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Community Voice: Taking it to the People, Guidelines for Conducting a Process Evaluation

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Master of Public Health Research Project

Community Voice: Taking it to the People, Guidelines for Conducting a Process Evaluation

By

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Submission Statement

Master of Public Health Research Project

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Abstract

Background

The Community Voice program is designed for African-Americans and explores key factors that can contribute to African-American infant mortality. This program was implemented in Henrico County based on Virginia Health Statistics that the White infant mortality rate average during the years of 2001-2005 was 5.3 deaths per 1,000 live births and in the same time period the infant mortality rate for African-Americans was 13.7 deaths per 1,000 live births. At the time of implementation of the program, no plans to evaluate the program had been made.

Objective

This evaluation was designed to develop guidelines regarding the evaluation process of the Community Voice program and develop evaluation tools that can be used by the agency to insure the fidelity of the program.

Methods

For the purposes of this project and the needs of Henrico County, six concepts are the focus of this process evaluation. These concepts are fidelity, dose delivered, dose received, reach, recruitment, and context. The developed evaluation guide includes information on data sources, the timing of data collection, tools to evaluate the six concepts, and a guide for data analysis and data synthesis.

Conclusion

By conducting a process evaluation, the Community Voice team will be able to determine if program objectives are being achieved, document strengths and weaknesses of the program, establish quality assurance, monitor performance, improve staff skills, promote community awareness, and meet public and fiscal requirements of accountability.

Introduction

About the Community Voice Program

The Community Voice program is designed for African-Americans and explores key factors that can contribute to African-American infant mortality (Scott & Wesley, 2008, p. 1). The curriculum discusses preconception, the relationship between folic acid and birth defects, prenatal care, preterm labor, low birth weight, nutrition, SIDS, immunizations, infant safety, and baby care (Scott & Wesley, 2007). The curriculum also examines the effects that smoking, alcohol, drugs, stress, racism, domestic violence, and father involvement can have on infant mortality (Scott & Wesley, 2008, p. 1). The curriculum is based on the Social Cognitive Theory of Learning with the belief that knowledge and awareness are preconditions for change. The curriculum is completed by participating in five two-hour sessions, with one session being taught per week. The program was developed this way because having a week between each session allows time for reflection, internalization of information, behavioral changes, and it provides time for making a long term commitment to the program. (Scott & Wesley, 2008, p.2-7)

The Community Voice program is for community residents who want to become lay health advisors. A lay health advisor is a person who is trusted in their community and is trained to take information back to community about issues that are affecting their health. These community residents can be anyone who is interested in reducing the infant mortality rate and can include men, women, teenagers, and grandparents. The curriculum does not assume any prior knowledge of medical procedures or terms and encourages participation and discussion.

The overall goal of the Community Voice program is to reduce the infant mortality disparity that exists between African-Americans and other races. The program also attempts

to improve other birth outcomes within African-American communities which include decreased pre-maturity rates, decreased low birth weights, and a decrease in the amount of babies dying from SIDS. (Scott & Wesley, 2007)

This curriculum was pilot tested in Lynchburg, Virginia during the years of 2000-2003. The infant mortality rate was 29.4 deaths per 1,000 live births for African-Americans in the city and 4.3 per 1.000 live births for Whites in the first year that the program was implemented. After running the program for three years the infant mortality rate decreased to 5.5 deaths per 1,000 live births for African-Americans in 2003. (Scott & Wesley, 2007).

Virginia state data reports found the White infant mortality rate average during the years of 2001-2005 for Henrico County was 5.3 deaths per 1,000 live births, for African-Americans in the same time period the infant mortality rate was 13.7 deaths per 1,000 live births (Virginia Department of Health, 2006). The three main causes of infant mortality in Henrico County during this time period were extreme immaturity, prematurity, and sudden infant death syndrome (SIDS) (Virginia Department of Health, 2009). The Henrico County infant mortality data was also analyzed by the specific regions of the county in which the deaths occurred, analyses found that the majority of the deaths were in the Fairfield and Varina areas of the county (Henrico Health Department, 2008).

The Plan to Reduce Infant Mortality

Because of this information, the Henrico County Health Department decided to focus interventions on deceasing infant mortality in areas of the county that have seen the greatest amount of infant deaths. The Henrico County Health Department developed a multi-faceted approach to dealing with the infant mortality issues in the county. The plan developed by the county included four steps. The first step was to identify the neighborhoods and apartment

complexes in the county who had seen the most infant deaths and were largely populated by the target population. The target population defined by the county was African-American women ages 13-45 in the Fairfield and Varina areas. The second step was to identify community organizations and faiths communities who would agree to partner with the health department to help educate small groups using the Community Voice curriculum. The third step in the Henrico County plan to reduce infant mortality was to pair educational resources with areas of need within the targeted communities. The fourth step was to engage a group of community leaders and organizations in an ongoing discussion about infant mortality and county efforts aimed at reducing the disparity and overall infant mortality rate. (Henrico Health Department, 2008)

In May 2009, the Henrico County Health Department, with support from the community, began implementation of the Community Voice: Taking it to the People program to help reduce the county's infant mortality rates. A missing element of the Henrico County Health Department's implementation of the Community Voice program is that no plan for evaluation had been set up to monitor the program. The Community Voice implementation guide has some evaluation tools listed in the appendixes, but there are no instructions for how to use these tools and they can easily be missed if a person is not looking for them.

A necessary requirement for any type of program is the evaluation. An evaluation by an organization like a health department usually focuses on the effectiveness and cost-efficiency of the program and is usually measured based on a behavioral, health or economic goals (Windsor, Clark, Boyd, & Goodman, 2004, p. 14). Some common purposes of an evaluation are to determine if program objectives were achieved, to document strengths and

weaknesses of a program, to establish quality assurance and monitor performance, to improve staff skills, to promote community awareness, and to meet public and fiscal requirements of accountability (Windsor et al., 2004, p.15).

Rather than waiting three years for an outcome evaluation to determine whether the Community Voice program will impact the health status and quality of life of residents by decreasing the county infant mortality rate, a process evaluation would be ideal for the Henrico County Health Department because they would be able to obtain and provide data to the stakeholders about how the program is being conducted and if specific interventional goals are being met. With limited resources, it will be helpful to know whether financially supporting the program is the most beneficial approach to lowering the infant mortality rate for the county.

What is a Process Evaluation?

According to Windsor, Clark, Boyd, and Goodman (2004) "the primary objective of a process evaluation is to document what a health promotion program has provided to a client, patient, employee, student or consumer and how well it was provided" (p. 132). A process evaluation helps to relate a better understanding of the parts that make up a program and show how these parts relate to the goal or outcome. Process evaluations also look at the core components of a program and determine if they are being implemented as designed. When a program is not implemented as designed this is referred to as a Type III error. A process evaluation can take on a formative approach, a summative approach, or both. A formative process evaluation take place during the early phases of a program and assesses the content, methods, materials, and instruments being used (Windsor et al., 2004, p. 27). From this data the program can be tweaked or changed if things are not working as planned. A summative

process evaluation uses data to determine the effectiveness of the program and to determine if the intervention is being implemented as it was intended and reaching the target population (Saunders, Evans, & Joshi, 2005, p. 136).

There are multiple concepts that can be analyzed when performing a process evaluation, however for the purposes of this project and the needs of Henrico County, six concepts will be the focus of evaluation. The first concept is *fidelity* which is the degree to which a program was successfully carried out as it was originally planned (Saunders et al., 2005, p. 139). To answer this question, the evaluation team needs to figure out what is the high standard of implementing this program. By measuring the fidelity of a program, the evaluation team can make any necessary adjustments to the program on an ongoing basis to guarantee the quality of the program. A second concept is *dose delivered* or completeness. This involves looking at the amount of sessions that were supposed to be delivered based on program guidelines versus the amount of sessions actually delivered by the instructors or staff. The third concept is *dose received* or exposure. Dose received looks at the number of participants who actually received the expected amount of training or education based on the program guidelines. The fourth concept important to a process evaluation is *reach*. Reach is defined as a specified proportion of the target population taking part in the program. The next concept is *recruitment*. This involves detailed procedures used to recruit participants into the program and maintenance of their involvement in the program. The last concept is *context*. Context involves looking at the environment (physical, social, and political) and determining if it had any impact on the implementation of the program or the program outcomes. (Linnan & Steckler, 2002, p. 12)

Objectives

The objective of this study is to develop a process evaluation plan for the Henrico County Health Department that can be used for the evaluation of the Community Voice: Taking it to the People program.

Methods

The Getting to Outcomes (GTO) framework was used in the development of this evaluation plan. The GTO framework consists of ten phases that can help guide a program developer through all phases of program planning from planning and implementation to evaluation and sustainability (Wandersman, Imm, Chinman, & Kaftarian, 2000, p. 392). This framework was chosen for several reasons. First the framework can be used at any stage of program planning to guide the program developer to the next stage. The second reason the GTO framework was chosen is because it does not have to be used in a linear form. The phases are presented in a start to finish sequence, but the framework is written so that at any stage, the program developer can gain some insight into the next step (Wandersman et al., 2000, p 394). Phases one through six deal with program planning and implementation. Since the Community Voice program is already being implemented, the most useful phase for this evaluation starts at phase seven which deals directly with process evaluation (Wandersman et al., 2000, 393). Phase seven provides information for the program developer on what measures to use and how to document implementation procedures.

The process evaluation for the Community Voice: Taking it to the People program will take on a formative and summative approach. The data collection and reporting times are very important so that the evaluators can provide feedback to the staff on what changes

may need to be made to provide better outcomes for the participants. If this program were fully funded, an outside evaluator or someone specifically designated to only perform the evaluation would be helpful, but due to budget constraints the program coordinator will be in charge of most aspects of the evaluation.

Fidelity

Fidelity is an overall measure of the quality of an intervention or program. To measure fidelity the question, Saunders et al. (2005) suggest asking, "To what extent was the curriculum implemented as planned?" (p. 140). The people who would be able to answer this question are the teachers and staff of the Community Voice program. The tool that will be used to measure fidelity is the 'Educator's Tracking and Evaluation Form' listed in Appendix A (Scott & Wesley, 2008). This form gives information about the date and location of class, the number of participants broken down by race and age categories, issues discussed, time session started, and time session ended. This will provide information on whether the sessions are being held for appropriate times and if the sessions are appropriately spaced apart. This record of each class will provide data on if the program is being implemented as planned. This measure can be biased because instructors may simply use the form to put the information that is expected of them and not be completely truthful about how the intervention was conducted. To help control for this, occasional observation of sessions will be completed by the program coordinator to measure the fidelity of the program implementation.

Dose Delivered

Dose delivered is directly related to the program implementation by the staff members. It measures the actions and behaviors of the staff that were responsible for

delivering the interventions. To measure the dose delivered concept, Saunders et al. (2005) suggest this focused question, "To what extent were all sessions within the program implemented?" (p. 140). The 'Educator Tracking and Evaluation Form' responses will be used to obtain results for this concept. For this concept, analyses will look at whether a specific staff member taught all sessions for a particular class or if there were multiple staff members within an entire five-week session. This will then be linked to post-test scores to determine if consistency among teachers was associated with better scores. The staff will also provide information on supplemental materials used and any handouts given to participants during each session. This will determine if all materials such as videos and suggested activities were used for the intervention.

Dose Received

This concept is similar to dose delivered but looks at participant participation. To measure the concept of dose received several questions must be answered. First, "What percentage of participants received all five session interventions?" Next, "Did participants enjoy the Community Voice curriculum and the associated activities?" Third, "Were the Community Voice instructors satisfied with the curriculum or are there topics that need to be discussed that are left out?" The final question for measuring dose received is, "To what extent were participants engaged in the curriculum?" To answer the first question, attendance rosters will be used to analyze the percentage of participants who attended all five sessions. The 'Lay Health Training Evaluation' tool listed in Appendix B will be used to answer the next question regarding participant satisfaction with the program (Scott & Wesley, 2008). This tool will be used to get feedback from each participant at the end of every session. The tool consists of ten multiple choice questions and leaves room for

feedback at the end of the form. The tool was developed to be short and only take a few minutes so that participants will not be asked to stay past the two hour session period. The questions related to Community Voice instructors will be assessed in a focus group setting with the instructors after everyone has taught an entire session. The program coordinator will be the facilitator for the focus group. If teachers are dissatisfied with the curriculum or feel that changes should be made to the curriculum in regard to certain topics, those changes can be made while the program is underway. The focus group will also be used to obtain feedback on the fourth question which discusses the engagement of participants in the curriculum. Engagement refers to the participation level from the participants throughout the sessions. This includes asking questions, sharing stories, or contributing to the discussions.

Reach

To answer the concept of reach, this question will be used, "Was the Community Voice curriculum delivered to at least 50% of African-American residents in the Fairfield and Varina Health Districts either directly through class room participation or by a lay health instructor within the county?' To obtain this information, attendance rosters collected by the teachers at each session will be used along with the 'Lay Health Reporting Form' located in Appendix (Scott & Wesley, 2008). Lay Health Reporting Forms are given to the lay health advisors at the completion of their final training session. Participants are asked to document contacts they make with residents of their community regarding Community Voice topics. The form includes space to document the age of people who topics were discussed with, the length of the discussion, and topics that were discussed. There is also room on the form for areas of concern that the Community Voice program could help the Lay Health Advisors with or topics that could be better explained by the outreach specialist. To analyze the reach

of the program, the number of students participating in the program through direct staff taught sessions or by a lay health advisor will be divided by the total number of people in the target population. To further validate the reach of the program. A 'Consumer Survey' will be given to all participants at the first Community Voice session. This survey can be found in Appendix D (Scott & Wesley, 2008). This anonymous survey collects data on age, race, sex, income, zip code, and additional factors Henrico County wants to know about participants. One of the most useful pieces of information on this form is the zip code. The zip code can be used to map out the areas of county with the least and the most involvement and may be able to be used in recruitment activities to know where more efforts need to be focused.

Recruitment

In order to continually recruit participants into the program, constant public awareness of the infant mortality issues must be seen within the impacted areas of the county. The Community Voice program must be marketed to the community whenever there is an opportunity. Therefore documentation related to partnerships, marketing and follow-up with participants who have completed the program must be kept so that recruitment can be measured. Several questions must be answered to look at the recruitment concept related to the Community Voice program. These questions will need to be asked of all Community Voice staff including the program director and the educational staff. The first question is "What recruitment strategies were used to attract individuals, groups, and or organizations to the Community Voice program?" (Saunders et al., 2005, p.140). A listing of community meetings, presentations, and activities will need to be kept by all members of the team who actively participate in community outreach. A log to help with keeping track of

these events has been developed and is listed in Appendix E (Scott & Wesley, 2008). This log collects information on the name of the organization or event, type of event, the date, the number of people in attendance, and the number of people recruited for the program. Saunders et al. (2005) suggest asking additional questions to get more information on the recruitment process these questions include, "What were the barriers to recruiting individuals, groups, and organizations?" and "What were the barriers to maintaining involvement of individuals, groups, and organizations?" (p. 140).

Another aspect of recruitment is nonparticipation. It may helpful to gain information from organizations that attended the initial stakeholder meeting on the infant mortality status of the county but decided to not participate in the program or partner with the health department. The reasons that these organizations state for nonparticipation can be used to adjust recruitment measures to eliminate some barriers of recruitment. These surveys will be delivered to these organizations through an email link to an online survey where the user can remain anonymous.

Context

Context refers to the environments that could have had a direct or indirect impact on the intervention (Linnan & Steckler, 2002, p. 8). Concerning the Community Voice program in Henrico County, the political environment may be an issue related to whether county officials support the program. To measure the concept of context, the question "What were barriers and facilitators to implementing the Community Voice curriculum?" will be asked in a focus group with the Community Voice staff members. These questions will be asked quarterly during Community Voice up-date meetings.

By measuring all of these components the process evaluation will be able to provide a clear picture of whether the Community Voice program in Henrico County is being implemented as planned and how much of the intervention is being given and received. The completed process evaluation will also provide information on whether the program is reaching the intended population and what barriers the staff may be having in implementing the program. A summary of the final process evaluation plan is listed in Appendix F.

Results

The program director can expect several short term outcomes from using the Community Voice process evaluation. One program level outcome that can be expected is to obtain ratings from the lay health advisors on the curriculum of the course and on the Community Voice instructors (University of Memphis, 2008). If the program has been implemented as planned most of the feedback from these ratings should be positive. Another expected program level outcome will be gaining knowledge on the effectiveness of the instructor (University of Memphis, 2008). The program director will also know if the team has met goals about the number of expected trainings and the expected number of participants to complete training versus the actual amount of trainings that occurred and the actual number of participants that completed all five two-hour sessions. By measuring reach, the program director will be able to determine how many of the trainings have been delivered within the target neighborhoods and among the target population. From the recruitment portion of the process evaluation, program directors should be able to determine organizations that have committed to hosting training sessions or a list of individuals who are committed to undergoing training to become a lay health advisor.

Discussion

In recent years, process evaluations are increasingly being used by organizations. One of the main reasons for this is the complexity of many social and behavioral interventions (Linnan & Steckler, 2002, p.1). The complexity of interventions exists because of the many sites that interventions may be conducted at or the multiple sessions that make up an intervention. Due to the increasing complexity, program implementers want to know which piece of the intervention is responsible for change and are of all of the pieces of the intervention necessary to create a change in thinking or behavior. Process evaluations provide the stakeholders with knowledge that can not be obtained by simply looking at the overall outcome of the intervention.

Process evaluations provide information on why an intervention was successful or unsuccessful. In times when finances are limited, it is important for an organization to know whether their money is being spent on effective interventions. A process evaluation can help to explain why a certain intervention may not have created the expected results. Process evaluations can also provide more understanding on interventions based on a particular theory (Linnan & Steckler, 2002, p. 2). Process evaluations can serve as the link to the constructs of a theory that are crucial to obtaining successful outcomes. By using data from the process evaluation, the theory constructs and interventions can be refined to improve the effectiveness of the entire program (Linnan & Steckler, 2002, p.2). Data will also provide information on whether certain pieces of an intervention provide better or worse outcomes when completed in certain conditions.

Process evaluations are also valuable because they provide qualitative data that cannot be obtained through traditional methods of research where quantitative data is the

gold standard (Linnan & Steckler, 2002, p. 3). Process evaluations incorporate both qualitative and quantitative data into its research methods to increase the amount of information that can be collected from an intervention.

Conclusion

Process evaluations when used correctly can be a valuable tool to an organization and provide helpful information on the success or failure of a program in meeting its expected goals. The primary objective of this study, which was to develop a process evaluation for the Henrico County Health Department for the Community Voice: Taking it to the People Program was achieved. The Henrico County Health Department will have to put this evaluation to use within its program to obtain results on whether their program is being successfully implemented. Future recommendations for health organizations are to first, realize the value of process evaluations and the data they can provide to the organization. Evaluations should be considered at the beginning of a program and not when the program is underway or coming to an end. If process evaluations are developed at the start of the program, all stakeholders can have input on the concepts that they think are important to include and they will be able to have input on how the evaluation is conducted. This leads to the second recommendation which is partnering with community organizations early on in the evaluation process. Having all stakeholders working together on the program and the evaluation is essential for achieving the best results from community and health department collaboration. Because so many pieces of the process evaluation include input not only from staff members of a program but members of the community their input is valuable to obtaining the most complete results from the evaluation tools. Last, process evaluations

should be conducted in comprehensive manner. Once the data is obtained it must be analyzed to gather results about the program.

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Educators Tracking and Evaluation Form

Date of Class:_____

Number of Participants:_____

Location of Class:_____

Name of Trainer:_____

Start Time:_____ End Time:_____

Were any activities done within the session? Yes No
If yes, what were these activities:_____

Were any supplemental handouts given to participants? Yes No
If yes, what handouts were used?_____

Issues Discussed this Session:_____

_____

Actions Taken From Discussion:_____

_____

Number of Participants by Gender and Relative Age:

Adult Females:_____ Teen Females:_____ Adult Males:_____ Teen Males:_____

Number of Participants by Race:

African American:_____ White:_____ Hispanic:____Asian:_____ Other:_____

Number of Evaluations Collected_____ (Attach Evaluations)

Comments from Trainer:_____

_____

_____

Relevant Quotes from Participants:_____

_____

Lay Health Training Evaluation

Please circle one answer for each question.

1. What did you think about the overall program?

Excellent Very Good Good Poor

2.	Did you learn anything new about pregnancy and infant health?	Yes	No
3.	Will you talk to others about what you have learned?	Yes	No
4.	Have you spoken to anyone about what you have learned? If yes, how many people have you spoken to?_____	Yes	No
5.	Was any of the information helpful to you personally?	Yes	No
6.	Did the instructor seem to know a lot about pregnancy and infant health?	Yes	No
7.	Did you enjoy the class?	Yes	No
8.	Did you like the location?	Yes	No
9.	Did you get all of your questions on the topic answered?	Yes	No
10.	Would you attend other Community Voice events?	Yes	No

Please check all that apply to the training.

_____interesting
_____useful
_____boring
_____went too slow
_____too short
_____didn't have enough information
_____confusing
_____too much information

Please feel free to make any comments about this program in the space below and on the back of this form.

_____

_____

Lay Health Reporting Form

Completed by:_____

Date of Presentation/Discussion:_____

Approximate age(s) of Participant(s):_____

Number in Attendance/Discussion:_____ Attach a sign-in sheet for group presentations

Length of Presentation/Discussion_____

Topics Discussed (check all that apply):

- Infant mortality _____
- Prenatal care _____
- Folic Acid _____
- Preterm Labor _____
- Nutrition _____
- Smoking _____
- Alcohol Use _____
- Drug Use _____
- Child Safety _____
- Breastfeeding _____
- Immunizations _____
- Kicks count _____
- Grief _____
- Planning for pregnancy _____
- Sudden Infant Death Syndrome (SIDS) _____
- Other _____

_____

_____

Were there any areas of concern that the Community Voice program could help explain?

_____

_____

Did you enjoy giving the presentation?_____

Will you do another presentation?_____

If so, would you like the assistance of Community Voice?_____

Consumer Survey

1. Age_____
2. Race_____
3. Sex_____
4. Zip code_____

Please circle one

5. Married Single Divorce/Separated In a Relationship Widowed

Please check the range that best describes your yearly income

6. ____Under $20,000 ____$20,000-$30,000 ____$30,000-$40,000 ____Over $40,000

7. Did you graduate from high school? Yes No
   Did you attend college? Yes No
   If yes, how many years did you complete?_____

8. Do you have children?
   If yes, how many months pregnant were you when you first got prenatal care?_____

9. Are there things about African-American infant death that you would like to discuss?

   _____

10. Do you know someone whose baby died? Yes No

Community Meetings/Presentations/Activities Log

Name of Organization or Event	Date	Number in Attendance	Number of Recruits	Presenter	Type of Presentation
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Final Process Evaluation Plan for Community Voice Curriculum Implementation

	Process-Evaluation Question(s)	Data Sources	Tools/Procedures	Timing of Data Collection	Data Analysis and Data Synthesis
Fidelity	**1. To what extent was the curriculum implemented as planned?**	**Community Voice teachers and staff**	**Educators Tracking and Evaluation Form and observation**	**Teachers to turn in report after each weekly session, at least one observation per teacher per 5 week session**	**Calculate score based on percentage of intended criteria met for each session.**
Dose Delivered	**2. To what extent were all the sessions within the program implemented?**	**Community Voice teachers**	**Educators Tracking and Evaluation Form**	**Teachers to turn in form after each weekly session**	**Calculate score based on percentage of intended sessions and activities completed**
Dose Received	**3. What percentage of participants received all five session?** **4. Did participants enjoy the CV curriculum and associated activities?** **5. Were the CV instructors satisfied with the curriculum?**	**CV participants and teachers**	**Lay Health Training Evaluation form and focus groups with open ended questions for teachers**	**After each session the students will complete the Lay Health Training Evaluation form. Focus groups will be held after each teacher has taught an entire 5 week session.**	**Participant responses will be analyzed based on frequencies, qualitative analysis of teacher responses in focus groups.**
Reach	**6. Was the CV curriculum delivered to at least 50% of African-American residents in the Fairfield and Varina Health districts?**	**CV participants and teachers**	**Attendance rosters collected by teachers, Lay Health Reporting Form used by participants, and zip codes from Consumer Survey**	**Attendance collected at every CV session, Lay Health Forms turned in by participants whenever outreach is performed, Consumer Survey completed at initial CV session.**	**Look at number of residents participating in CV either by direct instruction or Lay Health Advisors divided by the total number of residents. Zip Codes of participants will be analyzed to make sure target area is being saturated.**

Recruitment	**7. What recruitment strategies were used to attract individuals, groups, and/or organizations to the CV program?**	**CV staff**	**CV staff document all recruitment activities in program log**	**Daily, whenever outreach is performed**	**Description of procedures**
Context	**8. What were the barriers and facilitators to implementing the CV curriculum?**	**CV staff and teachers**	**Focus group with open ended questions**	**Focus groups will be held quarterly**	**Qualitative analysis to identify concepts.**