

UNIVERSITY OF BRISTOL

Contributing to the evidence base for sexual
health education policy: An outcome
evaluation of the 'Youth in Action' HIV and
AIDS education programme

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Abstract

This study conducts an outcome evaluation of the 'Youth in Action' (YIA) HIV and AIDS workshops carried out in 6 Secondary Schools across Bristol and North Somerset. A quasi-experimental design is adopted, using a self-completion survey to assess the extent to which the workshops had an impact on students' knowledge of HIV/AIDS and students' attitudes on HIV/AIDS issues. The workshops are found to have been successful in raising participants' knowledge of HIV and AIDS with significant gains in 7 out of the 12 knowledge measures. Moreover, the workshops are shown to have been successful in engendering more favourable attitudes on 8 out of the 11 attitudinal measures. Students' experiences of the workshops are also explored along with self-reported intentions for behavioural and/or attitudinal change post-workshop. The findings of this study contribute to the existing research evidence base for policy-makers of 'what works' in HIV prevention education for young people. Furthermore, the methodological experiences of conducting this study contribute to evaluation debates in the HIV prevention field.

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Chapter 1: Introduction and Background Material

The persistent lack of any cure or vaccine for HIV/AIDS has led to an acceptance that the most promising avenue for the prevention of HIV transmission lies in social interventions (Mays et al. 1989, Oakley et al. 1995, Rugg et al. 2004). Indeed since the spread of the HIV virus is uniquely rooted in fundamental social practices (Oakley 2004) and particular social norms it follows that, in the continued absence of medical solutions, the problem demands a social response. Interventions take all manner of different forms but typically target positive changes in ‘risky’ behaviours either directly or through improvements in knowledge and/or attitudes towards HIV/AIDS issues. To effectively tackle the spread of HIV, policy makers and programme funders need to establish which social interventions work and which do not.

This study conducts an outcome evaluation of the ‘Youth in Action’ (YIA) HIV and AIDS workshops conducted in 6 Secondary Schools across Bristol and North Somerset between 12th June and 2nd July 2009. It assesses the extent to which the workshops had an impact on students’ knowledge of HIV/AIDS and students’ attitudes and beliefs on HIV/AIDS issues. This study also explores students’ experiences of the workshops to gain an insight into their opinions of the programme and tentatively explores any self-reported intentions for behavioural and/or attitudinal change post-workshop. For background information on the YIA project and a description of the intervention please refer to Appendix 10.

In the broad multi-disciplinary field of policy research there is a useful distinction to be made between research ‘of’ policy and research ‘for’ policy (Nutley & Webb 2000)¹. This study sits comfortably in the latter and aims to contribute to the existing research evidence base for policy-makers of ‘what works’ in HIV prevention education for young people. Furthermore it is hoped that the methodological experiences of conducting this study will contribute to evaluation debates in the HIV prevention field.

The following section provides background information to help contextualise this study. It outlines the latest statistics on the prevalence of HIV and AIDS both globally and in the UK, before briefly discussing the UK HIV prevention policy context.

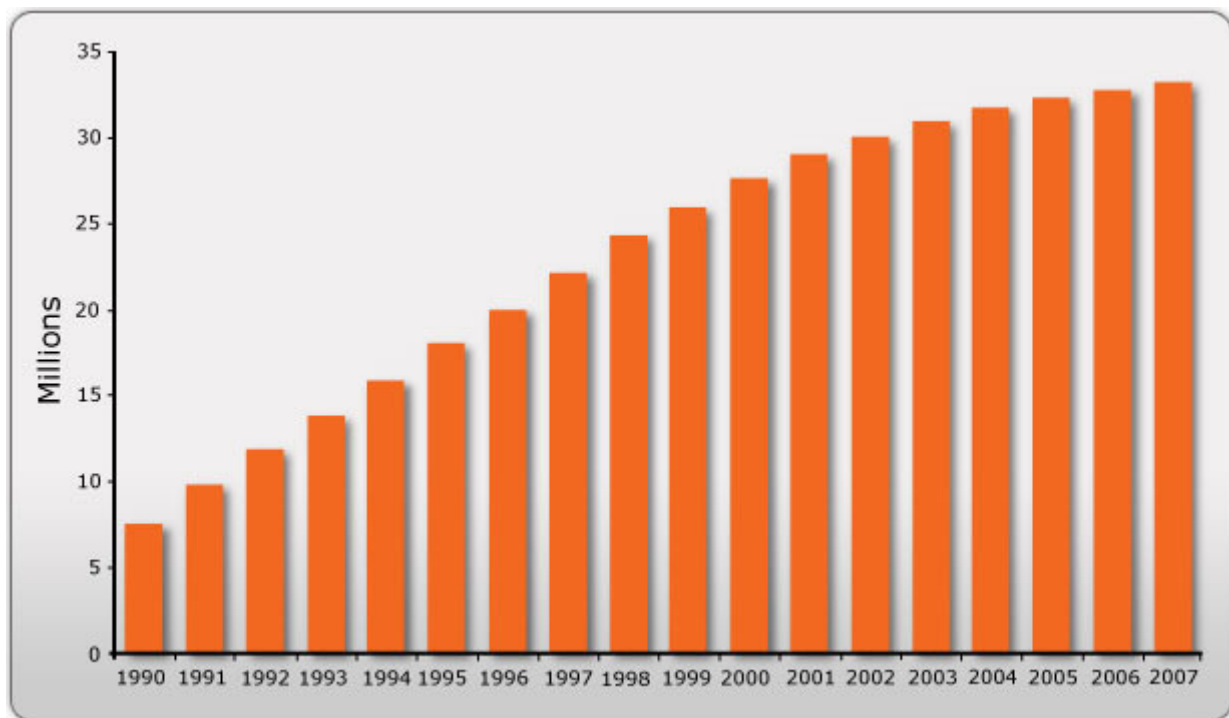
¹ Nutley and Webb (2000:15) suggest research ‘of’ policy “is concerned with how problems are defined, agendas set, policy formulated, decisions made and how policy is implemented, evaluated and changed.” Whilst research ‘for’ policy “is concerned to inform the various stages of the policy process” (Nutley and Webb 2000:15).

The State of the HIV and AIDS Epidemic Today

Global

In 2008 UNAIDS published its 'Report on the global AIDS epidemic'. This report estimated that in 2007 there were 33 million people living with HIV/AIDS across the globe (UNAIDS 2008). It was estimated that 2 million people died from AIDS in 2007 alone (compared with 1.7 million in 2001) and in the same year 2.7 million new people were infected with HIV. Alarmingly UNAIDS reported that young people under the age of 25 accounted for 45% of all new HIV infections globally during 2007. Sub-Saharan Africa remains the most affected area with 67% of the total population of people living with HIV estimated to reside there (UNAIDS 2008).

Figure 1. Global number of people living with HIV/AIDS: 1990 - 2007



Source: AVERT – <http://www.avert.org> Figure 1 shows that the number of people living with HIV/AIDS rose steeply between 1990 and 2007.

UK

The latest HIV prevalence figures available for the UK were published by the Health Protection Agency (HPA) in 2008 in their report 'HIV in the United Kingdom'. It was reported by HPA that at the end of 2007 there were an estimated 77,400 people in the UK

living with HIV, with 28% of these people thought to be unaware that they were infected (HPA 2008). The figure of 77,400 translates to 127 people living with HIV per 100,000 of the entire UK population (HPA 2008). The HPA (2008) report stated that there were 7,734 new persons diagnosed with HIV in 2007 (compared to just less than 3,000 in 1998), of who 4,887 were men and 2,846 were women. This translates to a new annual diagnosis rate of 16 per 100,000 men and 9 per 100,000 women (HPA 2008). In the local context relevant to this study the HPA (2008) reports that the diagnosed HIV prevalence per 1,000 for people living in the Bristol Primary Care Trust is 1.53 and in the North Somerset Primary Care Trust is 0.62 (compared with a national average of 1.27 per 1,000 people).

UK Policy Context

The state of the disease is clear; new cases of HIV are increasing both globally and in the UK. But what about the policy response? At a national level the key policy document of the last decade was the UK Government's 2001 'National Strategy for Sexual Health and HIV'. This strategy outlined the government's pledge to reduce by 25% the number of new HIV diagnoses by 2007 through increased investment in prevention, improved outreach services and a more joined-up and coordinated response (Department of Health 2001). This target has not been met, and new cases of HIV have significantly increased and are continuing to rise (Parliamentary Office of Science and Technology (POST) 2007). Furthermore, despite the continued rise in new HIV diagnoses central government funding for HIV prevention has decreased in real terms (taking account of inflation) since 1997 (POST2007).

This situation has led to widespread calls for a revision of the 2001 National Strategy and an increased level of funding and focus on HIV prevention through education (Independent Advisory Group on Sexual Health 2008). For example, one of the key recommendations of the HPA's 2008 report was that "HIV services and interventions to promote sexual health should be strengthened and expanded" (p.1). All this comes at a time when HIV awareness amongst young people in the UK is believed to be worryingly low and the numbers of people having unprotected sex is on the rise (HPA 2008). Indeed in spring 2009 a survey of 2,550 16-24 year olds commissioned by the 'Staying Alive Foundation' charity found that:

- Almost 60% of respondents believed that having unprotected sex did not put them at risk of contracting HIV

- 14% believed they could not contract HIV if they were not gay
- 13% believed they were too young for HIV to be a problem
- 8% believed the contraceptive pill would protect them from contracting HIV (Guardian 2009)

Such low awareness figures should also be seen in the context of dissatisfaction with the quality of Sex and Relationships Education (SRE) received in schools amongst young people. A survey by the UK Youth Parliament in 2007 reported that across the UK 40% of young people between 11 and 18 years of age believed that their SRE was either 'poor' or 'very poor'; with 33% of respondents reporting that their SRE education was 'average' (UK Youth Parliament 2007).

Chapter 2: Literature Review

The following literature review is structured in two broad sections. Part 1 deals with intervention debates in the field of HIV prevention and explores the literature on: the rationale behind social HIV prevention interventions with a particular focus on young people; the types of intervention with a focus on the peer education method; the debate between abstinence-only and abstinence-plus programmes; and the theory behind interventions and what they target. Part 2 tackles evaluation debates both in general and in the HIV prevention field in particular by exploring the literature on: evaluation research as policy ‘evidence’; the justification for conducting evaluations of HIV prevention programmes; and the debates between different forms of evaluations and their strengths and weaknesses.

Part 1: Intervention Debates

Different forms of social intervention in the HIV prevention field have evolved over time. In a review of evaluation of HIV prevention programmes across the world - between 1987 and 1995 – Coleman and Ford (1996) found that national prevention strategies have nearly all begun with blanket mass-media awareness campaigns. Numerous studies have shown such campaigns to be successful in reaching a large proportion of the total population and raising a basic level of awareness (for example see Mills et al. 1986 and Lehman et al. 1987). However, criticisms have persisted that such nationwide approaches miss out many of the most high risk groups in society (Coleman & Ford 1996) - typically identified as young people, men who have sex with men, commercial sex-workers and injecting drug users. The recognition that nationwide awareness campaigns do not always reach ‘high-risk’ groups has led to a gradual² re-focussing of most national prevention efforts (including the UK’s) away from a scattergun approach towards more targeted interventions (Coleman & Ford 1996).

Why target young people?

Of particular interest to this study are the existing rationales for prevention programmes which target young people³. From their extensive literature review Coleman and Ford (1996) found that the most common rationale for targeting young people was that it offered an opportunity to educate and inform people prior to becoming sexually active or at least early

² It should be noted that this shift towards more targeted interventions in the UK was met with much hand wringing over fears of the potential negative stigmatization such a focus may induce (Coleman & Ford 1996).

³ ‘Young people’ in this context typically refers to the age group of under 25’s.

on in the sexual life. There is evidence to suggest that the behaviours of young people who are not yet sexually active (or have not been sexually active for a long time) are easier to change than those of people who have been sexually active for a long time. For example, there are well established difficulties in changing the sexual behaviour of those already sexually active in terms of abstinence (see Shuey et al. 1999) but more success has been found in programmes which attempt to delay sexual debut (see Klepp et al. 1994). In addition Gallant and Maticka-Tyndale (2004:1349) found “evidence that stages of sexual development in youth influence programme outcomes”, and argue that this finding coincides with findings from “programmes in wealthier countries providing evidence that it is easier to establish low-risk behaviours than to change existing behaviours”. These findings suggest that there will often be a difference in receptiveness to interventions depending on whether the participant is a virgin or already sexually active, and arguably makes the case for interventions which target children while they are young.

Another common rationale for targeting young people identified by Coleman & Ford (1996) was that programme planners were influenced by the fact that young people are an easily reached group when compared with other high-risk groups⁴ since they are largely still in the school system. Thus an institutional setting and access point for the intervention is ready-made.

Existing evidence of ‘what works’ with young people in HIV prevention:

Informal methods

From their review of the literature Coleman and Ford (1996:329) found that there is “resounding support” for more informal intervention programmes that involve humour, interactivity and discussion “such as peer education, drama workshops, role plays and video tapes.” Such informal⁵ interventions have been found to be the most effective way of educating young people particularly when compared with the more traditional formal methods of education such as lectures given by health professionals or nominated school teachers (for example see Di Clemente et al. 1989 and Ashworth et al. 1992).

⁴ Such as men who have sex with men, commercial sex-workers and injecting drug users.

⁵ According to Gallant and Maticka-Tyndale (2004) the ‘active’ learning styles commonly associated with more informal sexual health education originate from theories of participatory pedagogy.

Of the informal methods identified above the relative merits of peer HIV education programmes and HIV interventions which use drama are of particular interest for this study. To begin with the latter, there is evidence to suggest that drama is an effective method of communicating HIV prevention messages, particularly to young people (see Blakey & Pullen 1991 and Harvey et al. 2000). For example Denman et al. (1995) conducted an outcome evaluation of a drama based intervention with schoolchildren which reportedly achieved significant gains in both knowledge and attitudes. However, a weakness in this area has been the low level of specificity in reporting the exact content of the interventions, and as such no more can be taken from these studies than a general level of support for the claim that young people respond well to informal teaching methods such as drama.

Moving on to the peer method, Coleman and Ford (1996) found peer education programmes to be especially effective in reducing HIV risk-related behaviours amongst young people (for example see Mellanby et al. 1995). The principle of peer education is that “members of a target group inform their fellow members about the transmission of HIV and appropriate prevention behaviours” (Coleman & Ford 1996:331). Evidence exists to suggest that students may be more likely to enjoy peer-led sex education and will thus engage more favourably—thereby potentially decreasing the future likelihood of risky behaviour (Mathie & Ford 1998). According to Milburn (1995:408) the theoretical heritage of peer education is usually considered to lie in social learning theory, which suggests that similarities between educator and pupil are thought to “increase the persuasiveness of any message” due to a greater level of identification with the educator. Furthermore, one of the key mechanisms by which peer education is argued to function is the purported strong influence of group norms over individual action (Fisher 1988).

In a critical review of sexual health peer education with young people Milburn (1995) found that peer health education has suffered from unclear and inadequate evaluation and therefore cautions against an uncritical acceptance of its widely held benefits. Indeed Milburn argues that the justifications for peer education in the studies she reviewed were largely articulated as ‘working hypotheses’ as opposed to evidenced assertions based on rigorous evaluations.

Abstinence-only Vs Abstinence-plus education programmes

In 2007 Underhill et al. conducted a Cochrane systematic review of ‘abstinence-only’ HIV infection prevention programmes in high-income countries⁶. They define ‘abstinence-only’ interventions as programmes which “promote sexual abstinence as the only means of preventing sexual acquisition of HIV; they do not promote safer sex strategies” (p.1). From their review Underhill et al. found only 13 methodologically sound evaluations. From these studies the authors conclude that there is no evidence to support either positive or negative impacts of abstinence-only interventions on HIV risk. They caution, however, that due to the geographical bias of the studies this finding may only be generalizable for US youth.

Following this review Underhill et al. (2008) conducted a further Cochrane systematic review but this time included only evaluations of ‘abstinence-plus’ programmes for HIV infection prevention in high income countries. Underhill et al. (2008:1) define ‘abstinence-plus’ interventions as programmes which “promote sexual abstinence as the best means of preventing acquisition of HIV, but also encourage safer-sex strategies (e.g. condom use) for sexually active participants.” The authors found no evidence of abstinence-plus interventions reducing rates of self reported sexually transmitted infections, but no negative consequences either. They also found mixed evidence of the ability of abstinence-plus interventions to alter behavioural outcomes, which they largely attributed to methodological problems and well established problems with behavioural reporting. The review did however find that, in terms of knowledge gains, abstinence-plus programmes were successful. Underhill et al. (2008) conclude by calling for comparison evaluations to be carried out comparing ‘abstinence-plus’ with ‘abstinence-only’ and ‘safe-sex’⁷ interventions.

Choosing your target... Knowledge, attitudes and behaviour:

The core goal of the majority of HIV prevention programmes is to reduce the likelihood that the target of the intervention will engage in risky behaviour which might lead to him or her contracting HIV. However, the way in which this goal is approached varies between programmes with some mixture of knowledge, attitudes, beliefs and behaviours usually

⁶ Underhill et al. (2007) note that abstinence only programmes are particularly popular and well funded in the US. In the UK context there is little evidence to suggest it has been a popular strategy, at least in mainstream society.

⁷ ‘Safe-sex’ interventions do not promote abstinence and focus on the promotion of safe sex strategies and methods.

targeted. Furthermore, there are additional goals such as reducing the stigma attached to people living with HIV/AIDS which come under the category of attitudes but are not clearly linked with risk-related behaviour in themselves. But how easily is each factor changed?

In a review of 11 published and evaluated HIV prevention programmes implemented in African schools Gallant and Maticka-Tyndale (2004) found that knowledge and attitudes have been most successfully changed, whilst behaviours have shown to be more difficult to change. More specifically they found that 10 out of the 11 interventions reported increased knowledge; 7 out of 7 programmes targeting attitudes reported at least some degree of improvement in the direction of more favourable attitudes towards HIV issues; whilst only 1 in 3 interventions focussed on sexual behaviours proved a success. From their review Gallant and Maticka-Tyndale (2004) found that the most common attitudes targeted were attitudes towards people living with HIV, abstinence and towards condom use. Whilst the most common behaviours targeted were age of sexual debut, recent intercourse activity, number of sexual partners and condom usage. In addition the authors reported a high level of success in programmes which tried to influence a more positive attitude towards people living with HIV or AIDS. However, success in engendering changes in attitudes towards abstinence and condom use proved more mixed and difficult, whilst they concluded that “perceptions of personal risk or susceptibility appear to be the most difficult to change” (Gallant & Maticka-Tyndale 2004:1344).

There is an ongoing debate in the literature on HIV prevention over the relationships between knowledge, attitudes and behaviours; particularly over the extent to which changes in knowledge and attitudes lead to behavioural change. It has been argued that the rationale for strictly information-giving interventions is that providing people with knowledge about the transmission and consequences of HIV/AIDS will inform future intentions to act and thus give rise to more reasoned behaviours (Coleman & Ford 1996). Coleman and Ford (1996:330) assert that the theoretical provenance to support this rationale exists in the ‘Theory of Reasoned Action’ and the ‘Health Belief Model’. However, Oakley et al. (1995) argue that there are well documented problems with the assumption that behavioural intentions are directly and uncomplicatedly linked to knowledge and attitudes. They argue that the relationship between knowledge and/or attitudes and behaviour is complex and criticise any assumptions of direct causal relationships between them.

Perhaps rather more pragmatically, Gallant and Maticka-Tyndale (2004) argue that there is sufficient support for the ‘common sense’ view that attitudes, beliefs and intentions are all important behavioural determinants. In relation to knowledge they argue that although “it is well recognized that knowledge is not sufficient to affect behaviour change, it may be a necessary condition” (p.1344). As a result Gallant and Maticka-Tyndale (2004) conclude that there is sufficient justification for the frequent targeting of knowledge and attitudes in HIV/AIDS prevention programmes.

Part 2: Evaluation Debates

Evaluation research as ‘evidence’: bridging the gap between research and policy

It has been frequently noted that over the last 15 years policy makers and professionals have increasingly expressed a commitment to ‘informed’ policy making based on research evidence (Becker & Bryman 2004). This has given rise to the terms ‘evidence based policy’ and ‘evidence based practice’. According to Becker & Bryman (2004:42) these are not new ideas and in the UK context were prominent in the 1960’s and 1970’s, however they argue that it is widely accepted that “the notion that policy and practice should be informed by research evidence has accelerated”.

The burgeoning discipline of evaluation⁸ research holds an interesting and important position in relation to the desire of policy makers to use research evidence to make informed policy decisions. Stern (2004) argues that in contributing to the ‘evidence base’ the discipline of evaluation serves to bridge the gap between the sometimes divergent worlds of academic research and policy and practice. The common ground which evaluation research and policy practice increasingly hold is their central interest in understanding ‘what works’. According to Stern (2004:48) evaluation research “provides the means to judge actions and activities in the public sphere in terms of values, criteria and standards.” Evaluation research also tends to have an objective of contributing to the improvement of whatever the object of evaluation may be (Stern 2004). This, Stern argues, means that there is usually a duty for evaluators to not only judge whether something works, but also to explain ‘why’ something works/doesn’t work, and to suggest ways things could be done differently in the future.

⁸ The term evaluation has been defined as: “the determination of the effectiveness, efficiency and acceptability of a planned intervention in achieving stated objectives” (Oakley et al. 1995:480). Or: “a rigorous, scientifically based collection of information about program activities, characteristics, and outcomes that determine the merit or worth of a specific program” (Rugg et al. 2004b:9)

The commitment of policy makers to the supposedly ideologically neutral position of only being interested in ‘what works’ is, of course, a little more complicated than it sounds. Taken at face value it is difficult to hold an opposing standpoint to somebody who claims to simply be committed to ‘what works’ since the logical binary is a commitment to ‘what doesn’t work’ – hardly a political trump card. However, it becomes apparent that the waters of this debate are muddied over the question of what constitutes ‘evidence’, and thus what the characteristics of ‘good’ research ‘evidence’ are⁹. This is not a debate that can be solved by simply looking at what research evidence is currently used to inform policy decisions. Indeed Becker and Bryman (2004) argue that since political factors and interests clearly shape the commissioning and selection of research evidence, the relative influence of research evidence on policy formation is arguably not a direct reflection of the rigour of data collection or the robustness of analysis. Instead, the debate over what constitutes ‘evidence’ remains largely a methodological and philosophical question.

In response to the need to define what counts as evidence it is well known that the fields of healthcare and medicine have developed an explicit ‘hierarchy of evidence’. However there is an ongoing debate over both the applicability of this model to other areas of social research, including the evaluation of social healthcare interventions, and the claim of randomised controlled trials (RCTs) to be the gold standard of research (Becker & Bryman 2004). For example, Harrison (2004:45) argues that there is doubt over how appropriate the hierarchy of evidence is in assessing “research into the outcomes of healthcare interventions or policies that are social...and/or diffuse...and/or complex”. Similarly Becker and Bryman (2004) insist that the policy sciences should resist the adoption of the traditional ‘hierarchy of evidence’ approach of the medicine and health sectors. They argue that it is better for researchers, professionals and policy-makers alike to recognise that different methods and designs have different strengths and weaknesses, and are best conceptualised as a continuum rather than a hierarchy. This broad debate will be returned to later in this review in the specific methodological context of discussions over the relative merits of outcome and process evaluations of HIV prevention programmes.

⁹ Another layer of complication beyond the purposes of discussion here is of course the political question of ‘for who’ something works.

Establishing the continued need for evaluating HIV prevention programmes:

The pressure to evaluate HIV/AIDS interventions has gathered momentum since the early 1990's, especially when compared with the early days of such programmes which, as Oakley et al. (1995) have noted, were often rushed in with little planning or evaluation. Contributing factors to this change include greater pressure on programmes to prove efficiency (particularly cost efficiency due to the expanding level of investment in programmes), effectiveness and a growing recognition of the need to make a clear contribution to future efforts to improve programme effectiveness (Coleman & Ford 1996). Moreover Peersman and Rugg (2004:141) argue that HIV prevention methods are coming under increased scrutiny and are being pressured to provide evidence of effectiveness in the context of a "false sense of complacency" about "the advancements in accessibility and efficacy of AIDS treatments". In this context, and in the context of inconclusive evidence of 'what works' in HIV prevention, Peersman and Rugg (2004) argue persuasively for the continued need to both implement and evaluate new prevention programmes. They argue that the challenge for researchers in this field is still to keep working towards a best-fit approximation of the type of prevention programme that will be the most efficient and effective for different target populations across a variety of social, cultural and epidemiological contexts.

Similarly, Rugg et al. (2004a) propose that whilst at a national level it may no longer be necessary to evaluate behavioural changes for every single project – particularly when interventions are following models with proven success – there is still much work to be done in relation to small scale evaluations. The authors acknowledge that a large number of small-scale intervention evaluations have been completed, but argue that not enough attention has been paid to reaching a consensus on the characteristics and methods of a 'good' evaluation. Consequently, Rugg et al. (2004a:43) conclude that "there remain significant knowledge gaps about what programs work best for which populations"¹⁰ and thus argue that "there is still a need for in depth evaluation studies that focus on the effects of new or innovative interventions" (p.43).

¹⁰ This finding is strongly supported by literature reviews conducted by Milburn (1995), Oakley et al. (1995) and Coleman & Ford (1996).

Types of evaluation

According to Oakley et al. (1995:480) the Panel on the Evaluation of AIDS Interventions put together by the US National Research Council identified 3 key types of evaluation:

1. *Formative* – involve identification of problems with strategies prior to design and implementation of the programme.
2. *Process* – focus on the process of implementation i.e. how the programme is actually delivered or experienced.
3. *Outcome* – aim to answer questions on the effectiveness of interventions in meeting specified goals.

To this list we can add a fourth ‘type’ that has grown in prominence in the evaluation literature, if not in the HIV prevention field in particular:

4. *Theory-based* – focus on the theory behind the intervention.

This review will now discuss the two types of evaluation which are of particular relevance to this study¹¹; process and outcome. Arguments for and against each type of evaluation will be outlined with the discussion focussed as much as possible on the particular context of evaluating HIV prevention programmes. The discussion here later informs the choices of evaluation type, design and methodology that are adopted in this study.

The evaluation literature is no stranger to the ongoing debate over the relative merits of quantitative and qualitative methodologies that have preoccupied the social sciences for so long¹². The battle lines are familiarly drawn whereby for quantitative Vs qualitative one can generally read off ‘outcome evaluation’ Vs ‘process evaluation’. Indeed Oakley et al. (2004:441) note that debates over process and outcome evaluations “relate closely to methodological debates about the relevance of experimental designs to complex social settings.” Consequently, for the sake of clarity it should be made clear that in the following sections of this literature review the term ‘outcome evaluation’ should be understood to imply a quantitative experimental or quasi-experimental design; whilst the term ‘process evaluation’ should be understood to imply a qualitative design.

¹¹ Discussion of formative evaluations is unnecessary here as the evaluation was set up long after the programme’s formation and design. For a brief discussion of theory-based evaluations see Appendix 1.

¹² For a good summary of the core positions in the evaluation debate see Davies (2000) for the qualitative position and Oakley (2000) for quantitative.

Outcome Evaluations

Outcome evaluations aim to answer questions on the effectiveness of interventions in meeting specified goals. In the case of outcome evaluations of HIV prevention programmes they are often concerned with measuring the impact an intervention has on some combination of its participants' knowledge, attitudes, beliefs, intentions or behaviours. In terms of methodology Gallant and Maticka-Tyndale (2004) found that self-completion surveys are the most common method used to measure such outcomes in HIV prevention programme evaluations. Furthermore they judged that studies which modified existing standardised questionnaires were preferable to those which developed their own questionnaires without proper consideration given to issues of content and/or construct validity.

Outcome evaluations typically use some form of experimental or quasi-experimental research design. Oakley is a key proponent of the use of experimental, quasi-experimental and trial based methodologies in the HIV prevention field in particular and in policy research more generally. Oakley et al. (1995:480) advocate the use of randomised controlled trials as “a remedy to the inferential uncertainties of non-experimental designs”. Oakley (2000) refutes what she perceives as the growing assertion (amongst certain sections of the research community) that such methodologies constitute a tired, positivist mentality – out of tune with the demands of policy research. Instead, Oakley (2000:323) asserts that experimental designs offer researchers the most robust route for establishing cause and effect¹³, and suggests that “reliable information about the effectiveness of public policy and social interventions is hard to come by using other means”¹⁴. Oakley (2000:72) stresses that what really sets ‘good’ research apart is “the awareness and acknowledgement of error” since such an awareness may limit the effect of such errors on what is concluded as knowledge.

Blamey and Mhairi (2007:440) argue that one of the key problems with experimental evaluations is that programme outcomes and impact are “aggregated across different groups of individuals in heterogeneous contextual settings and across the many and varied manifestations of a single social programme.” Thus experimental evaluations hold the assumption that the programme can be conceptualised as a consistent and uniform

¹³ From their more inclusive position that different research aims require different methodologies and designs Becker and Bryman (2004) also argue that RCT's and quasi-experimental designs are typically best for measuring causality, impact, and cause and effect.

¹⁴ Similarly Stephenson and Imrie (1998:611) argue that the “merits of randomised controlled trials in behavioural and psychosocial research do not differ fundamentally from those in clinical medicine.”

‘treatment’, and incorporate into their design a ‘black box’ in which the programme actually takes place (Blamey and Mhairi 2007).

Problems with existing outcome evaluations

Despite the potential benefits of outcome evaluations articulated above, in practice the field of HIV/AIDS prevention has suffered from a lack of methodologically sound outcome evaluations (Oakley et al. 1995, Peersman & Rugg 2004¹⁵). As part of a critical review of behavioural interventions for HIV/AIDS prevention Oakley et al. (1995) conducted a methodological review of 68 outcome evaluations of separate interventions. Using stringent criteria informed by the Cochrane approach to systematic reviews¹⁶ it was found that only 18 of the 68 studies under review were judged methodologically adequate. Methodological problems identified by the review included: absence of control groups¹⁷, small samples, short follow up measures and high attrition rates – which were largely in the region of 50% in the studies reviewed - the effects of which were often not discussed (Oakley et al. 1995). Oakley (2001) reports an important finding which further supports her critique over the lack of use of control groups. Oakley found that reports of effectiveness are higher from studies using a one group (no control) design when compared to reports of effectiveness from experimental and quasi-experimental designs.

Process Evaluations

The complexity of the social or ‘real’ world is often seen as an important justification for the use of randomized trials since complexity can be shared evenly between target and control groups (Oakley et al. 2004). But it can also be used as a justification for studying processes; that is to understand the complexity by monitoring how interventions are carried out in practice, or to understand how participants receive interventions or indeed the evaluation research itself (Oakley et al. 2004). According to Oakley et al. (2004:441) process evaluation research holds the aim of understanding processes such as “how a programme or intervention is developed, implemented and received rather than its impact.” Similarly, Backett-Milburn and Wilson (2000:95) surmise that process evaluations “aim to illuminate how an

¹⁵ For a summary of Peersman & Rugg’s findings which were very instructive for the design of this study please see Appendix 2.

¹⁶ Studies were judged against 3 main criteria; 1. Did they use control groups? 2. Was pre and post intervention data provided? 3. Were all targeted outcomes reported on? (Oakley et al. 1995).

¹⁷ This finding is further confirmed by Choi and Coates (1994) who also found a lack of control groups used in HIV prevention evaluations.

intervention or initiative actually works in practice and helps to make sense of the successes and the problems.”

Process evaluations were formally acknowledged to be a part of programme evaluation from the end of the 1970’s which went hand in hand with a rise in the popularity of qualitative methods in evaluation research (Backett-Milburn and Wilson 2000). Oakley et al. (2004:442-443) suggest that typical goals for process evaluations include: monitoring the implementation of the intervention such as numbers reached; recounting the contexts in which programmes were delivered; assessing whether the intervention was implemented as planned; and estimating programme costs. It is widely held by proponents of process evaluations that if such goals are met then process evaluations may allow researchers to explain successes or failures in the outcomes of a programme. Furthermore, when an intervention is implemented in many settings a process evaluation may allow explanation of variations in responses between sites (Oakley et al. 2004). Indeed process evaluations often look at the importance of ‘setting’. There are 3 main settings for sexual health education: schools, health care institutions and community spaces (Oakley et al. 1995). The logistical difficulties of conducting research in institutional settings such as schools are well documented (Backett-Milburn & Wilson 2000, Strange et al. 2003). Milburn (1995) stresses the importance of setting in understanding outcomes. She suggests that a programme may well develop differently across two apparently similar settings (such as two secondary schools) when different ‘contextual constraints’ are at play. In the school setting such contextual constraints could include the willingness and cooperation of staff, as well as the operational issues of programme delivery such as time allowed or efficient timetabling (Milburn 1995)¹⁸.

Common critiques of process evaluations centre on the issues of validity and generalizability, and are largely similar to those which are made of qualitative methodologies more generally. For example Pawson and Tilley (1997) criticise qualitative process evaluation approaches for not addressing external validity and for not providing definitive answers to questions of programme impact. They also argue that since qualitative approaches do not in general make an attempt to deliver generalizable results they cannot by themselves claim to fulfil all the requirements of policy-makers. Process evaluations are also critiqued for their limited capacity to deal with bias and error (Oakley 2000). Indeed, according to

¹⁸ Oakley et al. (2004) further argue that in the UK there is a widespread problem of the ‘marginal status’ of PSHE in schools generally; a problem they largely attribute to the lack of formal assessment in this area.

Peersman et al. (1998) process evaluations have been found to report greater levels of success than outcome evaluations – a finding which could be in part attributed to the lack of control for bias or error in findings.

Beyond the Outcome-Process divide?

The field of HIV prevention evaluations has begun to take some tentative steps towards recognition of the potential benefits of triangulation between process evaluation and experimental or quasi-experimental outcome evaluation designs. For example, whilst advocating the use of RCT's or quasi-experimental designs Peersman and Rugg (2004) also recognise the importance of gaining process measures and monitoring information in the interest of providing the most detailed and comprehensive evaluation.

As with much of the social sciences, concrete examples of how such a triangulation would actually look and function in practice are elusive; whilst the task of achieving a satisfactory balance between process and outcome data is understandably difficult. For example, in an article from 2004 Oakley et al. report an attempt to combine outcome and process data in the field of HIV prevention. The authors argue that using process evaluations in conjunction with experimental or quasi-experimental designs can be seen to provide a valuable broadening of the scope of research, and an antidote to some of the common critiques of the narrow focus of outcome evaluations. However, in their discussions of how to integrate process and outcome findings Oakley et al. (2004:457) take the arguably peculiar route of trying to translate “process-evaluation data into variables that can be combined with outcome data in statistical analyses.” This betrays an enduring positivist hierarchical ranking of outcome data above process data (despite protestations to the contrary), and perhaps undermines their goal of a successful marriage between the two that could satisfy both sides of an often terse methodological debate.

Chapter 3: Study Aims

This study aimed to make a contribution to the existing evidence base for policy-makers of ‘what works’ in HIV prevention education for young people. The literature review demonstrated that there was a continued need for conducting evaluations of new or innovative interventions, and that whilst a limited consensus does exist on the benefits of peer education, the use of drama and the abstinence-plus approach, there was a lack of conclusive evidence of ‘what works’ in the field of HIV prevention for young people. Moreover there was found to be a lack of consensus in the literature over the best type, design and method of evaluation for HIV prevention programmes. In relation to the particular characteristics of the Youth in Action intervention there were found to be no existing evaluations of HIV education programmes which involved people living with HIV/AIDS in the implementation; and no existing evaluations of interventions which involved a comparable ‘cross-cultural’ approach. Consequently, this study hoped to contribute to the existing literature on HIV prevention programmes by evaluating a new innovative type of intervention. In doing so it was hoped that the methodological experiences of conducting this study could contribute to evaluation debates in the HIV prevention field.

More specifically this study sought to conduct an outcome evaluation of the ‘Youth in Action’ HIV and AIDS workshops conducted in 6 schools in Bristol and North Somerset. It aimed to assess the extent to which the intervention had an impact on:

- Students’ knowledge of HIV/AIDS issues
- Students’ attitudes and beliefs on HIV/AIDS issues

The 6 hypotheses outlined on the following page were constructed to help answer these aims.

This study also aimed to explore students’ experiences of the workshops to gain an insight into their opinions of the programme and to tentatively explore any self-reported intentions for behavioural and/or attitudinal change post-workshop. In doing so this study intended to contribute to the existing evidence base on the effectiveness of ‘abstinence-plus’ and peer-to-peer HIV prevention programmes, as well the use of drama in such programmes. Furthermore, considering the apparent lack of evaluations of comparable programmes, this study hoped to provide a starting point for future discussion of HIV prevention programmes

which involve in the delivery of their message people whose lives have been directly affected by HIV/AIDS.

Hypotheses:

1. *Students in the training group would hold significantly higher levels of confidence in their own knowledge of HIV and AIDS post-intervention compared with pre-intervention.*

It was anticipated that the YIA workshops would have a positive influence on participants' confidence in their own knowledge of HIV/AIDS.

2. *Students in the training group would score significantly higher on the knowledge questions post-intervention compared with pre-intervention.*

It was expected that YIA workshops would have a positive influence on students' levels of knowledge on HIV/AIDS. This hypothesis is supported by the literature review which highlighted *some* evidence of the effectiveness of abstinence-plus, informal, peer-led and drama-based interventions in raising knowledge levels of young people.

3. *Students in the training group would display significantly more favourable attitudes towards HIV issues post-intervention compared with pre-intervention.*

It was anticipated that the YIA workshops would have a positive influence on students' attitudes towards HIV/AIDS issues. One of the key attitudes targeted was attitudes towards people living with HIV which was found in the literature review to be one of the most malleable attitudes. Furthermore one might intuitively expect that students' experiences of being taught by people whose lives they know have been directly affected by the virus (and may themselves have it) would have a powerful effect on any pre-conceptions they might hold. This hypothesis is also supported by the literature review which highlighted the perceived effectiveness of informal, peer-led and drama-based interventions in having a positive influence on young peoples' attitudes on HIV issues.

4. *Students who had participated in the HIV/AIDS workshops would hold a significantly higher level of confidence in their own knowledge of HIV/AIDS than students in the control group.*¹⁹
5. *Students who had participated in the HIV/AIDS workshops would score significantly higher on the knowledge questions than students in the control group.*²⁰
6. *Students who had participated in the workshops would display significantly more favourable attitudes towards HIV issues than students in the control group.*²¹

¹⁹ Please see explanation of hypothesis 1.

²⁰ Please see explanation of hypothesis 2.

²¹ Please see explanation of hypothesis 3.

Chapter 4: Methodology

The Approach

The rationale behind conducting an evaluation of the YIA HIV/AIDS education workshops was first and foremost to determine whether the workshops ‘worked’. More specifically, the evaluation’s *raison d’être* was to assess the effect of the workshops on student knowledge of and attitudes on HIV/AIDS. Consequently an outcome evaluation was selected as the best form of evaluation to answer questions on the effectiveness of the intervention in meeting its goals. The lack of explicitly articulated theory behind the programme coupled with time and funding constraints meant that a theory-based evaluation was not feasible²². Similarly a process evaluation was rejected on the basis that it would not satisfactorily establish cause and effect, whilst time and cost limitations dictated that an evaluation which included both outcome and process data was not feasible.

The literature review provided strong support for the argument that the most reliable designs for exploring cause and effect are experimental or quasi-experimental designs. The most rigorous of these is the randomised controlled trial (RCT) in a ‘pretest-posttest’ control group design (Campbell & Stanley 1972). Indeed an RCT of this kind would have arguably been the ideal design for this study; however, there were unavoidable constraints in place which dictated that a quasi-experimental ‘posttest-only’ control group design (Campbell & Stanley 1972) be adopted as the best available solution. The constraints included:

- At the time the evaluation was commissioned the choice of schools to receive the HIV/AIDS workshops was already decided and arranged, thus randomised allocation of schools to either experimental or control group was not possible. Similarly, the choice of which (and how many) students would participate both in the workshops and the evaluation was negotiated with each individual school and thus randomised allocation within schools was not possible either. Rather the approach adopted was simply to try and evaluate as many students per school as possible within the limits of time, resources and most importantly the willingness and cooperation of each school.

²² Particularly in light of the discussion in Appendix 1 of the high time and cost demands of theory based approaches.

- Whilst it was initially hoped that schools receiving the intervention and control group schools would both conduct a pre-test and a post-test with students it transpired that only the schools which received the intervention conducted both pre and post-tests. This was largely due to the difficulties encountered in attracting schools to participate in the research as control groups. Once a set of schools had been recruited to act as a control group it became apparent that eliciting agreement to conduct the same survey with their students twice in a few weeks with ‘nothing happening’ in between was a step too far.

Despite the constraints discussed, the post-test only design adopted for the evaluation is capable of making strong attributions of cause and effect (Campbell & Stanley 1972). Furthermore, whilst the strongest statistical comparison can be made between the post-test experimental and control groups, the fact that pre-test data was acquired in this study for the experimental group is still of great interest. Indeed the direct comparison between the pre-test and post-test data of the group which received the workshops arguably tells us a lot about the impact of the intervention. Particularly when you consider that pre-test and post-test occurred within 2-3 weeks of each other, and therefore the likelihood of there being other key factors (besides the workshops) implicated in changes in HIV knowledge or attitudes is arguably low.

Method and Measurements

To measure the impact of the HIV/AIDS workshops on students’ knowledge and attitudes a self completion questionnaire²³ comprising 33 closed questions²⁴ was adopted to allow a clear quantification of results; and to ensure that the surveys could be completed in less than 10 minutes so as to gain as large a sample as possible.

Following the recommendations of Gallant and Maticke-Tyndale (2004) discussed in the literature review, the survey questions were adapted from existing sources. The key benefit of this approach was that a selection of already piloted questions could be used quickly which was necessary in the tight time constraints of the evaluation. As a result, confidence in the construct validity of the outcome measurement instruments was higher than it would have been had the measures been constructed in a rush and not piloted satisfactorily.

²³ Full versions of the pre and post intervention surveys can be found in Appendices 3 & 4.

²⁴ Except for the post-intervention survey for the experimental group, which had two additional attitudinal statements; and three extra open questions at the end of the survey.

The knowledge section of the survey (question 11-21) was adapted from 2 existing pools of questions, links to which can be found in the bibliography: 1. AVERT (2009) - an international HIV and AIDS charity. 2. UNICEF (2009). The questions covered a range of knowledge areas that would be covered in the workshops including knowledge of:

- The key transmission routes of the virus
- Who is at risk
- Symptoms of the virus
- The difference between HIV and AIDS
- The concept of abstinence
- The continued absence of a cure

A multiple choice format was used for all the knowledge questions in the survey with a 'don't know' option included to try and reduce the level of error in the measurement by avoiding participants guessing at the correct answer.

The attitudes section of the survey (question 22-33) was adapted from the pool of measures that can be found in the Centre for Disease Control's (CDC) (1992) 'Handbook for Evaluating HIV Education'. The attitude measures were constructed as a series of statements (or attitudes) on HIV/AIDS related issues with a 'Likert' scale adjacent to allow an expression of the level of agreement with each statement. The attitudinal statements were focussed predominantly on two issues:

- Attitudes towards people living with HIV (5 statements)
- Attitudes towards the decision to abstain from sex or delay sexual debut (3 statements)

These attitudinal aspects were felt to be some of the strongest messages of the workshops, although by no means were they the only messages. However, it was decided that a balance had to be struck between successfully measuring the impact of the key messages of the intervention as fully as possible and the need to keep the surveys short and simple. It was hoped this would guard against participant fatigue and thus achieve the best possible response rate. The other three statements covered attitudes towards: condom use, the importance of

learning about HIV/AIDS for young people in Britain, and whether HIV/AIDS is solely ‘an African problem’²⁵.

The only adjustment made to the attitudinal statements from the CDC (1992) source was the replacement of the term ‘AIDS’ with the term ‘HIV’. It was decided that HIV was a more familiar term in the UK context, particularly since the quality of anti-retroviral treatment available in the UK has increased dramatically leaving far more people living with HIV (and for longer) than AIDS. Only questions 34-38 were developed independently, 3 of which were simple open questions which arguably required little in the way of piloting.

The first section of the survey (questions 1-9) consisted of 4 questions which would help form the unique identifier for each student (so as to allow a matchup between pre and post-test data for the experimental group), and 5 demographic questions. The participants’ gender, age, nationality, ethnicity and religious orientation was collected with British Census categories used.

In the drafting of the survey there was close consultation with the programme coordinators on the match between the outcome measures in the survey and the aims of the workshops. Once a draft of the survey was completed it was sent to the lead teachers from each school and to the PSHE Advisor for North Somerset for agreement and comments on suitability for the age group. A comment should be made here about the decision not to include behavioural measures in the survey. It can be suggested that since the ultimate goal of most HIV prevention programmes is to induce behavioural change it follows that the most comprehensive form of outcome evaluation will include some form of behavioural measure such as reported condom usage, number of sexual partners or experiences of needle sharing (Coleman & Ford 1996). However, in the context of this study there were two key factors which meant that behavioural measures would be inappropriate and unsuitable for this design. Firstly, the age group of the participants was 13-15 years of age (years 9 & 10) thus questions regarding sexual behaviour (such as number of sexual partners) were deemed inappropriate, particularly from the point of view of the schools who felt that parents would not give consent for such research. Secondly, the relatively short follow up time between pre

²⁵ Two additional statements were included in the post-test surveys for the experimental group which covered their attitudes towards learning about HIV/AIDS from ‘other young people’, and people from a ‘different culture’.

and post-tests meant that it is unlikely substantial behavioural changes would occur or indeed be accurately measured.

The survey was constructed online using a piece of online survey software called ‘Stellar Survey’. Whilst it was initially hoped that all schools would arrange for their students to complete the surveys online it transpired that some schools completed paper versions of the survey instead. This was largely due either to teachers not feeling comfortable with the technology or computer lab time-tabling issues. The full details of how each school conducted the survey are detailed in Figure 2.

Sample

When the evaluation of the YIA workshops was commissioned the details of the programme itself were largely already decided. Therefore the decisions over which schools would receive the workshops were already made and arrangements finalised. This meant that the population from which I would sample was already set for the experimental group and the sampling approach itself was simply to try and access as many students per school as possible within the time and resource constraints. This was clearly a non-probability sampling approach (Bryman 2008) however the decisions made by the schools over which classes were given time to take part in the evaluation were not motivated by any particular criteria other than convenience, and thus in a sense it was fairly random which classes took part from each school²⁶.

Four schools in total provided students to act as a control group. Two schools were contacted directly to act as control groups and two of the schools which were receiving the intervention provided control groups from their students who did not take part in the workshops. The HIV/AIDS workshops were delivered to students in either Year 9 or 10 depending on the school thus the ages of participants in the survey ranged from 13-15. Full details of the sample from each school are provided in Figure 2.

Once the schools had agreed²⁷ to participate in the research a letter²⁷ was sent out by the schools to all the parents of the pupils in the relevant classes. The letter advised parents that their children would be invited to take part in a short survey as part of an evaluation of the

²⁶ Particularly when you consider that form classes in secondary schools are not divided in any particular way and are largely random assignments in themselves.

²⁷ A copy of this letter is located in Appendix 5.

YIA workshops. The letter stressed that the students’ participation was entirely voluntary and that their responses would remain anonymous. The letter also contained an ‘opt-out’ section for them to sign and return should they not wish for their child to take part in the evaluation²⁸. On the day of the evaluation each school distributed an information sheet²⁹ to their pupils introducing the research in clear, simple English. The sheet stated the purpose of the study, how their answers would be used, that their participation was entirely voluntary, and that their responses would remain anonymous. The information sheet then provided an opportunity for students to confirm they understood this and provided a space for them to confirm their informed consent to take part in the surveys³⁰.

Figure 2. Description of Process

School →	School A*	School B**	School C*	School D*	School E**		School F*		School G*	School H*
Process ↓	(Experimental Group)	(Experimental Group)	(Experimental Group)	(Experimental Group)	(Experimental Group)	(Control Group)	(Experimental Group)	(Control Group)	(Control Group)	(Control Group)
Pre-Test	N=172	N=112	N=192	N=148	N=20	N/A	N=26	N/A	N/A	N/A
↓ Up to 1 week	↓	↓	↓	↓	↓		↓			
Intervention	N=266	N=190	N=240	N=180	N=22		N=50			
↓ Up to 2 weeks	↓	↓	↓	↓	↓	↓				
Post-Test	N=80	N=96	N=64	N=109	N=13	N=20	N=23	N=26	N=33	N=20

N = Number of students who completed each stage

* Indicates surveys completed online

** Indicates surveys completed in paper format

Ethics

There is an ongoing debate over the ethics of using control groups in the field of HIV prevention programmes from the viewpoint that you are withholding a ‘treatment’ which may prevent future harm (Oakley et al. 1995). However, for a relatively small scale intervention - which had limitations in terms of funding, resources and time available - this criticism is arguably diluted as clearly there were only so many schools the YIA group could fit into their

²⁸ There were no parental opt-out letters returned to any of the schools.

²⁹ A copy of this information sheet is located in Appendix 6.

³⁰ Full details of this process can be found in my ethics form located in Appendix 7.

trip. Indeed this particular line of critique is further obfuscated when you consider that part of the motivation for conducting the evaluation was to assist in the pursuit of funding for programme expansion - which would potentially allow more young people to receive the intervention.

The ethical issue of whether young people under the age of 16 should be able to give informed consent was partially circumvented by allowing parents of potential participants to remove their child from being invited to take part in the research if they so wished. Furthermore the survey was scrutinised by a teacher from within each school and North Somerset's PSHE advisor for suitability for the age group.

A full account of all further ethical considerations and procedures adopted in this study can be found in the approved 'Ethics Form' in Appendix 7.

Additional Reflections:

- The durability of results cannot be answered by this study design due to the relatively short-term follow up. However, it should be noted that the YIA programme co-ordinators are planning a further test after 12 months. This will eventually give the evaluation a more longitudinal design and allow conclusions to be drawn regarding the durability of any observed impacts³¹.
- Attrition rates between pre and post-tests for the experimental group were quite high. This was largely a reflection of the apparent decrease in motivation of schools to stay engaged with the evaluation process once they had received their workshops. Furthermore, since the post-test surveys were to be completed in the last few weeks of the summer term (a typically busy time in the school calendar) the teachers reported problems with having enough time to complete the surveys with as many students as before. There was no indication given by any of the schools involved that the attrition rates could be attributed to the students themselves declining to take part in the post-test survey. Rather it seems that logistical difficulties and a drop in teacher engagement with the research were largely to blame.

³¹ Although long term follow ups are widely advocated in outcome evaluations to measure sustainability of impact (Coleman & Ford 1996) interestingly Rugg et al. (2004b) take a more pragmatic approach towards evaluations of long-term effects. They suggest that the fact there are resource constraints present in most contexts dictates that it is unrealistic and indeed unnecessary for all evaluations to try and attribute long-term impacts to each specific programme.

- Obtaining control participants from two schools which had students in the experimental group clearly opened up the possibility of contamination effects such as students recounting to each other their experiences from the workshops. This was arguably potentially more problematic with School 'E' as the control and experimental groups were in the same year group.
- The decision not to collect process data was largely due to the time and resource constraints inherent in the evaluation. However, after observing the implementation of the programme in one of the schools it became clear that differences in the delivery of the programme were occurring within the school between classes and therefore were in all probability occurring between schools as well. After all the workshops were completed, these observations led to discussions with the co-ordinators of the YIA programme about the inconsistencies and particularities that occurred in implementation. Whilst such informal discussions could not be said to constitute a rigorous process evaluation, the insights obtained were recorded and constituted interesting contextual information that could add some depth to tentative explanations of unusual or inconsistent results obtained from the surveys. This experience highlighted the potential benefits of conducting a detailed process evaluation alongside a rigorous outcome evaluation – a reflection that will be expanded upon during the discussion of results.

Chapter 5: Results

Section A presents the results of those data analyses pertinent to the six hypotheses this study set out to test. Section B presents the results of the 5 questions related to students' experiences of the workshops, which were only asked to the training group at post-test.

Section A

The analysis is broken down into two distinct parts.

- Part 1 tests hypotheses 1-3 pertaining to the comparison between pre-test and post-test data for the training group only.
- Part 2 tests hypotheses 4-6 pertaining to the post-test data comparison between training and control groups.

Each hypothesis is listed, together with a summary of the results and the detail of the analyses underpinning these results. The chapter will begin by discussing some of the steps taken to ensure that the conclusions drawn were reliable.

Deciding when something was statistically significant

A statistical level of .05 was adopted for the analyses of all outcome measures. Therefore a result was deemed statistically significant if the data suggested that there was no more than a 5% probability that differences between the two groups had arisen due to factors other than membership of that group, or were due to chance. Statistical significance does not guarantee that the results would make practitioners or policy makers want to change their practice, but it is an important indicator of whether or not the intervention in question might be having an impact on those who are receiving it.

Preliminary analysis

A preliminary analysis of the data for Parts 1 and 2 was conducted and indicated no significant effects and/or interaction of gender, age, nationality, ethnicity, religion or the school variables with any other variables. Since no significant effect of these variables was observed, these factors were excluded from all of the following analyses. SPSS (version 16.0) was used for all the analyses that follow. Statistical outputs for each of the following analyses can be found in Appendix 8. Copies of the surveys used can be found in Appendices 3 & 4.

Part 1: Changes from pre to post-test – training group only

Final sample

The final paired pre and post-test sample³² from the training group consisted of 257 (male=121, female=136) participants³³. All participants were recruited from Years 9 & 10 thus the ages ranged from 13-15 years, with a mean age of 14.16³⁴.

Hypothesis 1

Students in the training group would hold significantly higher levels of confidence in their own knowledge of HIV and AIDS post-intervention compared with pre-intervention.

This hypothesis was operationalised through question 10 and was proved correct. Mean scores were analysed using a dependent samples T-test and showed a statistically significant result $t(254) = -11.55, p < 0.0001$. As shown in Table 1, the training group's level of confidence in their own knowledge of HIV/AIDS was significantly higher after attending the workshops than it was before. Prior to attending the workshops the students' gave themselves a mean knowledge rating (1 = very poor and 5 = very good) of 2.95 compared to after attending the workshops when students rated themselves at 3.55. The training can therefore be said to have had a positive effect on students' confidence in their own knowledge.

Table 1. Means of Self-rated knowledge

Time of test	N	Mean	Std. Deviation
Pre-test	255	2.95	0.746
Post-test	255	3.55	0.713

³² Figure 2 in the methodology chapter displays in detail the numbers of participants at each stage of the process.

³³ This number is smaller than the number of participants at both pre and post tests for the training group. This is a reflection of the difficulty in matching up surveys; largely as a result of pupils not being present the day of the survey, logistical difficulties in arranging for schools to ensure the same pupils took pre and post-tests, or students making mistakes in writing their unique identifier information.

³⁴ Tables displaying the breakdown of groups by nationality, ethnicity and religion can be found in Appendix 8.

Hypothesis 2

Students in the training group would score significantly higher on the knowledge questions post-intervention compared with pre-intervention.

This hypothesis was operationalised through questions 11-22. An initial analysis was made at the group level to compare the proportions of students who answered correctly pre and post workshops. Table 2 shows that a higher proportion of students answered correctly post-workshop compared to pre-workshop for all but one question (Q18).

Table 2. Comparison of group knowledge scores by time of test

	% of training group with correct answers by time of test	
	Pre-test ⁽³⁵⁾	Post-test ⁽³⁶⁾
Q11	94.2% (257)	98.4% (247)
Q12	96.5% (257)	98.0% (247)
Q13	59.5% (257)	82.6% (247)
Q14	29.2% (257)	57.9% (247)
Q15	48.8% (256)	51.7% (240)
Q16	68.4% (256)	70.0% (240)
Q17	48.0% (256)	80.8% (240)
Q18	81.2% (256)	80.0% (240)
Q19	55.9% (256)	63.9% (238)
Q20	84.8% (256)	88.7% (238)
Q21	75.8% (256)	85.7% (238)
Q22	67.6% (256)	81.1% (238)

However, due to the nature of the data the significance of these differences could not be tested in this way. Instead a comparison was made between paired pre-test and post-test data for the training group using the Wilcoxon signed-rank test. This test was used to establish if, and how, each student's response changed between pre and post-test i.e. precisely how many students kept the same response, how many answered incorrectly pre-test then correctly post-

³⁵ Total number of respondents in parenthesis.

³⁶ Total number of respondents in parenthesis.

test and vice versa. The significance of any level of change from incorrect to correct answers for each question could then be calculated.

Table 3 on the following page displays the significant results of the Wilcoxon signed-rank test and shows that the hypothesis was proved correct for questions 11, 13, 14, 17, 19, 21 and 22³⁷. This means that for these questions a significant proportion of students improved their answer. Consequently, the HIV/AIDS workshops can be said to have had a positive effect on students' knowledge of HIV and AIDS in relation to these questions.

Since the data was coded as 1=correct and 2=incorrect the table should be interpreted as follows:

- Negative Ranks = Number of students who answered incorrectly pre-test but answered correctly post-test.
- Positive Ranks = Number of students who answered correctly pre-test but answered incorrectly post-test.
- Ties = Number of students whose answers did not change.

³⁷ The data table for the remaining questions for which the hypothesis was not proved correct can be found in Appendix 8 and will be referred to in the discussion of the following chapter.

Table 3. Comparison of paired knowledge scores by time of test

		N	Z statistic	Significance (2-tailed)
Q11pre-test - Q11post-test (N=247)	Negative Ranks	12	-3.05	0.002
	Positive Ranks	1		
	Ties	234		
Q13pre-test - Q13post-test (N=247)	Negative Ranks	68	-6.57	0.000
	Positive Ranks	10		
	Ties	169		
Q14pre-test - Q14post-test (N=247)	Negative Ranks	89	-7.12	0.000
	Positive Ranks	16		
	Ties	142		
Q17pre-test - Q17post-test (N=240)	Negative Ranks	86	-8.49	0.000
	Positive Ranks	5		
	Ties	149		
Q19pre-test - Q19post-test (N=238)	Negative Ranks	48	-2.43	0.015
	Positive Ranks	27		
	Ties	163		
Q21pre-test - Q21post-test (N=238)	Negative Ranks	41	-3.15	0.002
	Positive Ranks	17		
	Ties	180		
Q22pre-test - Q22post-test (N=238)	Negative Ranks	50	-4.03	0.000
	Positive Ranks	17		
	Ties	171		

Hypothesis 3

Students in the training group would display significantly more favourable attitudes towards HIV issues post-intervention compared with pre-intervention.

This hypothesis was operationalised by Questions 23 – 33. Mean scores were analysed using a paired samples T-test the results of which can be seen below in Tables 4 & 5. The hypothesis was proved correct with statistically significant results achieved for all but three questions (Q26, Q28 & Q32). In all questions participants were asked to indicate their level of agreement with a statement on a 5 point likert scale (1=strongly disagree, 5=strongly agree). For each statement there is a response at one of the extreme ends of the scale (1 or 5) which is the ‘favoured’ or ‘desired’ response. For ease of interpretation these are grouped and presented below. Table 4 presents the data for questions for which the desired response was 5, whilst Table 5 presents the data for questions for which the desired response was 1.

Table 4. Attitudes for which the desired mean = 5

Question Number and Attitude Assessed	Pre-test Mean ⁽³⁸⁾	Post-test Mean ⁽³⁹⁾	T-statistic ⁽⁴⁰⁾	Significance (2-tailed)
Q23. Towards people living with HIV.	3.62 (1.10) N=208	4.13 (0.99) N=93	-7.13 (207)	0.000
Q28. Towards abstinence/delay of sexual debut.	4.02 (0.99) N=209	4.04 (1.09) N=209	-0.25 (208)	0.802
Q29. Towards people living with HIV.	3.45 (1.06) N=205	3.82 (1.09) N=205	-4.80 (204)	0.000
Q32. Towards the importance of HIV education for young people in Britain.	4.53 (0.68) N=203	4.52 (0.71) N=203	0.10 (202)	0.924

³⁸ Standard Deviation in Parenthesis

³⁹ Standard Deviation in Parenthesis

⁴⁰ Degrees of Freedom in Parenthesis

Table 5. Attitudes for which the desired mean = 1

Question Number and Attitude Assessed	Pre-test Mean (⁴¹)	Post-test Mean (⁴²)	T-statistic (⁴³)	Significance (2-tailed)
Q24. Towards people living with HIV.	1.93 (0.93) N=209	1.59 (0.84) N=209	5.40 (208)	0.000
Q25. Towards abstinence/delay of sexual debut.	2.10 (1.14) N=207	1.96 (1.07) N=207	2.12 (206)	0.036
Q26. Belief that HIV and AIDS is only an African problem.	1.75 (0.91) N=209	1.73 (0.89) N=209	0.26 (208)	0.799
Q27. Towards people living with HIV.	2.26 (1.01) N=209	1.93 (0.94) N=209	4.70 (208)	0.000
Q30. Towards abstinence/delay of sexual debut.	2.27 (1.18) N=206	1.99 (1.05) N=206	4.08 (205)	0.000
Q31. Towards condom use.	1.70 (0.99) N=204	1.50 (0.73) N=204	2.71 (203)	0.007
Q33. Towards people living with HIV.	1.93 (0.97) N=206	1.61 (0.76) N=206	5.88 (205)	0.000

⁴¹ Standard Deviation in Parenthesis⁴² Standard Deviation in Parenthesis⁴³ Degrees of Freedom in Parenthesis

Part 2: Comparison between post-test training and control groups

Final sample

The post-test sample comprised of 478 participants. Of these, 379 participated in the workshops (male=170, female=209), and 99 (male=45, female=54) were in the control group. All participants were recruited from Years 9 & 10 thus the ages ranged from 13-15 years, with a mean age of 14.23 years for the training group and 14.15 years for the control group⁴⁴.

Hypothesis 4

Students who had participated in the HIV/AIDS workshops would hold a significantly higher level of confidence in their own knowledge of HIV/AIDS than students in the control group.

This hypothesis was operationalised through question 10 and was proved correct. Mean scores were analysed using an independent samples T-test and showed a statistically significant result: $t(476) = 7.31, p < 0.0001$. As shown in Table 6, the training group's level of confidence in their own knowledge of HIV/AIDS was significantly higher after attending the workshops than the control groups. Students who attended the workshops gave themselves a mean knowledge rating (1 = very poor and 5 = very good) of 3.52 whilst students from the control group rated themselves at 2.91. The training can therefore be said to have had a positive effect on students' confidence in their own knowledge.

Table 6. Means of Self-rated knowledge

Condition type	N	Mean	Std. Deviation
training	379	3.52	0.729
control	99	2.91	0.771

⁴⁴ Tables displaying the breakdown of groups by nationality, ethnicity and religion can be found in Appendix 8.

Hypothesis 5

Students who had participated in the HIV/AIDS workshops would score significantly higher on the knowledge questions than students in the control group.

This hypothesis was operationalised through questions 11-22. A cross-tabulation was made comparing the proportion of correct answers for each question between training and control groups, and a Pearson Chi-Square statistic was generated to establish the significance of any association observed. Table 7 shows that the hypothesis was proved correct for questions 11, 12, 13, 14, 17, 21 and 22⁴⁵. Consequently, the HIV/AIDS workshops can be said to have had a positive effect on students' knowledge of HIV and AIDS in relation to these questions.

Table 7 displays for each question the percentage of correct answers by condition, the Chi-Square statistic and its significance value, and the odds ratio.

Table 7. Comparison of knowledge scores by condition type

	% of group with correct answers by condition type		Pearson Chi-Square (df=1)		Odds Ratio
	Training	Control	Value	Sig (2-sided)	
Q11	97.8%	89.8%	13.11	0.000	5.03
Q12	97.2%	87.8%	15.23	0.000	4.91
Q13	82.0%	52.0%	37.69	0.000	4.19
Q14	59.7%	26.5%	33.97	0.000	4.11
Q17	78.7%	44.3%	43.82	0.000	4.63
Q21	85.2%	66.0%	18.08	0.000	2.96
Q22	76.7%	67.0%	3.78	0.050	1.48

Taking Q11 as an exemplar we can see that a higher proportion of the students who took part in the training answered correctly to this question, and there was a significant association between the condition type and whether or not a student would answer correctly $X^2(1) = 13.11, p < 0.001$. This is congruent with the calculation that based on the odds ratio students were 5.03 times more likely to give the correct answer if they attended the training compared to if they did not. The data pertaining to the other 5 questions in the table can be read in exactly the same way.

⁴⁵ The results table for the remaining questions for which the hypothesis was not proved correct can be found in Appendix 8 and will be referred to in the discussion of the following chapter.

Hypothesis 6

Students who had participated in the workshops would display significantly more favourable attitudes towards HIV issues than students in the control group.

This hypothesis was operationalised by Questions 23 – 33. Mean scores were analysed using an independent samples T-test the results of which can be seen below in Tables 8 & 9. The hypothesis was proved correct with statistically significant results achieved for all but two questions (Q26, Q28). In all questions participants were asked to indicate their level of agreement with a statement on a 5 point likert scale (1=strongly disagree, 5=strongly agree). For each statement there is a response at one of the extreme ends of the scale (1 or 5) which is the ‘favoured’ or ‘desired’ response. Table 8 presents the data for questions for which the desired response was 5, whilst Table 9 presents the data for questions for which the desired response was 1.

Table 8. Attitudes for which the desired mean = 5

Question Number and Attitude Assessed	Training Mean (⁴⁶)	Control Mean (⁴⁷)	T-statistic (⁴⁸)	Significance (2-tailed)
Q23. Towards people living with HIV.	4.12 (1.03) N=312	3.77 (1.13) N=93	2.80 (403)	0.005
Q28. Towards abstinence/delay of sexual debut.	4.00 (1.13) N=312	3.86 (1.07) N=93	1.04 (403)	0.301
Q29. Towards people living with HIV.	3.80 (1.13) N=312	3.43 (1.12) N=93	2.74 (403)	0.006
Q32. Towards the importance of HIV education for young people in Britain.	4.49 (0.76) N=309	4.30 (0.89) N=93	2.03 (400)	0.043

⁴⁶ Standard Deviation in Parenthesis

⁴⁷ Standard Deviation in Parenthesis

⁴⁸ Degrees of Freedom in Parenthesis

Table 9. Attitudes for which the desired mean = 1

Question Number and Attitude Assessed	Training Mean (⁴⁹)	Control Mean (⁵⁰)	T-statistic (⁵¹)	Significance (2-tailed)
Q24. Towards people living with HIV.	1.60 (0.91) N=313	2.12 (1.14) N=93	-4.58 (404)	0.000
Q25. Towards abstinence/delay of sexual debut.	2.02 (1.11) N=311	2.46 (1.30) N=92	-3.19 (401)	0.002
Q26. Belief that HIV and AIDS is only an African problem.	1.70 (0.92) N=311	1.85 (0.90) N=93	-1.35 (402)	0.179
Q27. Towards people living with HIV.	1.90 (0.97) N=313	2.33 (1.14) N=92	-3.54 (403)	0.000
Q30. Towards abstinence/delay of sexual debut.	2.00 (1.10) N=311	2.40 (1.28) N=92	-2.96 (401)	0.003
Q31. Towards condom use.	1.56 (0.84) N=308	1.90 (1.14) N=93	-3.20 (399)	0.002
Q33. Towards people living with HIV.	1.65 (0.87) N=310	1.91 (1.01) N=93	-2.43 (401)	0.015

⁴⁹ Standard Deviation in Parenthesis⁵⁰ Standard Deviation in Parenthesis⁵¹ Degrees of Freedom in Parenthesis

Section B

The analyses in this section relate to questions 34 – 38 and are presented simply by order of question number. These questions were only asked to the training group at post-test.

Question 34 & 35:

The training group at post test had two additional attitudinal statements to complete which asked for their agreement (1=strongly disagree, 5=strongly agree) with two positive statements about learning from other young people and learning from people from a different culture. Table 10 shows that both statements received a high level of agreement and thus the students reported enjoying both the peer education method and the cross-cultural aspect of their workshops.

Table 10. Training group-only attitudes

Question Number and Attitude Assessed	Training Mean (⁵²)
Q34. Enjoyment of peer education method.	4.03 (0.95) N=308
Q35. Enjoyment of cross-cultural education.	4.19 (0.94) N=309

Questions 36 – 38:

N.B. Answers to the qualitative questions 36-38 were individually analysed for patterns and commonalities and then carefully coded and grouped into different themes. For each question the most common themes are presented in order of frequency⁵³ along with a brief explanation.

⁵² Standard Deviation in Parenthesis

⁵³ For each question a different level (number of respondents) was decided upon below which the theme would not be presented here. This depended upon the split of responses. Numbers do not equal the number of respondents since respondents' answers may have covered several themes.

Question 36: *What did you like most about the HIV and AIDS workshops?*

258 out of the 379 participants responded to this open question. The top 9 themes are presented below in table 11.

Table 11. Themed responses to question 36

Theme	Number of respondents	Comments
The play/performances	76	Comments cited the play and/or performances as one of the best things about the workshops.
Learning	43	Comments referred to 'learning' as what they liked most about the workshops, whether it was specifically about HIV and AIDS or unspecified.
Informal methods	40	Comments under this theme praised some aspect of the informal learning approach. Responses included praise for the use of drama/singing/dance in delivering their message, and often emphasised the perceived benefits of such an informal and interactive approach. For example: "Instead of just like, a boring speech, it was interactive, plus the play was brilliant, singing was awesome, and it got the point across in a really good way"
The people	34	These comments referred to 'the people' as one of their favourite things about the workshops, or simply praised the character/personality of the people they met.
Enjoyable/Fun	31	Comments simply stated they enjoyed the workshops.
Cultural experience	29	Responses referred to some element of the cultural experience, for example: "Being able to work with people from a different culture, learning about their culture and lifestyle."
Learning from people with real life personal experience of HIV/AIDS	26	Comments typically referred to the benefits in learning from somebody who has direct experience of HIV or AIDS. For example: "That they had experienced AIDS whether they knew someone who had it or they have it themselves and they knew what they were talking about instead of like a teacher saying stuff they read off the computer."
Humour	15	Responses here stated that the people and/or performances were funny.
Question & Answer sessions	15	Responses cited the question and answer/discussion sessions with the YIA group as a favourite.

Question 37: *What did you like least about the HIV and AIDS workshops?*

216 out of the 379 participants responded to this open question. The top 7 themes are presented below in table 12.

Table 12. Themed responses to question 37

Theme	Number of respondents	Comments
Nothing	89	Respondents either stated they liked everything or answered that they disliked nothing.
Question and Answer session	24	Comments under this theme focussed on the Q&A session with YIA. Responses included feeling awkward about asking questions, feeling uncomfortable with the long silences between questions and not knowing what to ask. For example: "The question and answer section was a bit awkward because there were long periods of silence."
Too short	13	These respondents felt the workshops were too short.
Don't Know	13	Respondents were unsure.
Difficult issues	10	Respondents found some material sad or unpleasant, for example: "Learning about the people who are suffering from HIV and AIDS"
Boring	8	Respondents felt the workshops were boring.
Difficult to understand	6	Respondents felt certain aspects were unclear or felt there was a language barrier.

Question 38: *If you think you may act differently in future because of what you've learned from the workshops, please tell us how.*

175 out of the 379 participants responded to this open question. The top 8 themes are presented below in table 13.

Table 13. Themed responses to question 38

Theme	Number of respondents	Comments
Attitudes towards people with HIV	40	Responses under this theme centred on a reported change in attitude towards people living with HIV/AIDS. Comments included not being afraid of people with HIV, treating people with more respect and treating people equally. For example: 'I will be more open to people with the virus and think more of them and how they live, and just remember they are normal people.'
Use protection (have safer sex)	33	Comments largely reported an intention to use a condom in the future and/or always practice safe sex.
Be more careful	21	Responses centred on a general intention to be careful or more cautious in the future.
No/wouldn't act differently	20	Comments simply stated 'no' with little expansion.
More aware of HIV/AIDS	16	Comments reported a general increase in awareness of HIV and related issues.
Don't know	11	Respondents were unsure.
Will not act differently as already aware	8	Respondents answered that they would not act differently as they were already aware, or already felt the same way as the workshops encouraged.
Get tested	6	Respondents reported an intention to get tested at the appropriate time.

Chapter 6: Discussion of Results

This study sought to conduct an outcome evaluation of the ‘Youth in Action’ HIV and AIDS workshops conducted in 6 schools in Bristol and North Somerset. Primarily it aimed to assess the extent to which the intervention had an impact on students’ knowledge of HIV/AIDS and students’ attitudes on HIV/AIDS issues. 6 hypotheses were tested to answer these questions. This study also aimed to explore students’ experiences of the workshops to gain an insight into their opinions of the programme and to tentatively explore any self-reported intentions for behavioural and/or attitudinal change post-workshop. The results from 2 closed attitudinal questions (Q34 and Q35) and 3 qualitative open questions (Q36-38) were used to meet these demands. This chapter begins with a discussion of the results obtained. Discussion of unexpected or negative findings are at times informed by observations made when viewing one of the workshops personally and/or the observations made by the YIA programme coordinators during informal discussions on implementation issues. Key recommendations for future workshop improvement are then summarised. The discussion then broadens out to consider the implications of this study for our understanding of ‘what works’ in HIV prevention for young people, as well as discussing the implications of the findings for evaluation research in the field of HIV prevention.

Research design and the issue of equivalence

Of the 6 hypotheses tested, hypotheses 1-3 pertained to the comparison between pre-test and post-test data for the training group only, and hypotheses 4-6 pertained to the post-test data comparison between training and control groups. As discussed in the methodology chapter of this study, ideally there would have been pre and post-test data obtained for both training and control groups, whilst the allocation of students to either training or control group would have been randomised. This would have meant the study would be a randomised controlled trial (RCT) in a ‘pretest-posttest’ control group design (Campbell & Stanley 1972). However, due to the practical constraints discussed in the methodology chapter it was only possible to obtain data for the control group at post-test and randomised allocation to condition type was not feasible. Consequently, this study adopted a quasi-experimental ‘posttest-only’ control group design without randomised allocation.

The problem of not having pre-test control group data and randomised allocation was that I could not be sure of the equivalence between control and training groups at pre-test. Thus conclusions drawn about the impact of the intervention from the comparison between post-test data (hypotheses 4-6) for control and training groups were open to the error of students in the training group having a higher level of knowledge and holding more desirable attitudes before the training even took place. However, this problem was partially counterbalanced by using the results of the comparison between pre-test and post-test data (hypotheses 1-3) for the training group to strengthen the findings of the post-test training Vs control comparison. Indeed, the discussion that follows is informed by a comparison between the findings of hypotheses 4-6 with those of hypotheses 1-3. Details of the comparison can be found in Appendix 9. Only results which were found to be significant in both are discussed here. This strategy strengthens any conclusions drawn about the efficacy of the intervention since the impacts discussed have been confirmed by both the post-test training and control comparison *and* the pre and post test comparison for the training group.

Knowledge of HIV/AIDS

Of the 4 hypotheses related to the impact of the workshops on students' knowledge, hypotheses 1 and 4 (which predicted that the workshops would increase students' confidence in their own knowledge of HIV & AIDS) were clearly proven, and hypotheses 2 and 5 (which predicted that the workshops would increase students' knowledge of HIV & AIDS) were partially proven⁵⁴. The workshops were particularly effective in increasing knowledge of the key transmission routes of the virus (Q11, 12, 13, 14 and 21). The workshops also increased students' knowledge of the concept of abstinence (Q17) and raised awareness of the ongoing absence of a cure for AIDS (Q22).

One of the areas of knowledge for which there were not significant results was questions on the risks of homosexual sex (Q16 & Q20). This could be explained by the fact that homosexual sex was not covered in as many of the workshops as had been planned. The YIA group did not cover this aspect in their drama performance and it was expected that the Terrence Higgins Trust (THT) trainers would cover this in the workshops after the performance. However, despite planning to have a representative from both YIA and THT in

⁵⁴ Hypotheses 2 and 5 were proven correct for 7 out of the 12 knowledge questions, although it should be stressed that none of the 5 questions for which the hypotheses were not proved correct demonstrated any negative impacts of the workshops.

each of the workshops it transpired that THT were underrepresented – with often only enough representatives to cover one out of four workshops. This meant that in practice the smaller workshops after the drama varied in the information they covered and students would perhaps only receive information on the risks of homosexual sex if they asked for it in the question and answer sessions.

A further knowledge question on which the workshops had no significant impact was question 15 on the transmission of HIV through saliva. This was a surprising result considering students had shown a high level of knowledge on question 13 which showed they understood that you could not get AIDS by sharing the cup of an HIV positive person. This result might be partially explained by the relative difficulty of question 15. Q15 was taken from the ‘expert’ section of AVERT’s knowledge test and involved quantities of saliva which may have confused some students. However, the message that HIV cannot be passed on through *any quantity* of saliva was perhaps not made clear enough through the training.

Two other knowledge questions for which the workshops did not produce significant gains were question 18 (on the symptoms of the virus) and question 19 (on the difference between HIV and AIDS). It is possible that the lack of significant results for these questions is a reflection of problems in the match-up between the content of the workshops and the output measures of the evaluation. Indeed the workshop I observed did not cover these aspects. This arguably highlights a weakness in both the programme and the evaluation in that the aims of the workshops in terms of knowledge topics were not clearly defined and thus outcome measures were approximated in some cases. Furthermore, the fact that a key part of the information-giving aspect of the workshops was covered in ‘question and answer’ sessions means that the exact topics of discussion inevitably varied from workshop to workshop.

Attitudes towards HIV/AIDS

Hypotheses 3 and 6 related to the impact of the workshops on students’ attitudes towards HIV and AIDS and were both proved partially correct⁵⁵. The workshops were effective in changing students’ attitudes towards people living with HIV with significant increases in favourable attitudes for questions 23, 24, 27, 29 and 33. The workshops were also successful

⁵⁵ The workshops had a significant positive impact on students’ attitudes towards 8 of the 11 attitudinal measures, with no negative impacts found for the other 3 questions.

in producing a positive change in attitudes towards condom use with a significant change observed for question 31. Furthermore the workshops were found to be largely successful in engendering more positive attitudes towards abstinence/delay of sexual debut, with significant results achieved for questions 25 and 30. This finding was contradicted by the results for question 28 which also measured attitudes towards abstinence/delay of sexual debut but did not achieve significant results. However, the mean results for the training group at pre-test for this question were already high and at the desirable end of the attitudinal scale. Consequently, although the training did not significantly affect the attitudes towards this statement the mean results at post-test remained high thus it is possible that the workshops merely supported students existing attitudes.

The same explanation can also be applied to question 32 for which the workshop also had no significant positive effect since mean results were similarly high for the training group at both pre and post-test levels. Question 32 measured attitudes towards the importance of HIV education for young people in Britain and although the workshops did not have a significant impact on this attitude the mean results at pre and post-test were in fact the highest of any statement. Consequently the lack of significant results for this question arguably should not be understood as a failing of the workshops.

The third statement for which the workshops did not have any significant effect was question 26. This question tested attitudes towards the belief that HIV and AIDS is only really an African problem and may have caused students confusion in the wording of the statement through the use of the term 'really'. This was an unfortunate error in the wording of the statement as students may have interpreted the statement as a belief that HIV and AIDS affects Africa more than anywhere else which would have in fact been correct. The aim of the measurement was to check that students did *not* believe that HIV/AIDS is only an African problem and thus not a problem for the UK.

Students' Experience of the Workshops

Questions 34 and 35 were additional attitudinal statements that were only given to the training group at post-test. Question 34 asked students' to indicate whether they enjoyed the experience of learning from other young people; whilst question 35 asked students to indicate whether they found it helpful to learn about HIV and AIDS from people from a different culture. Both statements received a high level of agreement and thus indicate that both the

peer education method and the cross cultural elements of the workshops were well received. However, the degree of confidence in these findings is reduced by the lack of comparative data since the questions could not be asked to either the training group at pre-test or the control group at post-test.

Question 36 asked students what they liked most about the workshops and the responses revealed that many students experienced benefits of the 'informal' approach to HIV education and the use of drama in particular as a method of conveying messages. Another common theme in the responses was the enjoyment of the cross-cultural element of the workshops as well as the benefits of learning about HIV from people with direct, personal and visceral experiences of the virus. Question 37 asked what students liked least about the workshops and found that the largest proportion of respondents felt that there was 'nothing' they disliked about the workshops. The second most common response indicated that some students felt that the question and answer sessions were a weakness; a response that was often accompanied by the explanation that there were too many awkward silences between questions. This suggests that the question and answer sessions might have benefited from being more structured, with perhaps material planned to keep discussions going between questions. Other negative aspects expressed by small proportions of respondents included feelings that the workshops were too short, boring and dealt with some difficult or uncomfortable issues.

Future Intentions

Question 38 gave respondents an opportunity to reveal whether they felt they would act differently in future as a result of the workshops and if so, how. The most common theme of difference reported was a change in attitude towards people living with HIV/AIDS leading to the intention to positively change behaviour towards people living with the condition. This finding reaffirms the previously-discussed success of the workshops in engendering more positive attitudes towards people living with HIV/AIDS and clearly shows that the workshops were effective in changing misconceptions and challenging negative stigmas associated with the disease. Further common responses included the intention to use protection (practice safe sex) in the future as well as a rather general intention to 'be more careful', 'cautious' or 'aware' in future.

Key recommendations for workshop improvement

- Programme suffered from a lack of clearly defined aims which in terms of evaluation made it difficult to get outcome measurement instruments closely matched to the content of the workshops. If programme's aims were more clearly defined in terms of outcomes then it would reduce the chance that future evaluations would miss out on any areas of effectiveness or try and measure changes in attitudes or knowledge that were not targeted.
- Improve consistency in implementation so that students receive largely the same information across all workshops. This could be achieved by ensuring a consistent balance between YIA and THT trainers in each workshop.
- Re-structure 'question and answer' sessions to allow a more structured discussion, with clearly defined outcomes for students in terms of knowledge or attitudes.
- Ensure that the risks of homosexual sex are specifically covered by workshops. This is an important aspect in terms of ensuring that the needs of both homosexual and heterosexual students are met equally.

Implications for understandings of 'what works' in HIV prevention for young people

This study aimed to make a contribution to the existing evidence base for policy-makers of 'what works' in HIV prevention education for young people. The key contributions are outlined below.

- The overall success of the YIA workshops supports the existing evidence that social interventions *can* be successful in achieving significant gains in both HIV/AIDS knowledge and attitudes towards HIV/AIDS issues (See Gallant and Maticka-Tyndale 2004). This study also supports existing evidence of the success of abstinence-plus programmes in raising knowledge of HIV/AIDS (Underhill et al. 2008). However, as Underhill et al. (2008) point out, further comparative work needs to be done on the relative merits of abstinence-plus Vs abstinence-only HIV prevention programmes.

- In addition the results support Gallant & Maticka-Tyndale's (2004) findings of a high level of success in programmes which tried to influence a more positive attitude towards people living with HIV or AIDS. However, contrary to the common difficulties in engendering changes in attitudes towards abstinence and condom described in the literature (Gallant & Maticka-Tyndale 2004) this study showed success of the YIA workshops in these areas.
- The particular success of the YIA programme in engendering positive changes in attitudes towards people living with HIV points to the potential for success of programmes which involve in their delivery people with very personal experiences of HIV/AIDS. The ability of trainers to speak from personal experience appears to strengthen their message when tackling negative stigma and discrimination. This finding warrants further investigation in future evaluations of similar programmes, perhaps by using focus groups to explore this apparent connection.
- The findings provide further evidence of the benefits of informal methods in HIV prevention programmes. This supports Coleman and Ford's (1996) assertion of the relative strengths of more informal intervention programmes that involve some combination of drama, peer education, humour, interactivity and discussion. Moreover the results provide support for the existing evidence which suggests that drama is an effective method of communicating HIV prevention messages to young people (see Blakey & Pullen 1991, Denman et al. 1995 and Harvey et al. 2000).
- Whilst the findings are insufficient to attribute the successes of the YIA workshops specifically to their distinctive cross-cultural element, there is enough evidence to suggest that the cultural experience raised the enjoyment levels of students and thus can be considered a potentially successful model for other programmes.

Implications for evaluation research in the field of HIV prevention

This study hoped that the methodological experiences of conducting this study could contribute to evaluation debates in the HIV prevention field. The key contributions are outlined below.

- The experiences of conducting this study suggest that outcome evaluations, where possible, should strive to achieve the experimental standards of a randomised

controlled trial (RCT) in a 'pretest-posttest' control group design. This should serve to simplify the analysis process and reduce the potential for bias and error in the results - giving greater confidence in findings.

- Crucially, however, the findings of this study support the view that, if resources allow, an outcome evaluation of this kind would be complemented by a detailed process evaluation (see Peersman and Rugg 2004 and Oakley et al. 2004). By incorporating a process evaluation into a study of this kind researchers would not falsely assume that the implementation of an intervention will be exactly as the planners intended (Akukwe 1999, Gallant & Maticka-Tyndale 2004), or assume that the programme can be conceptualised as taking place in a 'black box' (Blamey and Mhairi 2007). Indeed the experiences of this study suggest that implementation monitoring is an important aspect of evaluation, particularly when trying to explain poor or unexpected outcomes or inconsistencies in the data.
- On a practical level, ensuring that the evaluation research has support and 'buy-in' at the highest levels in schools is crucial in ensuring that the evaluation is taken seriously by teachers and commitments are fully met. Having the support of senior management (ideally the head teacher) should improve the response rates within schools and ensure that any practical or logistical difficulties specific to the school can be resolved quickly and efficiently.
- If time and resource constraints allow, having a researcher present at all points to introduce the research and oversee the completion of the surveys could improve consistency in the way the surveys are conducted (such as ensuring all surveys were completed online and not on paper).

Chapter 7: Conclusions

This study conducted an outcome evaluation of the 'Youth in Action' HIV and AIDS workshops conducted in 6 secondary schools in Bristol and North Somerset. Overall the workshops were found to be successful in raising participants' knowledge of HIV and AIDS with significant gains in 7 out of the 12 knowledge measures. Moreover it was found that after attending the workshops students were significantly more confident in their own knowledge of HIV and AIDS. The YIA intervention was particularly effective in increasing knowledge of the key transmission routes of the virus, with further successes in relation to understandings of abstinence and the continued absence of a cure. Furthermore, the workshops were shown to have been successful in engendering more favourable attitudes on 8 out of the 11 measures. In specific the YIA workshops were found to be effective in changing students' attitudes towards people living with HIV, as well as successfully producing a positive change in attitudes towards condom use, abstinence and the delay of sexual debut.

The findings of this study contribute to the existing research evidence base for policy-makers of 'what works' in HIV prevention education for young people. Indeed the results support existing evidence of the benefits of informal methods in HIV prevention programmes, with drama highlighted as a particularly effective vehicle for communicating HIV prevention messages to young people. Furthermore, both the peer education method and the cross-cultural aspect of the intervention were well received by participants. In addition, the achievements of the YIA programme in changing misconceptions and challenging negative stigmas associated with the disease points to the potential for success of programmes which involve in their delivery people with very personal experiences of HIV/AIDS.

The experiences of conducting this study were used to inform a contribution to evaluation debates in the HIV prevention field. In order to try and reduce bias and error it was suggested that outcome evaluations, where possible, should strive to achieve the experimental standards of a randomised controlled trial in a 'pretest-posttest' control group design. However, it was also argued that an outcome evaluation of this kind would be complemented by a detailed process evaluation. Indeed the experiences of this study suggest that

implementation monitoring is an important aspect of evaluation, particularly when trying to explain unexpected outcomes or inconsistencies in the data.

The persistent lack of any cure or vaccine for HIV/AIDS dictates that social interventions must play a vital part in any effort to prevent the spread of HIV. Despite the continued rise in new HIV diagnoses in the UK, central government funding for HIV prevention programmes has decreased in real terms since 1997 (POST2007). As this study has shown, social interventions *can* be successful in achieving significant gains in both HIV/AIDS knowledge and attitudes towards HIV/AIDS issues. Consequently, to tackle the spread of HIV, UK policy makers need to make a renewed commitment both to promote and fund HIV prevention programmes.

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Appendix 1

Theory-Based Evaluations

The two most prominent ‘theory-based’ evaluation methods are ‘Theories of Change⁵⁶’ (TOC) and ‘Realistic Evaluation⁵⁷’. Both TOC and Realistic Evaluations⁵⁸ require evaluators to examine the ‘theory’ of a programme. This should then “be used to inform the evaluation’s purpose and focus, and the key questions that it will address” (Blamey & Mhairi 2007:445). Perhaps the central element of both approaches beyond their focus on programme theory is the belief that understanding ‘context’ – be it social, political or organisational - is the key to successful evaluations. Both approaches recognise that context has a crucial impact on programmes’ relative success or failure and will often consist of factors beyond the control of programme designers, implementers and evaluators (Blamey & Mhairi 2007).

In a comparative review of both theory based approaches Blamey and Mhairi (2007) argue that a serious limitation on the potential usage of both approaches is that they are resource demanding and time consuming. Particularly when compared to more traditional evaluation approaches that are less concerned with the theory behind an intervention. More specifically, Blamey and Mhairi (2007:451) suggest that TOC evaluations require detailed consultation with all stakeholders to agree on the theories to be considered as part of the evaluation; whilst Realistic Evaluations require extra time for “evaluators to identify, prioritize and explore” potential programme theories. In conclusion to their review Blamey and Mhairi (2007:452) argue for “greater realism about the size of the evidence base that can be advanced within any one evaluation” – which clearly communicates a sceptical position in relation to the vast and all-encompassing theory-based evaluation methodologies. At the time of writing it appears that there has been no attempt so far to conduct a theory-based evaluation in the HIV prevention field, perhaps largely due to the issues outlined above.

⁵⁶ For detailed discussions see Connell et al. (1995) and Fullbright-Anderson et al. (1998).

⁵⁷ For the seminal text see Pawson and Tilley (1997)

⁵⁸ It is beyond the scope of this study to give a detailed account of these complex approaches to evaluation, particularly when you consider that there are no existing attempts at the practical application of either in the HIV prevention field. Rather a brief outline is given along with some tentative suggestions for why the approaches have not been used in this field.

Appendix 2

Peersman and Rugg (2004):

In a systematic review of 142 HIV prevention evaluations in Africa and Asia, Peersman and Rugg (2004:149) found that existing evaluations suffered from a number of methodological weaknesses - many of which correspond to those identified by Oakley et al. (1995). They identified a useful and instructive list of common flaws in the evaluations reviewed which also serve as barriers to their future use:

- 75% of studies reviewed did not use a control or comparison group
- Lack of transparency with few studies discussing 'negative' or 'no' effects
- Lack of discussion of attrition rates
- A general failure to report "on key information about the study population and intervention context"
- Age of study population missing in 21% of evaluations reviewed
- Sex of study population missing in 6% of evaluations reviewed
- 20% did not mention the intervention provider
- 8% did not specify whether the intervention took place in a rural or urban setting
- 9% did not specify the specific intervention setting e.g. took place in a school

Appendix 3 - HIV and AIDS Survey 1

(Used for pre-test training group and post-test control group)

ID Number

We need you to enter some simple information that will form your anonymous ID Number.

1. School Number (your teacher will tell you this): _____
2. Birth **date** and **month** (e.g. if your birthday is the 9th June you write 0906, or if your birthday is the 19th March you write 1903): _____
3. Last two letters of your first name (e.g. If your name is Peter you write 'er') _____
4. Will you take part in the HIV and AIDS workshop? (If **Yes** please circle the number **1** If **No** please circle the number **2**): 1 2

About you

To begin there are a few questions about you to help us understand your responses. **Please circle your answer.**

5. Are you: Female Male
6. What age are you? 12 13 14 15 16
7. How would you describe your Nationality?
 English Welsh Scottish
 Irish British Other
8. How would you describe your Ethnicity?
 White Black/Black British Asian/Asian British
 Chinese Mixed 'race' Other
9. What is your Religion?
 Christian Muslim Hindu Sikh
 Jewish Other No religion
10. How would you rate your knowledge of HIV and AIDS?
Very Good Good Average Poor Very Poor

Knowledge

The following questions will help us to understand what you know about HIV and AIDS. For each question **please circle the letter** that you think is the correct answer.

11. You could become infected with HIV if you:

- A. Have sex with an infected person without using a condom correctly.
- B. Don't wash your hands after using the toilet.
- C. Have not been vaccinated against it.
- D. Don't know.

12. HIV can be passed by:

- A. Hugging a person with AIDS.
- B. Sitting next to an AIDS-infected person on the bus.
- C. Sharing needles used for injecting drugs.
- D. Don't know.

13. Can you get AIDS from sharing the cup of an HIV positive person?

- A. Yes
- B. No
- C. Only if you don't wash the cup
- D. Don't know.

14. Can insects transmit HIV?

- A. Yes
- B. No
- C. Only mosquitoes
- D. Don't know.

15. How much saliva would it take to infect someone with HIV?

- A. 1 litre
- B. 10 ml
- C. HIV cannot be passed on through saliva
- D. Don't know.

16. Can a lesbian be infected with HIV?

- A. Yes.
- B. No.
- C. Only if she has sex with a man.
- D. Don't know.

17. What is abstinence?

- A. To refrain from sex
- B. To only have sex with one partner
- C. To lose your virginity
- D. Don't know

18. How can you tell if somebody has HIV or AIDS?

- A. Because of the way they act
- B. They look tired and ill
- C. There is no easy way to tell
- D. Don't know

19. What is the difference between HIV and AIDS?

- A. HIV is a virus and AIDS is a bacterial disease
- B. There is no difference between HIV and AIDS
- C. HIV is the virus that causes AIDS
- D. Don't know.

20. Does HIV only affect gay people?

- A. Yes
- B. No
- C. Only gay men
- D. Only gay women
- E. Don't know

21. Can a baby be born with HIV?

- A. Yes.
- B. No.
- C. Don't know.

22. Is there a cure for AIDS?

- A. Yes
- B. No
- C. Only available on prescription
- D. Don't know

Attitudes and Beliefs

Now we would like to find out a bit about your views on sex and HIV & AIDS.

This section asks whether you agree or disagree with a set of statements. Please read each statement, and then circle the number that best describes your view using the following scale; Strongly Agree (5), Agree (4), Not Sure (3), Disagree (2) or Strongly Disagree (1).

	<i>Strongly Agree</i> 5	<i>Agree</i> 4	<i>Not Sure</i> 3	<i>Disagree</i> 2	<i>Strongly Disagree</i> 1
23. I wouldn't mind being in the same classroom with someone who has HIV.	5	4	3	2	1
24. A person who has HIV shouldn't be allowed to eat lunch in the school canteen.	5	4	3	2	1
25. Teenagers who don't have sex are wasting their teen years.	5	4	3	2	1
26. HIV and AIDS only really affect people in African countries.	5	4	3	2	1
27. I would avoid a classmate who I heard had HIV.	5	4	3	2	1
28. It's okay not to have sex while you are a teenager.	5	4	3	2	1
29. I would feel comfortable hugging a close friend who has HIV.	5	4	3	2	1
30. People who don't have sex before they get married are strange.	5	4	3	2	1
31. People who use condoms during sex don't trust the person they're with.	5	4	3	2	1
32. Young people in Britain should learn about HIV and AIDS.	5	4	3	2	1
33. A person who has HIV should stay away from public places.	5	4	3	2	1

Thank you for your help with the survey!

If you would like to speak to somebody over the phone about anything related to HIV/AIDS you can call **The National AIDS Helpline on 0800 567 123**. The helpline provides a confidential, anonymous 24-hour free telephone counselling, information and referral service for those infected and affected by HIV and AIDS.

Appendix 3 - HIV and AIDS Survey 2

(Used for pre-test training group and post-test control group)

ID Number

We need you to enter some simple information that will form your anonymous ID Number.

1. School Number (your teacher will tell you this): _____
2. Birth **date** and **month** (e.g. if your birthday is the 9th June you write 0906, or if your birthday is the 19th March you write 1903): _____
3. Last two letters of your first name (e.g. If your name is Peter you write 'er') _____
4. Will you take part in the HIV and AIDS workshop? (If **Yes** please circle the number **1** If **No** please circle the number **2**): 1 2

About you

To begin there are a few questions about you to help us understand your responses. **Please circle your answer.**

5. Are you: Female Male
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10. How would you rate your knowledge of HIV and AIDS?
Very Good Good Average Poor Very Poor

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- C. Have not been vaccinated against it.
- D. Don't know.

12. HIV can be passed by:

- A. Hugging a person with AIDS.
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- C. Sharing needles used for injecting drugs.
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13. Can you get AIDS from sharing the cup of an HIV positive person?

- A. Yes
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- C. Only if you don't wash the cup
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- B. 10 ml
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- B. They look tired and ill
- C. There is no easy way to tell
- D. Don't know

19. What is the difference between HIV and AIDS?

- A. HIV is a virus and AIDS is a bacterial disease
- B. There is no difference between HIV and AIDS
- C. HIV is the virus that causes AIDS
- D. Don't know.

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- A. Yes
- B. No
- C. Only gay men
- D. Only gay women
- E. Don't know

21. Can a baby be born with HIV?

- A. Yes.
- B. No.
- C. Don't know.

22. Is there a cure for AIDS?

- A. Yes
- B. No
- C. Only available on prescription
- D. Don't know

Attitudes and Beliefs

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	<i>Strongly Agree</i> 5	<i>Agree</i> 4	<i>Not Sure</i> 3	<i>Disagree</i> 2	<i>Strongly Disagree</i> 1
23. I wouldn't mind being in the same classroom with someone who has HIV.	5	4	3	2	1
24. A person who has HIV shouldn't be allowed to eat lunch in the school canteen.	5	4	3	2	1
25. Teenagers who don't have sex are wasting their teen years.	5	4	3	2	1
26. HIV and AIDS only really affect people in African countries.	5	4	3	2	1
27. I would avoid a classmate who I heard had HIV.	5	4	3	2	1
28. It's okay not to have sex while you are a teenager.	5	4	3	2	1
29. I would feel comfortable hugging a close friend who has HIV.	5	4	3	2	1
30. People who don't have sex before they get married are strange.	5	4	3	2	1
31. People who use condoms during sex don't trust the person they're with.	5	4	3	2	1
32. Young people in Britain should learn about HIV and AIDS.	5	4	3	2	1
33. A person who has HIV should stay away from public places.	5	4	3	2	1

Thank you for your help with the survey!

If you would like to speak to somebody over the phone about anything related to HIV/AIDS you can call **The National AIDS Helpline on 0800 567 123**. The helpline provides a confidential, anonymous 24-hour free telephone counselling, information and referral service for those infected and affected by HIV and AIDS.

Appendix 5

Letter to Parents

Dear Parents and Carers,

This is to inform you that as part of their Personal, social and health education, pupils in Years 9 and 10 will shortly be taking part in workshops led by the Youth in Action group in collaboration with the Terrence Higgins Trust. The workshops use drama combined with question and answer sessions to teach young people about HIV and AIDs.

As part of the evaluation of the workshops pupils will be invited to take part in a short online survey before and after participating in the workshops. A Masters Degree student from the University of Bristol, Donald Wallace, will be undertaking this evaluation. The surveys evaluate what pupils have learnt about HIV and AIDS from the workshops and their attitudes towards these issues, but do not involve any questions about pupils' own behaviour.

The surveys will be completed anonymously and pupils will not be asked to give their name at any time. All of the completed surveys will be treated strictly confidentially in accordance with the Data Protection Act. Young peoples' participation in the study is completely voluntary and they can stop participating in the study at any point. The final report will be an important part of evaluating the impact of the Youth in Action project and will also be used by Mr Wallace for his masters' research project. Each school will receive a copy of the final report, as will North Somerset Council who have funded the Youth in Action project.

All parents and carers of pupils in years 9 and 10 are therefore being informed about this important study. If you do not wish your child to take part, please fill in the form below and return it to school by xx June.

Please only complete and return the form below if you do not want your child to take part in the study.

I do not wish my child _____ (insert name) to take part in the survey about the Youth in Action workshops.

Signed _____(insert name)

Parent/ Carer (delete as appropriate)

Appendix 6

Participant Information and Consent Sheet

About the Survey

You are being invited to take part in a quick online survey about HIV and AIDS. In the next few weeks some schools in your area will be having special workshops on HIV and AIDS.

This survey aims to understand:

- what you know about HIV and AIDS
- your attitudes towards HIV and AIDS

Your Participation

It is your choice whether you take part in these surveys and you can stop at any time. No one will know how you answered as you will not be asked to give your name at any time.

The results of the surveys will be used to help us understand what pupils know about HIV and AIDS and what they still need to learn. The study will also be used for a University of Bristol student's research project.

	Please Tick Box	
Consent	Yes	No
Have you read this information sheet?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had the opportunity to ask questions about the survey?	<input type="checkbox"/>	<input type="checkbox"/>
Do you understand that you are free to withdraw from the survey at any time without giving a reason?	<input type="checkbox"/>	<input type="checkbox"/>
Do you agree to take part in the survey?	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 7

SPS Research Ethics: request for approval for student research project

1. Student's name:

Donald Wallace

2. Programme:

MSc Public Policy

3. Year of study:

1

4. Project advisors:

Ailsa Cameron and William Turner

5. Date dissertation is to be submitted:

15th September 2009

6. Project title:

“Contributing to the evidence base for sexual health education policy: An evaluation of the Youth in Action HIV and AIDS education programme”

Background: I am undertaking this research project for my MSc in Public Policy dissertation but also as part of a broader evaluation of the ‘Youth in Action’ Project. ‘Youth in Action’ is a cultural exchange project which involves bringing together young people from schools in North Somerset and Bristol with a youth group from the Nkomazi Region of Mpumalanga, South Africa. The South African youths belong to a performing group which is part of a community-based organisation called ‘Thembaletu’ (‘our hope’) which provides support to 4,500 orphans whose lives have been affected by HIV and AIDs.

The 15 young people from Thembaletu, along with professionals from the Terrence Higgins Trust, will run workshops with Year 9 & 10 students using performance as a means of communicating important messages about HIV and AIDs. Dawn Snape – one of the ‘Youth in Action’ project co-leaders – approached the School for Policy studies looking for a Masters student to undertake the evaluation of the ‘Youth in Action Project’s HIV and AIDS workshops; which are being run in 7 secondary schools in North Somerset and Bristol.

The ‘Youth in Action’ group arrive in the UK on the 12th June with the workshops running between the 16th June and the 2nd July.

7. Please outline all research methods you will be using: (e.g. a survey questionnaire, face-to-face interviews, secondary data analysis, text analysis etc)

Survey questionnaire

If your research involves no participants i.e. you are not conducting a survey/ interviews/ focus groups complete section 9 and submit the form.

8. For those intending to carry out primary research:

8.1. Are you using a questionnaire, interview, focus group as part of your procedure? If **yes**, attach a copy of the questionnaire(s), topic guide and/or interview questions.

Yes, a questionnaire – copy attached.

8.2. Are you advertising for participants or posting a notice for volunteers? If **yes**, attach a copy of the advertisement or notice.

No.

8.3. Describe your interview participants: what populations form the basis of your sample? (e.g. general population, lone parents, mature students etc)

School pupils in Years 9 and 10 (aged 13-15) from schools across Somerset and Bristol.

8.4. Vulnerable / special populations:

Do your participants include any of the following:

- | | | |
|---|------------|-----------|
| 8.4.1. Children under the age of 16 | Yes | No |
| 8.4.2. People with mental health problems | Yes | No |
| 8.4.3. Older people | Yes | No |
| 8.4.4. Other students enrolled in your own classes | Yes | No |
| 8.4.5. Other special populations e.g. homeless, drug/ alcohol mis-users, victims of crime
(Please specify) | | |

8.4.6 If you answered yes to 8.4.1, 8.4.2, 8.4.3, and 8.4.5 your participants include vulnerable populations and you **may** require clearance from the Criminal Records Bureau. The criteria for requiring CRB clearance are that the researcher needs to work with the child/vulnerable adult on their own in the absence of (in the case of children) the parents, or the person acting in loco parentis, or (in the case of vulnerable adults) the person with a duty of care for the individual.

Do you require such clearance? Yes **No**

Have you received clearance? Yes No

PLEASE NOTE THAT YOU WILL NOT BE ABLE TO COMMENCE YOUR FIELDWORK UNTIL YOU HAVE HAD CRB CLEARANCE. PLEASE ENSURE THAT YOU APPLY FOR CLEARANCE IN AMPLE TIME

I will at no time be working on my own with a child under 16 – at all times I will be in the presence of a member of school staff or another researcher/project leader with the requisite CRB clearance.

- 8.5. Describe the source(s) of your participants and the selection criteria. Specifically, how will you obtain potential participants, and how will you contact them?

The potential participants in this study come from the seven schools in Somerset and Bristol who are receiving HIV and AIDs workshops from the 'Youth in Action' group. At schools that will be visited by the Youth in Action group, all pupils who are expected to attend a Youth in Action HIV/ AIDs workshop will be invited to take part in the survey as part of the overall evaluation of the Youth in Action project.

A letter in clear, simple English will be distributed to all parents of the pupils on behalf of the programme coordinator - Dawn Snape – by the schools. The letter will inform them that their children will be taking part in an HIV and AIDs workshop as part of their Personal, social and health education (PSHE). The letter will also state that their children will be invited to take part in a short survey as part of an evaluation of the educational success of the workshops. It will be explained that there will be one survey before and one survey after the workshops to gauge any changes in the students' knowledge, attitudes and beliefs surrounding HIV and AIDs (*not* personal behaviours). The letter will stress that the students' participation is entirely voluntary and that their responses will remain anonymous. The letter will also contain an 'opt-out' section for them to sign and return should they *not* wish for their child to take part in the evaluation.

Furthermore, an introductory information sheet in clear, simple English will be distributed to all pupils taking part in the workshops on behalf of the project leader - Dawn Snape - by the school. The sheet will state the purpose of the study, how their answers will be used, that their participation is entirely voluntary, and that their responses will remain anonymous. There will be boxes for them to tick to confirm they understand the above and confirm their informed consent to take part in the surveys.

North Somerset's PSHE Advisor and member of the Youth in Action Steering Group, Sue Walker, has agreed to help identify schools to be used as 'control groups'. She will speak to staff in these schools about their participation on my behalf. These will be schools not visited by the Youth in Action group, and the students invited to help with the study will also be in Year 9 and/or Year 10. They will be the 'control group' and they and their parents will be given a similar letter to that received by pupils at schools participating in the Youth in Action project. However, their letter will ask for their help with my MSc research project - focusing on young people's awareness, attitudes and knowledge of HIV/ AIDs. All the same assurances will be given about anonymity and confidentiality and the voluntary nature of their participation in the study.

Copies of these documents are attached.

- 8.6. Will you be asking questions that might disturb your participants emotionally or produce stress and anxiety? If **Yes** what plans do you have to deal with this (e.g. what support can be provided to them)

The questions on the survey will focus on awareness, attitudes and knowledge of HIV/ AIDs and will not deal with the more personal questions of behaviour/behavioural intentions. The 'Youth in Action' Secondary Schools Working Group has identified the possibility of stress and/or anxiety arising from discussion of the subject of HIV and AIDs in the workshops generally. Therefore teachers at participating schools are being asked to be particularly alert to any signs of distress and to provide pastoral care where required. As part of my briefing to teachers, I will also ask them to be aware of this possibility in relation to the surveys.

As part of the workshops, representatives of the Terrence Higgins Trust will also be available to answer any questions and to provide literature with help-lines and other sources of support. I will include a helpline number at the end of the surveys and in the initial introductory letter to pupils about the survey.

In the control group schools, I would anticipate less anxiety associated with the subject as they are expected to have had less direct exposure to the implications of HIV/ AIDs than those attending the workshops. However, the same helpline numbers will be provided on the initial letter and at the end of the survey and I will ask for leaflets about HIV/ AIDs to be distributed to each pupil at the end of the survey.

- 8.7. If there are prospective participants who might be especially vulnerable to risk as a result of your research describe all known and anticipated risks to the participants. How will you screen and eliminate all vulnerable participants from the study?

All pupils will be potentially vulnerable- anyone can be infected or affected by HIV/ AIDs and may therefore find the issues potentially upsetting. It will not be possible to screen out people who may be particularly affected by the issues. All pupils are invited to consider HIV/ AIDs in the workshops and will be given guidance about how best to minimize the risks of transmission or to minimize the risks of illness if they believe they may be infected. The research will simply measure how clearly the messages from the workshops have been heard and understood by participants.

Those in control group schools will not be given any new information about HIV/ AIDS until after they have undertaken the survey – at which point they will be given a help-line number and an informative leaflet. The purpose of the control group survey is to measure awareness and knowledge of HIV/ AIDs in the absence of the type of input provided by the workshops.

- 8.8. **Informed consent:** what procedures will you follow to ensure all of your participants give informed consent?

A letter in clear, simple English will be distributed to all parents of the pupils on behalf of the programme coordinator - Dawn Snape – by the schools. The letter will inform them that their children will be taking part in an HIV and AIDs workshop as part of their Personal, social and health education (PSHE). The letter will also state that their children will be invited to take part in a short survey as part of an evaluation of the educational success of the workshops. It will be explained that there will be one survey before and one survey after the workshops to gauge any changes in the students' knowledge, attitudes and beliefs surrounding HIV and AIDs (*not* personal behaviours). The letter will stress that the students' participation is entirely voluntary and that their responses will remain anonymous. The letter will also contain an 'opt-out' section for them to sign and return should they *not* wish for their child to take part in the evaluation.

Furthermore, an introductory information sheet in clear, simple English will be distributed to all pupils taking part in the workshops on behalf of the project leader - Dawn Snape - by the school. The sheet will state the purpose of the study, how their answers will be used, that their participation is entirely voluntary, and that their responses will remain anonymous. There will be boxes for them to tick to confirm they understand the above and confirm their informed consent to take part in the surveys. A briefing sheet for teaching staff will ask them to reiterate these points to the students when the survey is distributed and to emphasise that participation in the survey is completely voluntary. If they choose to participate, they will be told that they can still withdraw from participation at any point and they can choose not to answer any question(s) with which they feel uncomfortable. This will also be set out clearly at the outset of the survey itself.

The student information sheet will also make clear at the outset that the survey is in two parts - one before participation in the workshop and one after participation. Again, the letter will highlight that participation in both surveys is voluntary and can be withdrawn at any point.

At schools not visited by the Youth in Action group, those in Year 9 and/ or Year 10 will be invited to help with the study. They will be the 'control group' and they and their parents will be given a similar letter to that received by pupils at schools participating in the Youth in Action project. However, their letter will ask for their help with my MSc research project - focusing on young people's knowledge, attitudes and awareness of HIV/AIDs. All the same assurances will be given about anonymity and confidentiality and the voluntary nature of their participation in the study. They will be asked to complete only one survey (as there is no 'before' and 'after' stage to capture with this group).

Copies of these documents are attached.

In addition it should be noted that the survey will be seen and agreed to by the lead teacher from each school as well as Sue Walker - North Somerset's PSHE Advisor.

8.9. **Information for participants:** what information will you be giving to participants? E.g. letter of introduction, outline of project's aims etc. Please attach copies of any such information to this form.

A letter of introduction discussed above which will include informed consent section. Copy attached.

8.10 **Researcher safety:** are there any potential risks to you in undertaking this research and how will you deal with them? E.g. where will the fieldwork take place? Who will you notify with details of where and when you are doing the fieldwork? Will you take a mobile phone?

The surveys will be completed online by students in their respective schools or via a self-completion questionnaire. I will be accompanied at all times in the schools either by a teacher or one of the two project leaders – Dawn Snape and Jayne Morris-Thurgood. I will have a mobile phone on me at all times.

8.11 **Data management:**

8.11.1 How will the data you collect be stored? E.g. on a password controlled computer, (laptop or desk), cassette tape, minidisc, paper files in a locked draw/ cabinet?

The data from the surveys will be stored online in a password controlled environment of 'Stellar Survey, as well as on my personal laptop which is password protected. Both programme coordinators – Jayne Morris-Thurgood and Dawn Snape – will have access to and ownership of the data since a further evaluation outside of my MSc project will be undertaken one year after the workshops to determine any longer term effects.

8.11.2 Where will you keep this data? E.g. in your flat, in an office?

Please see above answer to 8.11.1. – My flat.

8.11.3 Do you have any concerns about the security of any of these locations?

No.

8.11.4 Data which is of a personal nature should be stored anonymously. How will you ensure that your data remains anonymous?

There will be no collection of names. Each pupil will be asked to use a unique identifier consisting of a two digit school code and a four digit number of their own choosing (such as a birthday, or some other memorable number for them). They will at no time be asked for their name on the surveys and will be identified only by this number.

8.11.5 At the end of the project, what is the strategy for data management? At what stage will data be deleted and how will this be done? (E.g. reformatting tapes or discs, confidential shredding of paper waste etc). **Because the School may require you to produce your data you should not destroy it until after your degree has been awarded.**

After the project, the data will be kept for 18 months as follow-up work may be conducted. One year after the workshops, pupils may be re-surveyed to determine the longer term impacts of the workshops on attitudes and behaviour. After this point, the data will be permanently deleted from any and all storage points.

Appendix 8 – Data Outputs

Demographics: Paired pre and post-test training

Gender		
	Frequency	Percent
Female	136	52.9
Male	121	47.1
Total	257	100.0

Age		
	Frequency	Percent
12	1	.4
13	34	13.2
14	144	56.0
15	78	30.4
Total	257	100.0

Nationality		
	Frequency	Percent
English	197	76.7
Welsh	5	1.9
Irish	1	.4
Scottish	1	.4
British	33	12.8
Other	20	7.8
Total	257	100.0

Ethnic Group		
	Frequency	Percent
White	228	88.7
Black/Black British	4	1.6
Asian/Asian British	11	4.3
Chinese	2	.8
Mixed 'race'	8	3.1
Other	4	1.6
Total	257	100.0

Religion		
	Frequency	Percent
Christian	59	23.0
Muslim	10	3.9
Hindu	1	.4
Jewish	2	.8
Other	8	3.1
No Religion	177	68.9
Total	257	100.0

Hypothesis 1

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Self rated knowledgeT1	2.95	255	0.746	0.047
	Self rated knowledgeT2	3.55	255	0.713	0.045

Paired Samples Test									
Paired Differences									
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
					Lower	Upper			
Pair 1	Self rated knowledge T1 - Self rated knowledge T2	-0.604	0.835	0.052	-0.707	-0.501	-11.553	254	0

Hypothesis 2

Questions for which the hypothesis was not proved correct

		N	Z statistic	Significance (2-tailed)
Q12pre-test - Q12post-test	Negative Ranks	6	-1.41	0.157
	Positive Ranks	2		
	Ties	239		
	Total	247		
Q15pre-test - Q15post-test	Negative Ranks	38	-0.35	0.725
	Positive Ranks	35		
	Ties	167		
	Total	240		
Q16pre-test - Q16post-test	Negative Ranks	32	-0.79	0.431
	Positive Ranks	26		
	Ties	182		
	Total	240		
Q18pre-test - Q18post-test	Negative Ranks	24	-0.56	0.579
	Positive Ranks	28		
	Ties	188		
	Total	240		
Q20pre-test - Q20post-test	Negative Ranks	22	-0.8	0.423
	Positive Ranks	17		
	Ties	199		
	Total	238		

Hypothesis 3

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Q23T1	3.62	208	1.102	.076
	Q23T2	4.13	208	.987	.068
Pair 2	Q24T1	1.93	209	.928	.064
	Q24T2	1.59	209	.840	.058
Pair 3	Q25T1	2.10	207	1.138	.079
	Q25T2	1.96	207	1.070	.074
Pair 4	Q26T1	1.75	209	.913	.063
	Q26T2	1.73	209	.892	.062
Pair 5	Q27T1	2.26	209	1.014	.070
	Q27T2	1.93	209	.940	.065
Pair 6	Q28T1	4.02	209	.995	.069
	Q28T2	4.04	209	1.091	.075
Pair 7	Q29T1	3.45	205	1.059	.074
	Q29T2	3.82	205	1.093	.076
Pair 8	Q30T1	2.27	206	1.179	.082
	Q30T2	1.99	206	1.052	.073
Pair 9	Q31T1	1.70	204	.986	.069
	Q31T2	1.50	204	.733	.051
Pair 10	Q32T1	4.53	203	.684	.048
	Q32T2	4.52	203	.713	.050
Pair 11	Q33T1	1.93	206	.970	.068
	Q33T2	1.61	206	.756	.053

Hypothesis 3 continued

Paired Samples Test									
		Paired Differences							
		Mean	Std. Deviation	Std. Error Mean	Interval of the		t	df	Sig. (2-tailed)
					Lower	Upper			
Pair 1	Q23T1 - Q23T2	-.514	1.040	.072	-.657	-.372	-7.133	207	.000
Pair 2	Q24T1 - Q24T2	.344	.923	.064	.219	.470	5.396	208	.000
Pair 3	Q25T1 - Q25T2	.140	.953	.066	.010	.271	2.116	206	.036
Pair 4	Q26T1 - Q26T2	.019	1.083	.075	-.129	.167	.256	208	.799
Pair 5	Q27T1 - Q27T2	.330	1.015	.070	.192	.469	4.703	208	.000
Pair 6	Q28T1 - Q28T2	-.019	1.101	.076	-.169	.131	-.251	208	.802
Pair 7	Q29T1 - Q29T2	-.371	1.107	.077	-.523	-.218	-4.797	204	.000
Pair 8	Q30T1 - Q30T2	.286	1.008	.070	.148	.425	4.080	205	.000
Pair 9	Q31T1 - Q31T2	.191	1.006	.070	.052	.330	2.714	203	.007
Pair 10	Q32T1 - Q32T2	.005	.735	.052	-.097	.107	.096	202	.924
Pair 11	Q33T1 - Q33T2	.325	.794	.055	.216	.434	5.880	205	.000

Demographics: Post-test training and control

Condition type * Gender Crosstabulation					
			Gender		
			Female	Male	Total
Condition type	training	Count	209	170	379
		% within Condition type	55.1%	44.9%	100.0%
	control	Count	54	45	99
		% within Condition type	54.5%	45.5%	100.0%
	Total	Count	263	215	478
		% within Condition type	55.0%	45.0%	100.0%

Condition type * Age Crosstabulation								
			Age					
			12	13	14	15	16	Total
Condition type	training	Count	1	41	207	129	1	379
		% within Condition type	.3%	10.8%	54.6%	34.0%	.3%	100.0%
	control	Count	0	10	65	23	1	99
		% within Condition type	.0%	10.1%	65.7%	23.2%	1.0%	100.0%
	Total	Count	1	51	272	152	2	478
		% within Condition type	.2%	10.7%	56.9%	31.8%	.4%	100.0%

Crosstab									
			Nationality						
			English	Welsh	Irish	Scottish	British	Other	Total
Condition type	training	Count	281	7	1	2	63	25	379
		% within Condition type	74.1%	1.8%	.3%	.5%	16.6%	6.6%	100.0%
	control	Count	75	1	2	0	18	3	99
		% within Condition type	75.8%	1.0%	2.0%	.0%	18.2%	3.0%	100.0%
	Total	Count	356	8	3	2	81	28	478
		% within Condition type	74.5%	1.7%	.6%	.4%	16.9%	5.9%	100.0%

Crosstab									
			Ethnic Group						
			White	Black/Black British	Asian/Asian British	Chinese	Mixed 'race'	Other	Total
Condition type	training	Count	324	10	18	3	14	10	379
		% within Condition type	85.5%	2.6%	4.7%	.8%	3.7%	2.6%	100.0%
	control	Count	90	2	1	2	3	1	99
		% within Condition type	90.9%	2.0%	1.0%	2.0%	3.0%	1.0%	100.0%
	Total	Count	414	12	19	5	17	11	478
		% within Condition type	86.6%	2.5%	4.0%	1.0%	3.6%	2.3%	100.0%

Crosstab										
			Religion							
			Christian	Muslim	Hindu	Sikh	Jewish	Other	No Religion	Total
Condition type	training	Count	93	13	2	2	4	11	254	379
		% within Condition type	24.5%	3.4%	.5%	.5%	1.1%	2.9%	67.0%	100.0%
	control	Count	28	1	3	1	1	4	61	99
		% within Condition type	28.3%	1.0%	3.0%	1.0%	1.0%	4.0%	61.6%	100.0%
	Total	Count	121	14	5	3	5	15	315	478
		% within Condition type	25.3%	2.9%	1.0%	.6%	1.0%	3.1%	65.9%	100.0%

Hypothesis 4

Group Statistics					
	Condition type	N	Mean	Std. Deviation	Std. Error Mean
Self rated knowledge	training	379	3.52	.729	.037
	control	99	2.91	.771	.077

Independent Samples Test						
		t-test for Equality of Means				
		t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Self rated knowledge	Equal variances assumed	7.306	476	.000	.608	.083
	Equal variances not assumed	7.070	147.039	.000	.608	.086

Hypothesis 5

Questions for which the hypothesis was not proved correct

	% of group with correct answers by condition type		Pearson Chi-Square (df=1)		Odds Ratio
	Training	Control	Value	Sig (2-sided)	
Q15	49.1%	42.3%	1.44	0.231	1.33
Q16	67.5%	66.0%	.083	0.774	1.07
Q18	77.6%	70.1%	2.33	0.127	1.48
Q19	63.4%	64.9%	.081	0.776	0.94
Q20	88.7%	81.4%	3.50	0.061	1.78

Hypothesis 6

Group Statistics					
	Condition type	N	Mean	Std. Deviation	Std. Error Mean
Q23	training	312	4.12	1.026	.058
	control	93	3.77	1.134	.118
Q24	training	313	1.60	.905	.051
	control	93	2.12	1.141	.118
Q25	training	311	2.02	1.110	.063
	control	92	2.46	1.296	.135
Q26	training	311	1.70	.917	.052
	control	93	1.85	.896	.093
Q27	training	313	1.90	.974	.055
	control	92	2.33	1.140	.119
Q28	training	312	4.00	1.130	.064
	control	93	3.86	1.069	.111
Q29	training	312	3.79	1.130	.064
	control	93	3.43	1.117	.116
Q30	training	311	2.00	1.098	.062
	control	92	2.40	1.284	.134
Q31	training	308	1.56	.843	.048
	control	93	1.90	1.143	.118
Q32	training	309	4.49	.763	.043
	control	93	4.30	.894	.093
Q33	training	310	1.65	.867	.049
	control	93	1.91	1.007	.104

Data from hypothesis 6 continued on the following page.

Independent Samples Test										
		Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Interval of the	
									Lower	Upper
Q23	Equal variances assumed	3.262	.072	2.798	403	.005	.348	.124	.103	.592
	Equal variances not assumed			2.651	139.930	.009	.348	.131	.088	.607
Q24	Equal variances assumed	7.699	.006	-4.578	404	.000	-.521	.114	-.745	-.297
	Equal variances not assumed			-4.042	128.272	.000	-.521	.129	-.776	-.266
Q25	Equal variances assumed	9.651	.002	-3.190	401	.002	-.437	.137	-.707	-.168
	Equal variances not assumed			-2.933	132.940	.004	-.437	.149	-.732	-.142
Q26	Equal variances assumed	.528	.468	-1.347	402	.179	-.145	.108	-.357	.067
	Equal variances not assumed			-1.364	154.167	.174	-.145	.106	-.356	.065
Q27	Equal variances assumed	9.416	.002	-3.536	403	.000	-.425	.120	-.661	-.189
	Equal variances not assumed			-3.246	132.469	.001	-.425	.131	-.684	-.166
Q28	Equal variances assumed	.356	.551	1.036	403	.301	.137	.132	-.123	.396
	Equal variances not assumed			1.067	158.243	.288	.137	.128	-.116	.389
Q29	Equal variances assumed	.068	.794	2.740	403	.006	.365	.133	.103	.626
	Equal variances not assumed			2.757	152.450	.007	.365	.132	.103	.626
Q30	Equal variances assumed	9.958	.002	-2.964	401	.003	-.402	.136	-.669	-.135
	Equal variances not assumed			-2.723	132.809	.007	-.402	.148	-.694	-.110
Q31	Equal variances assumed	12.749	.000	-3.195	399	.002	-.348	.109	-.562	-.134
	Equal variances not assumed			-2.722	123.704	.007	-.348	.128	-.601	-.095
Q32	Equal variances assumed	2.519	.113	2.030	400	.043	.191	.094	.006	.376
	Equal variances not assumed			1.864	134.780	.065	.191	.102	-.012	.393
Q33	Equal variances assumed	1.644	.201	-2.433	401	.015	-.259	.107	-.469	-.050
	Equal variances not assumed			-2.245	135.424	.026	-.259	.115	-.487	-.031

Appendix 9

Comparison of results between paired hypotheses:

- **Hypotheses 1 and 4:** Both proved correct for question 10.

- **Hypothesis 2:** Proved correct for questions 11, 12, 13, 14, 17, 19*, 21, 22

- **Hypothesis 5:** Proved correct for questions 11, 12, 13, 14, 17, 21, 22

* Question 19 is therefore discounted from the discussion as it was not proven in both cases.

- **Hypothesis 3:** Proved correct for questions 23, 24, 25, 27, 29, 30, 31, 33

- **Hypothesis 6:** Proved correct for questions 23, 24, 25, 27, 29, 30, 31, 32*, 33

* Question 32 is therefore discounted from the discussion as it was not proven in both cases.

Appendix 10: Description of the Intervention

Background to the ‘Youth in Action’ Project

The Youth in Action (YIA) project brought 15 young people and 2 adult mentors from the Nkomazi Region of Mpumalanga, South Africa, to North Somerset and Bristol to engage in a unique youth exchange programme between 12th June and 2nd July 2009. The 15 young people, along with professionals from the Terrence Higgins Trust (THT), ran HIV and AIDS workshops⁵⁹ with Year 9 & 10 students in 6 Secondary Schools in Bristol and North Somerset.

The YIA group are aged between 17 and 24 (8 males, 7 females) and are supported by a community based charity in South Africa called Themba lethu – meaning ‘our hope’ (www.thembalethu.org). Themba lethu are a home-based care charity working in villages around Nkomazi. This area of South Africa has one of the highest HIV infection rates in the world; it is also an area of immense poverty with unemployment running at 65%. Themba lethu provide palliative care to those living with HIV and AIDs as well as practical and psychological support to 4,500 AIDs orphans and vulnerable children.

YIA is one of Themba lethu’s well established programmes and in the South African context aims to help create employment, give young people a sense of self-worth and raise awareness of HIV and AIDs. The group who came to the UK are part of the educational-arm of Youth in Action that go out into schools within the Nkomazi region using dance, music and drama to perform to other youngsters educating them with facts about HIV and AIDs.

Key characteristics of the YIA Workshops

- Peer education
- Informal approach using drama, dance and music to communicate about HIV & AIDS
- Cross-cultural – learning about the impacts of HIV and AIDS from an African perspective
- Trainers are people with personal experience of HIV and AIDS

⁵⁹ The young people also performed at numerous concerts and community events in the south-west.

- Abstinence-plus approach⁶⁰
- Also delivered by a professional from the Terrence Higgins Trust

Aims of the YIA Workshops

1. Increase knowledge of HIV and AIDS
2. Engender positive attitudes towards HIV and AIDS issues
3. Reduce the likelihood of risky behaviour in the future

Outline of the YIA Workshops*

Activity	Duration	Setting	Areas Covered
1. Performance of a poem about HIV written by YIA	5 mins.	Year-group assembly	Living with HIV/AIDS, stigma, testing, abstinence
2. YIA drama performance	35 mins.		
3. YIA question and answer session	45 mins.	Smaller classroom groups	Transmission, delay of sexual debut, abstinence, living with HIV/AIDS, testing, symptoms
4. THT games and activities session	45 mins.	Smaller classroom groups	Transmission, symptoms, risky behaviour, delaying sexual debut

*N.B. Each school received this programme once.

⁶⁰ The YIA group utilised an ‘abstinence-plus’ approach to sexual health education. Their core message was ‘safe sex or no sex at all’. This message is largely similar to what Gallant and Maticka-Tyndale (2004) identified as the ‘ABC’ approach to prevention. They found that this message was the most common across much of sub-Saharan Africa.

⁶¹ ABC approach: “First and foremost, Abstain from sex until marriage; if not abstaining, Be faithful to one, uninfected partner; if this is not possible, use a Condom” (Gallant & Maticka-Tyndale 2004:1339).