men in these ages tend to have more stable jobs, making the workplace an access site with the employers permission. Public service occupations i.e. policemen, firemen, postal and sanitation workers are good candidates for information on health activities.

The topic guidelines for middle-age men do not differ from those for younger adults, except for emphasizing screening for chronic diseases and encouraging greater awareness of symptoms of serious health problems. The guidelines for younger men on sexuality and intimate relationships are also appropriate for middle-age males. It is easy to overlook the fact that many men in this age group experience profound changes that impact their sexual and reproductive activities, and their health. The reasons for these changes are varied, ranging from loss of a partner to spousal infidelity, and changes in mood and sexual desire. Loss of a partner may put the sexually active

middle-age male in the same risk category for STDs, HIV/AIDS, and unintended pregnancy as younger males. Even in a stable relationship, there can be serious health problems, like erectile dysfunction or depression, which may impact sexual and emotional health, but are not confronted because of fear or ignorance. Despite the widespread nature of sexual and reproductive health concerns among middle-age men, there are few community-based health education programs that address these needs.

Topic Guidelines: Older and Elderly Males, Ages 60+

Men age 60 and over have most of the same sexual health concerns as their younger counterparts, although perhaps less concern about reproductive health. They also have some unique sexual health concerns. For example, in addition to what is written about middle-age men above, older and elderly men have a greater prevalence of prostate conditions, erectile dysfunction, reduced sexual stamina, and slowed sexual response. These are often associated with feelings of lost masculinity and lowered self-esteem.

Other health problems, prevalent among men in this age group, such as heart disease, cancer, and arthritis often interfere with intimate sexual activity. Finally, a large proportion of older and elderly men have suffered the loss of their partner. There are few community-based educational programs that address the sexual health needs of older and elderly men.

6. PLANNING, MONITORING, AND ASSESSING PROGRESS TOWARD GOALS

Essential to any educational program is an integrated process of planning, monitoring, and assessing progress toward the goals of the interventions. This is not as difficult and burdensome as it is often perceived to be, and can be extremely useful in helping to direct limited resources to the most productive areas of activity. An integrated process means that the planning of interventions is based on reliable information about the needs of the target population, the implementation of the interventions occurs as planned, and some measure is taken of how close the interventions come to achieving their goals.

The need to monitor and assess progress is critical. Interventions do not always go as planned, especially in the complex reality of the community. When that happens, the information from the ongoing monitoring and assessments can be used to make modifications in the current interventions, and adjustments in the planning of future interventions.

Having documented evidence of an intervention's success is always beneficial; whether it is used to inform an agency's advisory board, market the intervention to the community, or request support from potential funding sources. Funding sources expect programs to be accountable, so organizations are requested to provide evaluation information as a condition of funding.

Issues Around Planning, Monitoring, and Assessing Progress

A common monitoring and assessment concern of CBO/FBO administrators is the drain these activities produce on in-house staff, program time, and meager budgets.

Assessment Versus Service

The major benefit of monitoring and assessing progress toward goals is improved efficiency and effectiveness of programs. A well-designed plan for monitoring and assessing progress will easily recover its costs in savings by helping administrators decide which aspects of the program are on or off-track, and how well each component is working. This occurs by reducing the possibility that a program will be ineffective, a drain on resources necessitating expensive corrective action and facilitates the identification of the areas that would benefit from more efficient spending.

Forms of Monitoring and Assessing Activities

Monitoring and assessment activities should be tailored to the specific program. They should include attention to both the processes and outcomes of the intervention. Monitoring and assessment activities should also measure the qualitative and quantitative aspects of the intervention.

Preferred Source of Monitoring and Assessing Activities

Monitoring program activities and assessing progress toward goals are management tools for decision-making and staff development. These tools are most useful when incorporated during the planning of programs as an integral part of the implementation. They not only make it possible to measure success, but also to diagnose program deficiencies that may prevent intended goals from being accomplished. With this information administrators can make the changes necessary to correct the deficiencies, often while the program is in progress.

When the monitoring and assessing are done either from within the organization, or by people close enough to the organization that they are thoroughly familiar with its goals and capability, these benefits are realized to their fullest. While external evaluators can generally provide an independent opinion on whether a program achieves stated outcomes, it is more difficult and costly to use them for monitoring and assessing process activities within the program. Since few CBOs/FBOs have staff that they can assign exclusively to monitoring and assessment because of a lack of expertise or time, it often seems expedient to contract with outside independent professionals to satisfy the requirements of boards and funding sources for program evaluation. Unless care and time are taken to educate the evaluators about the organization's goals and capabilities, as well as about the specific program's goals, the results could be less useful and satisfying than anticipated. In summary, the education of the evaluators is not without costs to both staff and evaluator time. There are no programmatic or economic shortcuts to useful results from the monitoring of activities and assessment of outcomes. Monitoring and assessment are an essential part of any CBOs/FBOs program that relies on external funding for its continued existence. They need to be included as integral components of the program from its inception.

Developing and Implementing a Monitoring and Assessment Protocol

The primary purpose of monitoring activities and assessing progress toward goals is to strengthen programs by providing systematic information about how well each of its components is functioning, and how well the program is achieving its intended outcomes overall. Apart from

verifying that the project is achieving its intended outcomes, the best use of monitoring and assessment information will be to make adjustments and corrections that improve the implementation process.

There are also two secondary purposes that will be addressed by monitoring and assessing progress toward goals:

- ▶ Assess the effectiveness of the procedures and tasks used to implement the project, so that if the project is successful the managers will know why, and if it is not successful, they will know why not. This is essential if the project is to be replicated. Activities that are not contributing to project goals can be revised or discarded; those that are can be retained with confidence.
- ▶ Determine how well the organizational structure of the organization is able to support the project and contribute to its success.

To realize the full potential of a monitoring and assessment protocol, it should be structured to provide the program coordinator with useful information in a timely manner. The protocol should be flexible to accommodate changes in project designs and methods as needed during the implementation, and should also include a range of monitoring and assessment techniques to capture as much of the variety of the project as possible.

With the participation of program management and staff in the design and implementation of the monitoring and assessment process, a collaborative component will develop that will be beneficial to all personnel involved with the project. The management and staff will benefit from the organizational and planning skills gained by participating in monitoring and assessments. The organization's ability to design, implement, and evaluate future projects will also be strengthened by the process.

The general framework of monitoring and assessment consists of the following four components:

- ▶ **Formative Phase.** The Formative Phase of monitoring and assessment is designed to assess the strengths and weaknesses of planned projects before they are implemented. Its basic purpose is to maximize the chance of success before the project starts. This includes reviewing the information base on which a proposal is built; assessing the appropriateness of its methodology and the rigor of any data-gathering instruments, and the scientific and social legitimacy of the project; as well as ascertaining that an appropriate monitoring and assessment protocol is included in the project design.
- ▶ **Action Phase.** The Action Phase of monitoring and assessment examines the procedures and tasks used to implement a project, including administrative and organizational aspects, methods of intervention and data collection, and how the information gathered will be used. The purpose of the Action Phase of monitoring and assessment is to maximize adherence to the project plan and timetable, and to provide information with which to assess the roles of individual components of the project in relation to its success or failure. As mentioned above, this phase of monitoring and assessment is essential if a project is to be successfully replicated.

- ▶ **Outcome Phase.** The Outcome Phase documents the results of a project, and occurs on two levels: the first is to measure whether the project objectives were achieved, i.e. Which activities were successfully completed?; How many people participated? The second is to measure the effects on the target population by determining if the project goals were achieved, i.e. Was knowledge, compliance, and participation, improved? If in the course of developing the monitoring and assessment protocol it is determined that a project is unlikely to have effects on these issues, then the person responsible for the monitoring and assessment should work with the organization to appropriately redesign the project.
- ▶ **Impact Phase.** The Impact Phase focuses on the long-term results of the project. These will depend on the specific goals of the individual projects, but examples of long-term results relevant to some programs include changes in pregnancy rates, secondary changes in morbidity and mortality associated with pregnancy and sexual activity, maintenance of behavior changes intended to reduce pregnancy, lowered rates of recidivism, and lower absenteeism from work or school, among others. Because of the time frame and costs associated with impact evaluations, they should be undertaken selectively.

7. ADDITIONAL CONSIDERATIONS

Of all the external stakeholders that impact the availability of health educational programs for males, federal and state health agencies should be considered a priority because of their broad array of funding, and other resources. In order to take advantage of these resources, before, during and after funding, it is necessary to have a basic understanding of how public health agencies operate. Listed below are some of the grant terms commonly associated with federal and state health agencies.²⁷

Administrative Requirements – The general business management practices that are common to the administration of all grants, such as financial accountability, reporting equipment management, and retention of records.

Application – Generally, a request for financial support of a project or activity submitted to HHS or specified forms and in accordance with instructions provided by the HHS awarding office.

Appropriation Act – The statute that provides the authority for Federal agencies to incur obligations and to make payments out of the U.S. Treasury for specified purposes.

Approved Budget – The recipient’s financial expenditure plan, including any revisions approved by the awarding office, for carrying out a grant-supported project or activity. The approved budget includes Federal funds and may require non-Federal participation, the amount of which is specified on the initial award document and on any subsequent revised or amended award notice.

Award – Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements in the form of money or property in lieu of money, by the Federal Government to an eligible recipient. The term does not include technical assistance, which provides services instead of money; other assistance in the form of loans, loan guarantees, interest subsidies, or insurance; direct payments of any kind to individuals; and

contracts which are required to be entered into and administered under procurement laws and regulations.

Budget Period – The intervals of time into which a multi-year period of assistance (Project period) is divided for budgetary and funding purposes. Budget periods are usually 12 months long but may be shorter or longer, if appropriate.

Catalog of Federal Domestic Assistance – A catalog published twice a year which describes assistance programs administered by the Federal government. This Government wide compendium of Federal programs lists projects, services, and activities which provide assistance or benefits to the American public.

Categorical Grant – A grant having a specifically defined purpose.

Cooperative Agreement – An award instrument of financial assistance where “substantial involvement” is anticipated between the HHS awarding office and the recipient during performance of the contemplated project or activity. “Substantial involvement” means that the recipient can expect Federal programmatic collaboration or participation in managing the award.

Direct Cost – Those cost that can be specifically identified with a particular project, program, or activity.

Funding Period – The period of time when Federal funding is available for obligation by the recipient.

Grant – Financial Assistance (including cooperative agreements) in the form of money, or property in lieu of money, by the Federal government to an eligible recipient. The term does not include any Federal procurement subject to the Federal Acquisition Regulation (FAR); technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to individuals.

Grants Manager/Officer (GMO)/Grants Officer – The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant (s) or cooperative agreement (s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration, policies and provisions. He/She works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

Health Science Administrator (HSA) – In PHS, the awarding office official who is responsible for the technical, scientific, or programmatic aspects of a grant. This official may also be referred to as the program officer or project officer. Such individuals deal with the recipient organization staff to assure programmatic progress and work closely with the Grants Management Officer and the grants management staff in the overall administration of grants.

Independent or Objective Review – An advisory competitive review of discretionary grant applications usually conducted by peer/expert review groups.

Indirect Costs – Those costs that are incurred for common or joint objectives and therefore cannot be identified readily and specifically with a particular sponsored project, program, or activity but are nevertheless necessary to the operations of the organization. For example, the

costs of operating and maintaining facilities, depreciation, and administrative salaries are generally treated as indirect costs.

No-cost Extension – An extension of time to a project period and/or budget period to complete the work or the grant under that period, without additional Federal funds or competition.

Program Announcement – A granting agency’s formal published announcement of the availability of Federal funding through one of its assistance programs. The announcement invites applications and provides such information as eligibility and evaluation criteria, funding preferences/priorities, how to obtain application kits, and the submission deadline.

Program Official/Project Officer – The individual designated as the official responsible for the programmatic, scientific, and/or technical aspects of HHS programs. He/she serves as the counterpart to the Department’s Grants Management Officer who is responsible for all business management aspects of a grant.

Project Costs – The total allowable costs, as set forth in the applicable Federal cost principles, incurred by a recipient (and the value of the in-kind contributions made by third parties) in accomplishing the objectives of the award during the project period.

Project Period – The total time stated in the Notice of Grant Award (including any amendments) for which Federal support is recommended. The period will consist of one or more budget periods. It does not constitute a commitment by the Federal government to fund the entire period.

GLOSSARY OF TERMS

Asset mapping—Identifies resources and programming available to meet need assessments.

Convenience sample—A group of individuals who are chosen because of their ready availability, not on a scientific (probability) basis, and who are not necessarily representative of the target audience.

Educational programming—Presentation of information in a manner designed to raise an individual's awareness of a problem or situation, and to increase the likelihood that the individual will act in a beneficial way.

Focus group—A group of selected individuals convened to discuss a specific topic for the purpose of obtaining qualitative information about the topic. Individuals are selected because of their particular viewpoints or roles relating to the topic. A predetermined set of discussion points serves as a guide to the discussion.

Interview—The collection of data from individuals using a structured format to ensure comparability of responses between individuals.

Key informant—A person in a position of leadership, or who has special knowledge of a group.

Listening group—A group of individuals convened to discuss a specific topic for the purpose of obtaining qualitative information about the topic. Similar to a focus group, but less formally organized and scripted.

Logic model—Model that describes a logical sequence of associations, usually attempting to relate cause and effect through a series of intermediate relationships.

Model—Set of abstract ideas used to explain observed relationships in terms understandable to the individual.

Needs assessment—a formal process—which is the first step in a community health improvement process—of identifying problems and assessing the community's capacity to address health and social service needs.

Participants—Individuals who are actively engaged by the educational programs and likely to receive the most benefit from them.

Probability sample—A systematic collection of data from a scientific representative sample of the target audience.

Stakeholders—People and organizations that are affected by the CBOs/FBOs program.

Theoretical model—Model that employs concepts based on theory to explain observed relationships. In health behavior, the most common theoretical models use concepts from behavioral science to explain why people do, or do not, behave in ways favorable to their health. A non-theoretical model is one based on observed associations, without regard to whether the observed pattern of associations corresponds to any theoretical expectations.

REFERENCES AND RELATED READINGS

-
- ¹ U.S. Census Bureau. 2000. *Statistical Abstract of the United States, 2000*. Washington, D.C.
- ² U.S. Department of Health and Human Services. 2000. Volume 1, p. 11. *Healthy People*. Washington, D.C.
- ³ U.S. Department of Health and Human Services. 2000. Volume 2, p. 1-55. *Healthy People*. Washington, D.C.
- ⁴ Rich, John A., and Marguerite Ro. 2002. *A Poor Man's Plight: Uncovering the Disparity in Men's Health*. A Series of Community Voice Publications. Boston, M.A. W.K. Kellogg Foundation.
- ⁵ U.S. Department of Health and Human Services, Office of Population Affairs, Office of Family Planning. 1970–mid 1990's. *Family Planning Annual Report (FPAR), Bureau of Community Reporting Requirements (BCRR)*. Washington, D.C.
- ⁶ Gruchow, H.W. 2002. "Life Trades: Health in the Balance." University of North Carolina, Greensboro, N.C.
- ⁷ Models Work Group November 2001–June 2002. Washington, D.C. Male Advocacy Network.
- ⁸ Butler, J.T. 1994. p. 72. *Principles of Health Education and Health Promotion*. Englewood, CO: Morton.
- ⁹ West, C. (1996). Black Sexuality: The Taboo Subject. p. 225-229 in K. E. Rosenblum and T.C. Travis (Eds.). *The Meaning of Difference*. New York. The McGraw-Hill Companies, Inc.
- ¹⁰ McGinnis, J.M. 1997. "Forward." In K. Glanz, FM Lewis, and BK Rimer, *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco: Josey-Bass, Inc.
- ¹¹ Glanz, K., F.M. Lewis, and B.K. Rimer. 1997. *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco, Cal.: Josey-Bass, Inc.
- ¹² Bandura, A. 1977. "Self-Efficacy: Toward a Unifying Theory of Behavior Change. *Psychological Review* 84: 191–215.
- ¹³ Glanz, K., and B.K. Rimer. 1995. *Theory at a Glance: A Guide for Health Promotion Practice*. NIH Publication 95-3896. Bethesda, Md.: National Institutes of Health, National Cancer Institute.
- ¹⁴ Hochbaum, G.M. 1958. *Public Participation in Medical Screening Programs: A Sociopsychological Study*. PHS publication 572. Washington, D.C: U.S. Government Printing Office.

-
- ¹⁵ Becker, M.H., ed. 1974. "The Health Belief Model and Personal Health Behavior." *Health Education Monographs vol. 2*.
- ¹⁶ Strecher, V.J., and I.M. Rosenstock. 1997. "The Health Belief Model." In K. Glanz, F.M. Lewis, and B.K. Rimer, *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco, Cal.: Josey-Bass, Inc.
- ¹⁷ Baranowski, T., C.L. Perry, and G.S. Parcel. 1997. "How Individuals, Environments, and Health Behavior Interact." In K. Glanz, F.M. Lewis, and B.K. Rimer, *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco, Cal.: Josey-Bass, Inc.
- ¹⁸ Montano, D.E., D. Kasprzyk, and S.H. Taplin. 1997. "The Theory of Reasoned Action and The Theory of Planned Behavior." In K. Glanz, F.M. Lewis, and B.K. Rimer, *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco, Cal.: Josey-Bass, Inc.
- ¹⁹ Prochaska, J.O., C.A. Redding, and K.E. Evers. 1997. "The Transtheoretical Model and Stages of Change." In K. Glanz, F.M. Lewis, and B.K. Rimer, *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco, Cal.: Josey-Bass, Inc.
- ²⁰ U.S. Department of Health and Human Services. 2000. *Healthy People 2010*. Volumes 1 and 2. Washington, D.C.
- ²¹ Carkhuff, Robert R. 1980. *The Art of HELPING IV*. Amherst, MA. Human Resource Development Press, Inc.
- Combs, A., Avila D., and Purkey, W. 1978. *Helping Relationships: Basic Concepts for Helping Professions*. Boston. Allyn and Bacon.
- ²² Sonenstein, F.L., K. Stewart, L.D. Lindberg, M. Pernas, and S. Williams. 1997. *Involving Male in Preventing Teen Pregnancy*. Washington D.C.: Urban Institute.
- ²³ Sonenstein, F.L., ed. 2000a, p. 30. *Young Men's Sexual and Reproductive Health: Toward a National Strategy—Framework and Recommendations*. Washington, D.C.: Urban Institute.
- ²⁴ Merck Research Laboratories. 1992, p. 1575–77. *The Merck Manual of Diagnosis and Therapy* (16th edition). Rahway, NJ.
- ²⁵ Eisen, Marvin, and others. 2000, p. 10-11. *Teen Risk-Taking: Promising Prevention Programs and Approaches*. Washington, D.C.: Urban Institute.
- ²⁶ Sonenstein, FL, ed. 2000b. *Young Men's Sexual and Reproductive Health: Toward a National Strategy—Getting Started*. Washington, D.C.: Urban Institute.
- ²⁷ U.S. Department of Health and Human Services, 1994. *Grants Policy Directive System*. Grants Policy Directive 1.02, HHS Transmittal 94.01. Washington, D.C.