AMP!

Piloting an **A**rts-based **M**ultiple-Intervention **P**eer-Education Approach to Adolescent Sexual Health Education and HIV Prevention in North Carolina

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A FINAL EVALUATION REPORT SUBMITTED TO THE UCLA ART & GLOBAL HEALTH CENTER

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Executive Summary

The face of HIV and other sexually transmitted infections in the United States (US) has changed. Youth ages 13-29 are particularly at risk, accounting for 39% of new HIV infections in 2009 (CDC, 2012). The US South, including North Carolina (NC), is disproportionately affected by the HIV/AIDS epidemic. Findings from the Center for Disease Control and Prevention (CDC)'s Youth Risk Behavior Survey (YRBS) (2011) indicate that teens from this region engage in more risky sexual behavior on average than adolescents nationally. The increase in HIV incidence combined with high risk sexual activity captured by the YRBS indicates a need for an increased focus on HIV education and prevention, particularly among high school-aged youth.

In Spring 2011 Art and Global Health Center (AGHC) at UCLA reached out to potential partners at the University of North Carolina at Chapel Hill (UNC) to propose expanding the *AMP!* (**A**rts-based, **M**ultiple intervention, **P**eer-education) program in North Carolina (NC). *AMP*! is a sexual health education and HIV prevention approach developed in Los Angeles through a collaboration between the UCLA Art and Global Health Center (AGHC) and the HIV/AIDS Prevention Unit of the Los Angeles Unified School District (LAUSD). The *AMP!* model is multi-layered and multi-disciplinary and necessitates building partnerships across disciplines. In NC, AGHC established a broad-based partnership, building ties across diverse university departments and centers focused on communication studies and the performing arts, public service and public health, as well as with Chapel Hill-Carborro City Schools, where the program was piloted.

A project team consisting of a project manager, university course instructor, principal investigator, and 6 graduate students worked with university and school district stakeholders to plan, implement, and evaluate the intervention during Spring 2013. The goal of the pilot implementation of *AMP!* in NC was to assess the effectiveness and feasibility of the theater-based HIV prevention approach in the context of the southern United States. The project has larger implications as it also aims to fill two important gaps in the intervention literature: 1) the dearth of studies on US-based theater interventions and 2) the lack of rigorous evaluation of such interventions. The guiding research questions for the pilot study were:

- What is the efficacy of *AMP!* for program participants?
- What is the experience of university students participating in the Sex Ed Squad that delivers *AMP!*?
- What is the feasibility of *AMP!* in North Carolina public high schools?

We used a mixed methods (quantitative and qualitative) approach that included surveys, focus groups, in depth interviews, and observation. The instruments used with high school and university students were adapted from research colleagues in Los Angeles, and interview guides and observation instruments were designed in North Carolina. This methodological approach emphasized triangulation, or the use of multiple sources of data to maximize consistency and increase credibility, dependability, and trustworthiness of the findings (Lincoln & Guba, 1985).

Findings spoke both to the effectiveness of the intervention for high school program participants, the influential experience for university participants, the challenges and lessons learned during the pilot year, as well as key considerations for program feasibility and scale up.

Among high school participants, statistically significant results were found for increases in HIV knowledge, changes in attitudes and awareness, as well as likelihood of condom use and partner communication at the time of the post-test for participants who had received the intervention. Focus group data with a subset of high school participants corroborated that HIV knowledge was an important part of the intervention, and additionally revealed that stigma reduction was a successful key element of *AMP!* Participants described changes in attitude about HIV as well as PLWHA and an increased awareness of susceptibility. Furthermore students reflected on the content and quality of sex education and expressed being cognizant of the comprehensive approach that *AMP!* promoted.

Qualitative findings from the undergraduate participants provide strong evidence of the impact *AMP!* had on participants' HIV/AIDS knowledge, self-empowerment, and communication. Participants expressed understanding information about sexual health and HIV, and related this an increased sense of empowerment and ability to communicate with peers and providers. They became driven to become advocates and willing to speak out against stigma. Participants also recognized important limitations related to their preparations as peer educators and ability to impact behavior – both their own and that of high school students.

Findings related to feasibility illustrated a complex number of factors and systems that must be taken into consideration for successful implementation of *AMP!* The state's cultural and political climate is paramount, as is understanding the school district climate and classroom setting context. *AMP!* must respond and engage with these complex layers in order to be successfully implemented. In addition, the logistical complexity of the intervention was recognized as a major challenge during the pilot year, and an area to target for improvement in future iterations. Stakeholders made concrete suggestions about clarifying program objectives, designing learning objectives, and developing written guidelines for program delivery and teacher follow up. Furthermore, successful implementation also requires the strengthening of the partnership between UNC and UCLA via a clear structure for communication, support, and accountability.

The data also revealed clear recommendations related to research (both instrument design as well as methods used), intervention planning and implementation, project management, partnership development, and dissemination. These findings are critical to consider, both to strengthen the existing program and facilitate future expansion into other school districts in North Carolina. In conclusion, *AMP!* was successfully piloted, with significant findings and important lessons learned. The careful analysis and recommendations provide a strong foundation for making data-driven decisions that can improve the *AMP!* program and help promote engaging and meaningful approaches to sexual health education and HIV prevention.

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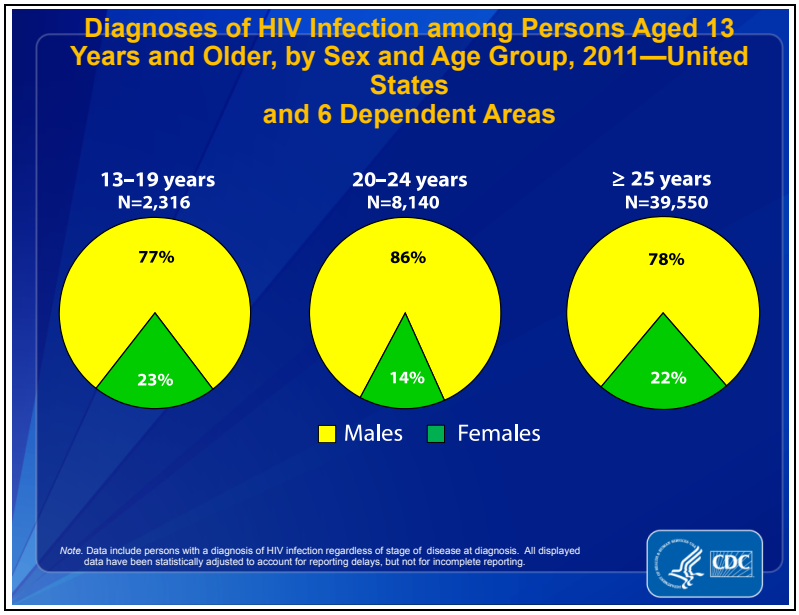
Introduction & Background

Problem Statement

The face of HIV and other sexually transmitted infections (STI) in the United States (US) has changed. Youth ages 13-29 are particularly at risk, accounting for 39% of new HIV infections in 2009 (CDC, 2012). The US South, including North Carolina (NC), is



disproportionately affected by the HIV/AIDS epidemic. In the Southeast region (defined by the US Census as Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, Delaware, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma, and Texas) the 2010 rate of HIV diagnoses was nearly 29% higher than the national average. While the majority of HIV cases are found among adults, the proportion of adolescents and young adults ages 13-24 living with HIV in NC has increased from 15.9% of all reports in 2006 to 22.9% in 2010 (NC DHHS, 2011). As of 2010, the prevalence (proportion of people in the population with a condition) of HIV infection in North Carolina was 0.7% among youth ages 15-19 and 3.8% among ages 20-24 (NC DHHS, 2011). Youth incidence rates (number of new cases in a given time period) in 2010 were 5% among those aged 15-19, and 17% among those aged 20-24 (NC DHHS, 2011). The sharp increase in both prevalence and incidence between the 15-19 and 20-24 age groups reflects the national trend. Findings from the Center for Disease Control and Prevention (CDC)'s Youth Risk Behavior Survey (YRBS) (2011) indicate that teens from this region engage in more risky sexual behavior on average than adolescents nationally. Of NC students surveyed in 2011, 49.3% reported having sexual intercourse, compared to 47.4% in the US (CDC, 2011). About 9% of all high school students in NC reported having had sex for the first time at the age of 13 or younger, and nearly 17% of students had had sex with four or more partners (CDC, 2011). In the same sample population in NC, 46.3% reported not using a condom during last sexual intercourse, compared to 39.8% in the US (CDC, 2011). The more encounters and sexual partners an adolescent has without using protection, the greater risk of exposures to STI and HIV/AIDS (NC Department of Public Instruction). The increase in HIV combined with the high risk sexual activity captured by the YRBS warrants an increased focus on HIV education and prevention, particularly among high school-aged youth.

The challenges to providing HIV education in North Carolina are numerous, however, and framed by the larger debate about comprehensive sex education. Since the 1960s, sex education in schools throughout the United States has been affected by national and state political climates (Irvine, 2002). Nationally, a conservative political agenda regarding sexuality emerged during the mid-1990s and, for the first time, federal funding was made

available for "abstinence-only" education grants to states (Bach, 2006). NC passed the School Health Education Act in 1996, which required schools to teach an abstinence-only-until-marriage curriculum, permitting comprehensive sex education only after the local board of education conducts a public hearing and review of education materials (N.C. Gen. Stat. § 115C-81, 1995).

Research has shown that abstinence-only programs are ineffective at reducing sexually transmitted infections (STIs), delaying age at first sex, and reducing teen pregnancy (Kohler et al., 2008; Trenholm et al., 2007). Studies have also shown that youth who receive comprehensive sex education programs are more likely to use condoms if sexually active and are less likely to experience an unplanned pregnancy (Kirby, 2007; Kohler et al., 2008). Additionally, a parent opinion poll on youth sex education conducted in NC reported that 91.8% of parents thought comprehensive sex education should be taught in public schools, over 95% felt that transmission and prevention of STIs including HIV/AIDS should be included in the curriculum, and 76.7% believed classroom demonstrations of how to correctly use a condom are important (UNC Survey Research Unit, 2009).

In response to these findings, the Healthy Youth NC Coalition formed to advocate for comprehensive sex education in all public schools and, in 2009, the Healthy Youth Act (HYA) was passed (Preston, 2009). The HYA requires that youth receive both the abstinence-only program and a comprehensive sex education curriculum (House Bill 88, Healthy Youth Act of 2009). The HYA provides a much broader landscape for sex education and the opportunity for local school boards to include course content without holding a public hearing (House Bill 88, Healthy Youth Act of 2009). Specific topics of instruction include how HIV and other STIs are transmitted, effectiveness and safety of all FDA-approved risk-reduction and contraception methods, available resources for testing and treatment, and HIV/STI infection rates among youth (House Bill 88, Healthy Youth Act of 2009). The Healthy Youth Act provides an opportunity to incorporate comprehensive sexual health education into the curriculum and to develop and implement innovative ways to promote HIV prevention.

Literature Review of Evidence-Based Interventions

Evidence-based programs are interventions that have undergone rigorous evaluation and demonstrate evidence of efficacy (CDC, 2012). The CDC identifies the following national programs as evidence-based sexual health promotion/HIV prevention interventions for youth in high school settings: *All4You!*, *Cuidate!*, *Draw the Line/Respect the Line*, *My Body: My Voice*, *Project AIM*, *Reducing HIV and AIDS through Prevention* (RHAP), *Reducing the Risk*, *Safer Choices*, the *State of Georgia AIDS Education Program*, and *Teens for AIDS Prevention* (TAP) (CDC, 2012). These evidence-based interventions commonly deliver four types of activities: traditional pedagogical techniques, skill-based exercises, arts-based exercises, and experiential education. Traditional pedagogical techniques include classroom instruction, group discussions and exercises, and video presentations. Skills-based exercises deliver HIV prevention and sexual health messages through games, condom demonstrations, and role plays. Examples of arts-based program components include arts-making workshops, dance, drama, photography, and music. Finally, experiential education program components use non-traditional methods and real-world experiences such as engaging in community service activities and writing newspaper opinion editorial articles to engage students in learning about HIV/AIDS and sexual health.

Though all of these program components are effective, some are more effective than others at reducing youth sexual risk behaviors. Behavioral theory-based programs, arts-based programs, and peer education programs are of particular importance in stemming these risk behaviors. Interventions that used theory to address norms and teach skills and those that feature creative intervention activities showed greater reductions in sexual risk behaviors than interventions that were not guided by a specific theoretical model that addressed critical aspects of risk reduction (Coyle, 2006, Coyle, 2004, Campbell, 2009). Creative, arts-based interventions, such as *My Body: My Voice*, resulted in higher self-reported self-efficacy to negotiate condom use, behavioral intention to use condoms, and knowledge of HIV/STIs. In addition, peer education was more effective than traditional teaching methods such as instructor lectures in increasing HIV and sexual health knowledge among students in an urban New Jersey high school (Mahat, 2008). Theory and arts-based programs actively engage youth in changing their attitudes, beliefs, and self-efficacy and increasing their knowledge about sexual health. Interventions that provide theory- and evidence-based approaches to HIV prevention are best equipped to serve youth and effect lasting behavior change. Such approaches are promising and several arts-based interventions have been developed for high school youth, yet greater evaluation of these programs is needed to determine their effects.

Project Background & Rationale

AMP! (**A**rts-based, **M**ultiple intervention, **P**eer-education) is a sexual health education and HIV prevention approach developed in Los Angeles through a collaboration between the UCLA Art and Global Health Center (AGHC) and the HIV/AIDS Prevention Unit of the Los Angeles Unified School District (LAUSD). *AMP!* provides young people with crucial information and prevention strategies in a novel way – through school-based performances and workshops developed by undergraduate students in a college course who are trained in HIV, health education, and interactive theater, as well as presentations and discussions with HIV+ speakers. Performances, which amplify school health curricula content, are based on undergraduates' lived experiences and attuned to adolescent needs and realities. The interactive theater methods employed by *AMP!* evolved from the pioneering work of Brazilian thinker Augusto Boal, who utilized drama as a platform through which participants could rehearse social change. Boal sought to break down barriers between spectators and the dramatic action of performance through his *Theater of the Oppressed* (Boal, 1979). To do this, he created techniques that empower spectators to play a part in the drama by directing the action, suggesting solutions to conflict, replacing characters in the action, or having dialogue with characters about their motivations (Conrad, 2004; Francis, 2011, Schaedler, 2010). In much the same way, public health interventionists apply these approaches to offer participants a platform through which they can rehearse changes in health behavior.

Resources Leveraged to Build Partnerships and Support Program Development, Implementation and Evaluation in North Carolina

In 2011 Art and Global Health Center (AGHC) at UCLA reached out to potential partners at Emory University and the University of North Carolina at Chapel Hill (UNC) to propose expanding the *AMP!* program to Georgia and North Carolina (NC). The *AMP!* model is multi-layered and multi-disciplinary and necessitates building partnerships across

disciplines. In NC, AGHC established a broad-based partnership, building ties with diverse university departments and Centers focused on communication studies and the performing arts, public service and public health to build a foundation for implementation and evaluation of the *AMP!* pilot program. AGHC also built ties with the local public school district, the Chapel Hill-Carrboro City Schools, one of two districts in Orange County, NC.

Funding and In Kind Support

To support this partnership effort, partial program funding was provided through a grant from the Ford Foundation, which enabled AGHC to hire Program Manager, Arianna Taboada, MSW, MSPH. *AMP!* NC received a Ueltschi course development grant from the Carolina Center for Public Service's APPLES Service-Learning Program to support the development of a course in the Communication Studies department, COMM 390 Performing Sexual Health (UNC Sex-Ed Squad), and the involvement of Amy Burtaine, Program Coordinator, Campus Health Service-based Interactive Theatre Carolina, as course instructor. AGHC also partnered with the UNC Center for Health Promotion and Disease Prevention (HPDP), a CDC-funded Prevention Research Center (PRC), and its Community-Based Participatory Research (CBPR) Core headed by Dr. Alexandra Lightfoot, EdD, to provide research and evaluation support. Towards the end of the pilot year, AGHC put Ford Foundation funds towards a percentage of Dr. Lightfoot's salary to offset her involvement in the pilot study over the implementation year. With proposal development support from AGHC staff, Dr. Lightfoot applied for and received a Developmental Award from UNC's Center for AIDS Research (CFAR) to cover the study costs of program staff (partial salary for Program Manager) and research activities (transcribing costs, etc.). CFAR funding enabled the NC-based *AMP!* pilot program to hire a doctoral-level Research Assistant with strong quantitative skills to help with analysis. *AMP!* NC received considerable in-kind support from university resources as well. The program leveraged the expertise of public health graduate students in the Health Behavior department at the UNC Gillings School of Global Public Health and sponsored a Capstone team whose work focused on materials for adaptation and evaluation of *AMP!* NC. The project also benefited from the excellent qualitative skills of an MPH student in Health Behavior who completed her Practicum with *AMP!.*

Roles of Project Team

As Project Manager, Ms. Taboada, a graduate of the UNC School of Social Work with an MSW, MSPH joint degree, played an essential role in managing all aspects of the project, including reaching out to potential partners, maintaining communication with AGHC, negotiating with the school district, assisting with the communication studies course, serving as preceptor for the Capstone Team and a practicum student, preparing the IRB application, managing logistics in cooperation with the school district for program components, including performances, condom negotiation workshops and HIV+ speaker visits, implementing research components including the consent process, survey and focus group administration, analysis of qualitative data, including college student and stakeholder focus groups, and compilation of study findings. Dr. Lightfoot, Adjunct Assistant Professor in Health Behavior at the UNC Gillings School of Global Public Health, worked closely with Ms. Taboada to oversee the development, implementation and evaluation of the research and evaluation components and co-analyze stakeholder data. Ms. Burtaine, MFA, director of Interactive Theatre Carolina based at UNC's Campus Health Services, conducted the college student course and worked with the Sex Ed Squad to develop and deliver the performance and the condom negotiation workshops. The Capstone

Team, which included Health Behavior MPH graduate students Stephanie Finkbeiner, Amanda Houpt, Susan Kirtz, and Megan Nelson, conducted two literature reviews (excerpted in this report) on HIV prevention in schools and the use of interactive theater as a tool for HIV prevention, a summary of how *AMP!* aligns with NC Essential Standards for the state Reproductive Health and Safety Unit, a short-term evaluation plan for *AMP!*, evaluation tools for the NC *AMP!* pilot study, and a long-term evaluation plan for *AMP!* based on the CDC evaluation framework. Research Assistant/doctoral student Tamara Taggart, MPH conducted quantitative analysis of survey data and co-analyzed qualitative data and Practicum student Trang Tran, MPH Candidate, led the qualitative analysis process of the high school focus group data. Research team members Taboada, Lightfoot, Taggart and Trang were involved in writing up results for this report and will be involved in disseminating findings in both professional and community settings.

University Course Development and Delivery

The course "Performing Sexual Health: UNC Sex Ed Squad" was offered during Spring 2013 in the Department of Communication Studies. The instructor of record, Amy Burtaine, was awarded a competitive Ueltschi course development grant from the Carolina Center for Public Service's APPLES Service-Learning Program. The funds supported the development of the course, supplies, and a small instructor stipend. The syllabus was adapted from Bobby Gordon's syllabus at UCLA to meet the rigorous requirements of an APPLES service-learning course. Amy Burtaine and Arianna Taboada designed the learning objectives, course modules, reading list, and assignments, and the final syllabus was approved by the Department of Communication Studies in August 2012. The full syllabus can be found in the appendices section of this report (Appendix A).

The course began with a 2-week theater intensive where students explored the history, theories and strategies behind activist theater, specifically sexual health education theater as it has been used both locally and globally. Students studied the the work of several socially engaged theatre practitioners and examined how humor, personal narrative and non-judgmental, sex-positive approaches have been utilized to open empowering and educational dialogues about sexual health by and for a diverse range of communities. Through improvisation and guided writing exercises, they developed a script for the performance. The remainder of the course students rehearsed and toured an engaging and challenging piece of activist theater aimed at educating ninth graders in the Chapel Hill-Carrboro City Schools about HIV/AIDS and sexual health. In addition to touring, students had weekly class meetings, readings, papers, and weekly postings that both complemented, and helped them critically reflect on their experience.

School District Outreach

With these elements in place at the university level, *AMP!* NC program staff reached out to the local school district to build a partnership and seek approval to implement and evaluate *AMP!* in North Carolina. Chapel Hill-Carrboro City Schools (CHCCS), where *AMP! NC* was piloted is one of two districts in Orange County. Program Manager Taboada reached out to district administrators who oversee health programs and curricula for the school system to describe the *AMP!* approach and enlist their support for piloting the program in the CHCCS schools. The *AMP!* program was approved by the Health Coordinator of the CHCCS district as an enrichment activity for 9th grade students enrolled in health classes in conjunction with the Reproductive Health and Safety Unit, the curriculum unit that covers sex education, and implemented during Spring 2013.

School Context for AMP! Pilot in NC

The CHCCS district has been promoting comprehensive sexual health education for several decades, making it an ideal location to test the feasibility of an innovative program such as *AMP!* County-level statistics ranked Orange County 49th highest in HIV incidence of 100 NC counties, reporting a 2010 HIV incidence rate of 6.2/100,000 population (NC DHHS, 2011).

Gaps Addressed by AMP!

As described above, rising incidence rate of HIV in NC warrants intensified efforts to promote HIV prevention. The project has larger implications as it also aims to fill two important gaps in the intervention literature: 1) the dearth of studies on US-based theater interventions and 2) the lack of rigorous evaluation of such interventions.

Theater-based interventions have been widely used to promote health in an international context. They have been applied to a range of public health problems, including substance abuse and obesity (Guttman et al, 2008; Stephens-Hernandez et al, 2007; Haines & Neumark-Sztainer, 2008), as well as HIV/AIDS prevention and sexual health promotion (Daykin et al, 2008; Joronen et al, 2008; Glik et al, 2002). Despite the widespread use of theater-based interventions internationally, few formal evaluations have been conducted to explore their effectiveness. Indeed, several systematic reviews of theater-based interventions to prevent HIV/AIDS emphasized the need for more rigorous evaluation efforts (Simons, 2011; Daykin et al., 2008; Joronen et al., 2008; Glik et al., 2002).

A review of the literature on theater-based HIV prevention interventions conducted by the graduate student Capstone team informed our evaluation goals and strategies. Studies reviewed reported significant increases in HIV knowledge, positive attitudes, and reported intent to change behaviors (Denman et al., 1995; Harvey et al., 2000; Kamo et al., 2008; Joronen et al., 2008; Daykin et al., 2008), indicating that drama-based HIV/AIDS prevention interventions have the potential to yield positive changes in participants. Yet the studies' limitations, such as small sample size, make it hard to generalize findings and suggest that more evaluation is needed to increase the evidence supporting theater-based interventions. The goal of our pilot study was to pilot *AMP!* among adolescents in two CHCCS public schools (one intervention/one control) to evaluate its effectiveness, the implementation process, and feasibility for scale up.

Evaluation Design & Questions

The broader goal of our pilot implementation of *AMP!* in NC was to assess the feasibility of the theater-based HIV prevention approach in the context of the southern United States. Furthermore, because the *AMP!* program was implemented simultaneously in three cities — Chapel Hill, Atlanta, and Los Angeles — during the 2012-13 school year, the project offers the rare opportunity to evaluate process and outcome data across the multiple sites study with near-identical interventions in each location. The pilot evaluation study therefore allows us to assess preliminary feasibility in North Carolina, as well as determine the feasibility for scale up through a larger NIH-funded study.

We used a quasi-experimental mixed-method study design to explore the implementation process and assess intervention outcomes and the qualitative experience of: 1) high school

students, 2) undergraduate students, 3) high school health teachers, and 4) key stakeholders. All research staff completed Human Research Ethics training prior to their involvement in the study and the study protocol was approved by the Institutional Review Board (IRB) at the University of North Carolina at Chapel Hill.

Our guiding research questions for the pilot study were:

- What is the efficacy of *AMP!* for program participants?
- What is the experience of university undergraduate students participating in the Sex Ed Squad that delivers *AMP!*?
- What is the feasibility of *AMP!* in North Carolina public high schools?

Our evaluation used a mixed-methods approach to address the research questions. We used quantitative methods (a web-based survey) to assess the efficacy of *AMP!* for 9th grade students in the Chapel Hill-Carrboro City School district. In addition, we used qualitative methods (focus groups and semi-structured interviews) to assess the experience of college students, high school health teachers, and key stakeholders to draw conclusions regarding the feasibility of adapting *AMP!* to meet the needs of North Carolina school districts. The timeline of program and evaluation activities is outlined below and the methodology is described in greater detail in the section that follows.

Program & Evaluation Activities

There are a total of 3 program components and 13 evaluation components. These components are illustrated below, while the evaluation activities are described in detail in the Methodology section of the report on page 10.

Table 1: Calendar of Program and Evaluation Activities, January – June 2013

Program Activities	**Jan**	**Feb**	**March**	**April**	**May**	**June**
1. Sex Ed Squad Performances			X	X		
2. Condom workshops				X		
3. HIV Positive Speakers					X	
Evaluation Activities						
1. High school survey (pre)		X	X	X		
2. High school focus group #1			X			
3. High school focus group #2					X	
4. High school focus group #3					X	
5. High school focus group #4					X	
6. High school survey (post)			X		X	
7. Undergraduate survey #1	X					
8. Undergraduate focus group #1	X					
9. Undergraduate survey #2			X			
10. Undergraduate focus group #2		X				
11. Undergraduate survey #3				X		
12. Undergraduate focus group #3				X		
13. Key informant interviews					X	X

Description of Program Components

1. UNC Sex-Ed Squad Performance: Undergraduate students from the UNC course use humor, the performing arts, and honest, personal stories in an engaging 30-minute performance, followed by a 20-minute discussion to educate high school students about sexual health and HIV. Topics covered include: safe sex, stigma, HIV transmission, virginity, and testing.

2. Condom Negotiation and Demonstration Workshop: Undergraduate students lead high school students in a workshop to teach about how to properly use a condom, and how to discuss using condoms with a potential partner or parent. The workshop begins with warm up activities, and then presents three short scenarios where the characters must learn to communicate effectively. Interactive theater techniques bring high school students on stage to explore solutions to the situation at hand.

3. HIV+ Speakers: HIV+ individuals share their personal stories of what it's like to live with HIV, in an effort to reduce stigma against people living with the virus. Speakers share their story of diagnoses, behaviors that put them at risk, disclosure, and medication.

Methodology

The study design called for the use of methods that are aligned with positivist and constructivist paradigms. Positivism seeks to measure and quantify behavior in order to present empirically verifiable data and draw conclusions about causal relationships. It is a paradigm that scientists rely on to figure out whether interventions work or not and what impact they have. The high school survey and focus group methods used this paradigm to gauge program efficacy and impact. The constructivist theory considers multiple truths and is helpful in understanding experiences and processes. This approach helped guide the exploratory approach to the university surveys, focus groups, and the in depth interview guides. Both paradigms were important in helping us select methods aimed at understanding both outcome and process data (LeCompte & Schensul, 1999).

Table 2: Overview of Methods Used: *AMP!* NC, January – June 2013

Method	Description of Method	Description of Sample
Quantitative Surveys	A quantitative survey to measure students' knowledge of HIV, sexual behaviors, usage of alcohol and other drugs, and attitudes towards people living with HIV	317 high school students at control and intervention schools
Open Ended Surveys	An open ended survey that explores domains of sexual health knowledge, attitudes and behavior, as well as reflections on the Sex Ed Squad	10 undergraduate students enrolled in the Sex Ed Squad course
Focus Groups	7 small group discussions (4 with high school, 3 with college) facilitated by a project team member understand program participants experiences	6 high school students at intervention school 10 undergraduate students enrolled in the Sex Ed Squad course
Semi Structured In-depth Interviews	6 interviews with key informants who could comment on the effectiveness and feasibility of the program	3 high school health teachers at intervention school 2 district level health coordinators at intervention site 1 university course instructor for the Sex Ed Squad course
Field Notes	6 months of field notes collected during program implementation and data collection	All components of program and during focus group discussions
Post-performance feedback	Anonymous written feedback collected from high school students after each Sex Ed Squad performance about a question they had or something they had learned	All 9th grade health students attending the Sex Ed Squad performances (approximately 250 students)

Quantitative Surveys: High School Participants

RECRUITMENT AND SAMPLING

Two schools with comparable demographics were identified by the CHCCS Health Coordinator to participate in the study. The Health Coordinator selected one school to receive the intervention and the other school to be the control. In total, 317 students were enrolled in the study, 169 in the control condition and 148 in the intervention condition.

The recruitment procedures were identical at both sites. A member of the project team went to all 9th grade health classes at both intervention and control schools to explain the *AMP!* program and the research project, answer any questions, and distribute a packet that included: 1) a description of the program components (interactive performance, condom negotiation workshop, HIV+ speakers) and opt-out permission form for participation in program activities and 2) an information sheet about the study with parental consent forms approved by the UNC IRB for student participation in the pre and post surveys and focus groups. Only youth whose parents granted them permission to take part in the two surveys and focus groups and who provided their own assent were eligible for the study. All students, except those whose parents had selected to opt out, were able to participate in the *AMP!* program activities. There were very few parents who selected to opt out of participation in program activities. The majority of parents also elected to grant permission for their children to participate in the study components.

PROCEDURES

The Principal Investigator and *AMP!* Project Manager worked with the district Health Coordinator in addition to each school's administration and health education teachers to establish and coordinate study procedures in accordance to the protocol approved by the IRB. The protocol was labor and time-intensive. The web-based survey was administered pre- and post-intervention by study personnel via school-provided computers. This necessitated project team members to attend every Health class at both intervention and control schools to administer the survey. All students in each class were assigned computers. Students with parent permission were given one link on a small slip of paper. Students without parent permission were given a different link. The students with parental permission were asked to complete an assent form and then to access the survey via the link provided. Ineligible students completed an alternative online activity assigned by the teacher. The pre-intervention survey was administered at the intervention school throughout February 2013 and at the end of the semester (four month follow up) in May 2013. The control school is on a quarter schedule (February-March and April-May) and the survey was administered to all 9th grade health students at the beginning of each quarter, February and April, and at the end of the quarter in March and May. No names were collected on the surveys to ensure anonymity. Instead, each participant created a unique identifier using the first letter of each student's street name, the first two digits of the street number and the two digit number that describes his/her birth order. [Note: selecting the components of the identifier necessitated considerable back and forth with the IRB which was concerned with participant privacy and confidentiality, especially given the age of study participants and content area of the surveys]. The survey administration schedule was designed to collect data immediately prior to and directly after students received the Reproductive Health and Safety Unit taught by their health teachers at the control school and students received the *AMP!* components enriching the Unit at the intervention school. Pre and post surveys were matched using the unique identifier.

MEASUREMENT

The survey instrument was comprised of several question types and responses including multiple choice, dichotomous, and 4-point Likert scale. At baseline and follow-up the survey queried students about their level and quality of knowledge on HIV and AIDS facts and transmission; attitudes toward engaging in high-risk behaviors associated with HIV and AIDS transmission; attitudes toward seeking testing and counseling for HIV and AIDS; attitudes toward people living with HIV and AIDS; and substance use/abuse and HIV risk.

Individual behaviors related to sexuality, sexual practice, sexual and reproductive health, and risk behaviors associated with contracting HIV such as substance use/abuse were also assessed.

The measures included items from the Center for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey (YRBS) from the Youth Risk Behavior Surveillance System (YRBSS) (CDC, 2004) the WHO/UNESCO knowledge, attitudes and practices survey instrument for adolescents (WHO, 1989) and the Towards a Healthy Tomorrow survey (Stanton, 1998). All of these measures are reliable and valid for adolescents, and were approved by the district Health Coordinator for classroom administration. The YRBS assesses individual risk behaviors including substance use and sexual practices and behaviors. Additional questions for the *AMP!* survey were drawn from the WHO/UNESCO instrument, a tool especially useful for evaluating sexual experiences and risk behaviors among youth, and the Towards a Healthy Tomorrow instrument, a US survey that has been useful in evaluating HIV knowledge, testing, risk and protective behaviors including sexual initiation and condom use. The items from the WHO/UNESCO assess attitudes about not engaging in high-risk behaviors associated with HIV transmission (e.g., substance use while engaging in sex, not using condoms, etc.). Items from the Towards a Health Tomorrow instrument assess HIV knowledge, HIV testing and stigma towards people living with HIV. Student demographic questions captured race/ethnicity, gender, and sexual orientation.

DATA ANALYSIS

Statistical analyses were performed only on pre-specified hypotheses using an intent-to treat protocol with participants analyzed in their assigned study conditions irrespective of the number of *AMP!* program components attended. Data were not treated as multilevel (level 2 school, level 1 students) because: 1) *a priori,* participating schools were selected because of their similarities in socio-demographics, sexual education curriculum, school policies, and geographic location; 2) characteristics of students in the sample were similar in socio-demographic, sexual behavior, HIV specific knowledge and attitudes, HIV testing behaviors, and drug and alcohol use variables across both conditions; and 3) fixed effects were not statistically significant, indicating limited effects from our nested data.

SAS 9.3 was used for data management and analyses. Proc univariate was used to assess assumptions of normality and variances for regression models. At baseline (pre-test) descriptive statistics were calculated to summarize socio-demographic variables, sexual experience, and drug and alcohol use. Differences between study conditions at baseline were assessed using independent t-tests for continuous variables and chi-square analyses for dichotomous variables. We used p-values less than .10 as the criterion to identify potential covariates. None of the variables tested resulted in statistically significant (p-value of .10 or less) differences between the two study conditions. As such, no additional variables were included in our models to assess intervention efficacy as covariates. Additionally, contrast codes were entered into the models as fixed effects to determine if there were classroom level differences at baseline, which could potentially bias analyses. Our contrasts were not statistically significant and were not included in our models.

To examine intervention effects, logistic regressions were conducted to compute odds ratios for dichotomous outcomes; chi-square tests were used to assess differences between control

and intervention conditions in the trend in ordinal response and small count data; analysis of variance (ANOVA) was used for continuous outcomes.

RATIONALE AND LIMITATIONS

Surveys systematically collect information on a topic by asking individuals questions to generate statistics about a group to which the individuals represent. Health surveys ask questions about a variety of factors that influence, measure, or are affected by an individual's health and health behaviors. Surveys are often used in intervention research to help evaluators determine the effectiveness of an intervention and to make inferences regarding the utility of intervention components in practice.

Web-based surveys are particularly useful in quantitative data collection because they eliminate some of the response errors that occur with paper and pencil surveys, such as missed questions. Web-based surveys have also been shown to decrease the amount of respondent and interviewer bias that occurs when using telephone or face-to-face survey techniques. Although costly, web-based surveys are less taxing on the respondent and tend to have higher response rates than direct mail or telephone surveys. Additionally, they decrease some of the error associated with manual data entry, such as inconsistent scoring.

Despite the aforementioned strengths of using a web-based survey to assess intervention effectiveness, the survey instrument administered for this study has several limitations that affected data analyses. First, there are several questions that are either too ambiguous or are written with judgment or bias (see table 1). These questions may result in respondents not understanding the question or response choices. Second, not pre-assigning unique identifiers, or identification numbers, to students made it particularly challenging to determine statistical significance in observed differences in pre and post test scores across the two conditions. This challenge arose because we were unable to track changes in desired outcomes (e.g. HIV knowledge, behavior, and attitudes) pre- and post-intervention for each student. Third, question order has been shown to affect the way people respond to survey questions; this is of particular concern with surveys that ask about sensitive topics such as sexual behavior. Lastly, the survey assesses some concepts that have not been completely addressed by the intervention, which then raises concerns about social desirability in participant responses (see table 1).

Recommendations to improve overall survey quality can be found on page 47.

Table 3: Examples of problematic survey questions

Survey question	Concern
I am likely to take an HIV test by the end of the year	Ambiguity; end of year could refer to either the end of the calendar year or the end of the school year.
I know at least one place in my community where I can find condoms	Access to community condom resources is not addressed by the intervention.
The last time you had sexual intercourse, what method(s) did you or your partner use to prevent pregnancy	Bias; if engaging in oral or anal intercourse with a partner, pregnancy prevention may not be a concern.

Open Ended Surveys: Undergraduate Participants

RECRUITMENT & SAMPLING

All undergraduate students (N=10) enrolled in Communication Studies 390.002 Performing Sexual Health: UNC Sex-Ed Squad course were asked to complete an anonymous open-ended response survey pertaining to their knowledge, attitudes, beliefs, and behaviors about sexual health at three time points during the semester.

PROCEDURE

Prior to the data collection, participants provided written informed consent. Students were reminded that all data would be de-identified and would not have any impact on their course grade. The surveys were made available on the course webpage and completed outside of the regularly scheduled class time. Participants completed a paper-based survey prior to the first day of class, a web based survey after the intensive but prior to their performance tour, and the final web-based survey after the completion of the course.

MEASUREMENT

Surveys were designed by a UCLA researcher specializing in social networks and adolescent health and administered and analyzed by NC-based project team members. All questions were open-ended, and sample questions included, "Do you know your HIV status currently?", "Do your friends ask you questions about sex, or sexual health?", and "How good are you at thinking clearly when you're turned on? Comment on your response." The follow up surveys were modified to assess for any changes since the previous time point. For example "Since you became a member of the UNC Sex-Ed Squad have you been tested for HIV? STIs? Why or why not?" and "Since becoming a member of the UNC Sex-Ed Squad have your friends asked you questions about sex or sexual health?" Demographic data were collected separately.

DATA ANALYSIS

Due to the unique nature of the survey design, we used a mixed method analysis approach. The quantifiable data was entered into Excel and analyzed by hand to generate basic descriptive statistics. No statistical tests were performed given the small sample size. Qualitative responses were imported into Atlas.ti and analyzed in conjunction with focus group data, see page 19 for a detailed description of the thematic analysis technique used.

RATIONALE & LIMITATIONS

An open-ended survey was used in order to take an exploratory approach to understanding undergraduate students' knowledge, attitudes, beliefs, and behaviors related to sexual health and HIV. The information was collected anonymously to protect students' privacy, ensure that personal data was unidentifiable, and facilitate information-sharing without the social pressure inherent in a focus group discussion. In addition, particular care was taken to preserve confidentiality with responses by removing names and other identifiers from the data and findings. To enhance rigor in qualitative analysis, principles of verification were used to test provisional conclusions for their authenticity and trustworthiness with a focus on credibility, dependability, and confirmability (Lincoln & Guba, 1985). The small sample size is a limitation with regard to quantifiable data, and as such, we are unable to conclude if findings are significant. Also, modification of the

instrument from baseline to follow-up and final survey limited the ability to measure individual change over time.

Focus Groups: High School Participants

RECRUITMENT & SAMPLING

High school students at the intervention school were invited to participate in a series of four focus groups (guides included in Appendix D), one after each *AMP!* component was delivered, and a final focus group after the entire program. A member of the project team distributed consent forms and described the purpose of the focus groups after each component (per the protocol required by the IRB) to the students in each of the participating classes. Students were instructed to bring the consent form home to be signed by a parent or guardian if they agreed to their child's participation in the focus group. Students were reminded that their participation or non-participation in the focus group would not affect their grade. The parental consent form clearly described the structure and aims of the focus group and explained that participation was voluntary. The sample of students for the focus groups was therefore self-selected and voluntary. The convenience sample was diverse in terms of race/ethnicity and gender, although not necessarily representative of school demographics.

PROCEDURE

Prior to data collection, participants provided written informed consent from their parents. Participants also signed informed assent forms on the day of the focus group discussion. Semi-structured focus groups of 2-4 participants were conducted at four time points throughout March-May 2013. Focus groups were conducted during the school lunch period in a private conference room on-site. Focus group participants were provided pizza and drinks for their participation in the session. The audio recordings were transcribed verbatim for further analysis.

Focus Group 1: The first focus group was conducted in March after the ninth grade students had watched the UNC Sex-Ed Squad's performance. Two students (White female, Black male) participated, and the focus group was facilitated by a graduate student member of the Capstone Team while another member of the project team served as the note-taker. The discussion lasted approximately 40 minutes.

Focus Group 2: After the ninth grade students participated in the Condom Negotiation and Demonstration Workshop, they were invited to the second focus group, which was conducted in May. Two students (Black males, one repeat participant from first focus group) participated, and the focus group was facilitated by a project team member. The discussion lasted approximately 20 minutes.

Focus Group 3: The third focus group was conducted in May after the ninth grade students had HIV+ speakers visit their classroom to share stories. Four students (White female, 2 Black females, and Black male repeat participant from second focus group) participated, and the focus group was facilitated by a project team member while a graduate student served as note-taker. The discussion lasted approximately 30 minutes.

Focus Group 4: To get overall feedback on the entire *AMP!* program, a fourth focus group was conducted in May after all program components had been implemented. Two students (Black males, both repeat participants) participated, and the focus group was facilitated by a project team member while a graduate student served as note-taker. The discussion lasted approximately 20 minutes.

MEASUREMENT

High school focus group guides were developed by the UNC graduate student Capstone team based on past focus group guides from the UCLA *AMP!* program. The focus group guides were reviewed and received input and approval from research staff from all implementation sites (LA, NC and GA) before usage. The guides contained questions about strengths and weaknesses of *AMP!* components, relatability, knowledge and skills gained, and communication. Sample questions from the discussion guide for the first focus group included, "What are the main take-away messages that you remember from the Sex-Ed Squad performance?" and "Could you relate to any of the actors or situations in the performance?" The second focus group guide was similar, but it asked more questions about what the students had learned from the workshop, such as "What do you think is the best way to learn about how to use a condom?" The third focus group guide asked students about their attitudes toward HIV+ individuals after having HIV+ speakers visit their classroom. Sample questions included "Before you participated in the HIV+ speaker activity, what are some words you might have associated with someone who is HIV+?" and "Did you talk to anyone about the HIV+ speakers?" The fourth focus group guide contained questions for overall feedback about *AMP!*, such as "Is there anything you would change about these presentations in the future?"

DATA ANALYSIS

Data were analyzed by members of the project team. The primary coder gathered initial impressions through reading the transcripts several times and created a preliminary matrix of concepts that arose from the data. With regular input from the evaluation team, the primary coder developed a codebook with a priori codes derived from the *AMP!* logic model and inductive codes based on emergent concepts in the matrix. The primary coder and the second coder independently coded one focus group and convened to discuss coding variations, code meanings and potential gaps in the codebook. The codebook was refined according to the feedback. The two coders independently coded the remaining transcripts and reconvened to resolve any coding disagreements. Focus group discussion data were analyzed in Atlas.ti v6.2. Thematic analysis, a flexible method of identifying and analyzing patterns in qualitative data, guided the analysis process and the write-up of findings. Memos, code reports and query tools were used to identify salient themes in relation to the evaluation questions.

RATIONALE & LIMITATIONS

Focus group discussion is an efficient way to generate a range of ideas and feelings participants have, and we believe this qualitative approach was valuable in helping us to understand the high school students' experiences with *AMP!*. Yet there were limitations and drawbacks as well. A general drawback of focus groups is that the information may not be generalizable to other groups. Second, although focus group discussions provide deeper insights into participants' experiences, focus group members may not participate equally (Kitzinger, 1995). In relation to our project, since it was a self-selected sample, there may be a self-selection bias because students who participated may have stronger feelings or

interest in *AMP!* than their peers. Most important to our project, we had a low turn-out for the focus groups with a total of 6 participants over the 4 sessions with several who returned to multiple discussions. We believe this was a result of the study protocol required by the IRB which asked that we send home consent forms for each focus group, rather than for participation in the study components (survey and focus groups) as a whole. Teachers had advised us to limit parent burden by consolidating all consent into one form, yet because of the sensitive nature of the study, the IRB required us to gather informed consent for each component. At several of the focus group sessions, in fact, the project team had to send home high school students who wanted to participate because they had not returned their parental consent forms. Despite these limitations, the focus group discussions provided rich data to complement the survey data collected.

Focus Groups: Undergraduate Participants

RECRUITMENT & SAMPLING

All undergraduate students (N=10) enrolled in the Communication Studies 390.002 Performing Sexual Health: UNC Sex-Ed Squad course were invited to participate in focus groups to discuss their involvement in the implementation of *AMP!* North Carolina. There were 3 focus groups conducted throughout the semester to understand the processes of change that students who participated in the course (also known as the Sex-Ed Squad) underwent from the beginning of the performance development process through delivering the performances in the high school.

PROCEDURE

Prior to the data collection, participants provided written informed consent. All focus groups were conducted at UNC outside of students' regularly scheduled class time. The first and third focus groups were conducted in person, while the second was conducted as on online chat on the course webpage. Focus groups were digitally audio-recorded and transcribed verbatim for qualitative analysis. For the second on line chat, information was collected anonymously to protect students' privacy, ensure that personal data was unidentifiable, and facilitate information-sharing without the social pressure inherent in a focus group discussion. In addition, particular care was taken to preserve confidentiality with responses by removing names and other identifiers from the data and findings.

Focus group 1: Undergraduate members of the Sex-Ed Squad participated in the first focus group in January at the start of the semester. The focus group was conducted after the first day of class and immediately prior to participating in the two week intensive where they generated the material for the performance. Ten participants were split into two groups of five, and two facilitators (one graduate student, and one project team member) led the discussion using identical focus group guides developed by the UCLA researcher who developed the surveys. The focus group discussion lasted for approximately an hour and a half.

Focus group 2: The second focus group was conducted at the end of February after the Sex-Ed Squad had the opportunity to preview the show for a campus audience but before they performed for high school students. The focus group discussion was facilitated as an online chat, and all ten participants responded to the posted questions and each other's posts.

Focus group 3: The third and final focus group was conducted at the end of April, after the course was complete. Participation was low due to the focus group being during finals week. Two students participated, and a project team member facilitated using a focus group guide developed by the UCLA researcher who developed the surveys. The focus group discussion lasted for approximately and hour.

MEASUREMENT

Focus group guides were designed to raise questions about what brought students to the course, what they hoped to gain from the program, and what they thought about sexual health and sexual health programming. Sample questions from the discussion guide for the first focus group included, "What are the content areas that you feel most comfortable talking about with your peers and with high school students?" and "How would you describe your knowledge about sexual health issues?" The discussion guide for the second focus group was similar, but included questions that asked students about their experiences during the course of the first half of the semester. Sample questions included "What changes have you noticed in yourself as a result of being a member of the UNC Sex-Ed Squad?" and "What do you hope to gain by bringing the performance and workshops into high schools later this semester?" The discussion guide for the third focus group asked students to reflect on the process of touring and the perceived impact for themselves and the high school students. Sample questions included "What has been the most challenging part of being a member of the UNC Sex-Ed Squad this semester?" and "What impact do you feel you have had on the students for which you performed?"

DATA ANALYSIS

Data was analyzed by members of the project team. Systematic analysis was conducted using a codebook that was developed at the Emory site by a team of graduate students, and then adapted and applied to the UNC data. A priori codes were drawn from the *AMP!* logic model and survey questions, with inductive codes emerging at each site based upon local analysis teams reading through the data. The transcripts were read several times by two members of the research team to gather initial impressions. After collaboratively identifying major themes that responded to the evaluation questions, as well as emerging themes, the codebook was revised. Transcripts were then imported into Atlas.ti v6.2, codes applied, code reports read, and memos written. Code reports and query tools were used to identify salient themes and discuss how the codes related back to evaluation questions. The primary coder worked to refine the codebook and code all surveys and focus group transcripts, with regular input and communication with a second coder. The second coder then independently coded the documents and the two coders came together to resolve code meanings and identify commonalities and contradictions in their work.

RATIONALE & LIMITATIONS

Focus group discussions provide deeper insight into the experience of the program at the undergraduate level, which is especially important given that the program is relatively new and has never been evaluated at the undergraduate level. Our goal was to add an assessment component to the college experience to identify major themes related to college-level learning that can lead to specific recommendations for domains to be included in a quantitative survey to evaluate undergraduate changes in attitudes belief and behaviors in future program implementation.

Though there are several benefits to using qualitative methodology, we realize the results of the evaluation in NC may not be generalizable to other groups involved in the larger program in Los Angeles and Atlanta.

In Depth Interviews: Key Stakeholders

RECRUITMENT & SAMPLING

Semi-structured in-depth interviews were conducted with six key informants, including high school health teachers (N=3), school district health coordinators (N=2), and the undergraduate course instructor (N=1) with the aim of capturing the participants' perspectives on what aspects of *AMP!* worked well, what aspects did not work well, and how the intervention could be modified or improved.

PROCEDURE

Prior to the data collection, the key informants completed consent forms, and teachers were also asked to fill out a short, optional questionnaire providing demographic and work history information. The interview guide, which was developed collaboratively with other intervention sites, included questions on professional background, as well as several sections designed to assess the pilot intervention and feasibility for scale up. The interviews were digitally audio-recorded and transcribed verbatim for analysis. The interviews ranged from 30-60 minutes and were conducted by two members of the project team trained in qualitative research methods. Identifying information was stripped from the transcripts before qualitative analysis.

MEASUREMENT

The interview guides were designed with slight variations for each type of key informant. The guide designed for the course instructor at Emory was adapted for UNC. All guides included sections addressing professional background, responses and reactions to the program, challenges or barriers related to program implementation, and program sustainability. Sample questions included "What were the key messages that you think students will take away?" and "In what ways could the *AMP!* program enhances its approach to better support the curriculum?" In NC we also added questions to understand the particular context of comprehensive sex education in the south and to discern how this program might be received in other districts. See Appendix F for the full instrument.

DATA ANALYSIS

As with the focus groups, the in-depth interviews were transcribed verbatim and were read several times by two members of the project team to gather initial impressions. A priori codes were pulled from the guides, and emerging themes noted during the initial reading. A codebook was drafted and codes applied using Atlas.ti v6.2. Code reports and query tools were used to identify salient themes and discuss how these related back to evaluation questions, specifically program feasibility.

RATIONALE & LIMITATIONS

The in-depth interviews provided rich, descriptive data by posing open-ended questions that addressed process and program feasibility. The interviewers were able to probe for depth of response, obtaining information about topics that were not directly observable during program implementation. The qualitative data also allowed for the exploration of local context and culture in attempts to evaluate the nuances of North Carolina school

settings. The small sample size and range of key informant roles prevent the information gathered from being generalizable.

Field Notes and Triangulation

Field notes were recorded by hand by the Program Manager and then transcribed following each component of the intervention (performances, workshops, and speakers) as well as during high school focus group discussions. The notes served as an additional data source to confirm and identify contradictions in primary data as analysis was conducted. Multiple sources were used to corroborate findings based on the qualitative research premise that collecting data using different methods and comparing themes found across data sources helps maximize consistency and increase credibility, dependability, and trustworthiness (Lincoln & Guba, 1985). This process is known as triangulation and was applied at each level of analysis.

Findings

Data were systematically collected and analyzed. Table 4 illustrates the timeline for data collection, which took place Jan-June 2013 and analysis, which began in May as the intervention was completed and concluded in July 2013.

Table 4: Calendar of Data Collection and Analysis Activities

Data Collection & Analysis	Jan.	Feb.	Mar.	April	May	June	July	Aug.
1. High school survey (pre)		X	X	X				
2. High school focus group #1			X					
3. High school focus group #2					X			
4. High school focus group #3					X			
5. High school focus group #4					X			
6. High school survey (post)			X		X			
7. Undergraduate survey #1	X							
8. Undergraduate focus group #1	X							
9. Undergraduate survey #2			X					
10. Undergraduate focus group #2		X						
11. Undergraduate survey #3				X				
12. Undergraduate focus group #3				X				
13. Key informant interviews					X	X		
14. Statistical analysis						X		
15. Qualitative analysis					X	X	X	
16. Writing up of results					X	X	X	X

The high school surveys were analyzed separately from the high school focus groups, while the undergraduate surveys and focus groups were analyzed together. The results are therefore reported on in three different sections. The key informant interviews were broken out into teacher interviews and other stakeholders, and analyzed separately, specifically looking at issues of feasibility and process. The feasibility section reports on findings from these interviews, as well as the high school focus groups, undergraduate surveys, undergraduate focus groups, and field notes.

High School Participants Survey Results

Baseline

Of the 317 ninth grade students enrolled in the study, 169 were assigned to the control condition and 148 to the intervention condition. Most participants reported having been taught about HIV and AIDS in school (86%) and were not sexually active (82%). At baseline, no differences were observed in socio-demographic characteristics, sexual behaviors, HIV knowledge, or drug and alcohol use (Table 5).

Questions regarding sexual behaviors were asked of students who responded yes to having ever had sexual intercourse. For the purposes of this study, sexual intercourse was defined as having oral, anal, or vaginal sex. Approximately 11% of the participants in the control condition and 15% in the intervention condition had engaged in sexual intercourse at baseline (Table 5).

Table 5: Baseline Comparison between the Control and Intervention Condition

	Control Condition N (%) (n=169)	Intervention Condition N (%) (n=148)	X^2 test (*P*-value)
Race/Ethnicity			.695 (.4044)
-Asian	50 (29.94%)	16 (11.51%)	
-Black or African American	14 (8.38%)	17 (12.23%)	
-White or Caucasian	105 (62.87%)	98 (70.50%)	
-Hispanic or Latino/a	15 (9.04%)	10 (7.25%)	
Gender			.466 (. 7920)
-Male	68 (41.21%)	62 (44.60%)	
-Female	93 (56.36%)	73 (52.52%)	
Socioeconomic Status			.319 (.8527)
Qualify for free or reduced lunch	23 (14.02%)	22 (15.71%)	
Sexual Orientation			6.750 (.2399)
-Straight/heterosexual	149 (90.30%)	127 (90.71%)	
-Gay/homosexual	0 (0.00%)	2 (1.43%)	
-Bisexual	6 (3.64%)	1 (.71%)	
-Lesbian	1 (.61%)	1 (.71%)	
-Other	1 (.61%)	5 (3.57%)	
Sexual Behaviors			3.461 (.1772)
Ever had sexual intercourse	18 (10.65%)	21 (14.89%)	

A comparison of the sexual risk behaviors of the *AMP!* NC sample to those reported nationally in the Youth Risk Behavior Surveillance System (YRBSS) indicates that participants in the *AMP!* NC pilot engage in fewer sexual risk behaviors. *AMP!* NC participants' sexual debut occurs at a later age and they have fewer lifetime sexual partners relative to the national average reported in the 2011 YRBSS. The total percentage of *AMP!* NC participants who reported not using a condom at last intercourse is 41.32%, which is slightly higher than the national rate (39.8%) for ninth graders. However, condom use in the sample population was still better than the NC YRBSS sample, where 46.3% of surveyed youth reported not using a condom during last sexual intercourse (CDC, 2011).

Table 6: Baseline Comparison of Sexual Behaviors between Control and Intervention Condition

	Control (n=18) N (%)	Intervention (n=21) N (%)	X^2 test (*P*-value)
Age at Sexual Debut:			7.274 (.7920)
-11 years old or younger	3 (16.67%)	0 (0.00%)	
-12 years old	1 (5.56%)	1 (4.46%)	
-13 years old	2 (11.11%)	2 (9.52%)	
-14 years old	6 (33.33%)	11 (52.38%)	
-15 years old	5 (27.78%)	6 (28.57%)	
-16 years old	0 (0.00%)	1 (4.76%)	

-17 years old or older	1 (5.56%)	0 (0.00%)	
Number of Sexual Partners:			7.236 (.1239)
-1 person	6 (33.33%)	15 (71.43%)	
-2 people	6 (33.33%)	2 (9.52%)	
-3 people	2 (11.11%)	2 (9.52%)	
-4 or more people	4 (22.22%)	2 (9.52%)	
Condom Use at last intercourse:			1.871 (.5996)
-Yes	10 (55.56%)	12 (57.14%)	
-No	8 (44.44%)	8 (38.20%)	
Pregnancy Prevention at last intercourse:			3.185 (.2034)
-No method was used to prevent pregnancy	5 (27.78%)	4 (19.05%)	
-Condoms	9 (50.00%)	11 (52.38%)	
-Birth control pills	4 (22.22%)	5 (23.81%)	
-An IUD	2 (11.11%)	0 (0.00%)	
-A shot, patch, or ring	1 (5.56%)	0 (0.00%)	
-Withdrawal	3 (16.67%)	4 (19.05%)	
-Some other method	1 (5.56%)	2 (9.52%)	
-Not sure	1 (5.56%)	3 (24.29%)	
Alcohol or drug use at last intercourse	9 (50.00%)	1 (4.76%)	1.381 (.1790)

Attrition

Among the 317 participants completing baseline assessments, 300 (94.6%) were available to complete the post-intervention assessment. Attrition analyses indicated no difference between those students completing the post-intervention assessment and those unavailable for post-intervention assessment.

Intervention Effects

HIV/AIDS Knowledge

At follow-up, participants in the intervention reported higher HIV/AIDS knowledge scores relative to the control condition (Table 7). The intervention condition had a higher difference in their HIV/AIDS knowledge score relative to the control condition; 1.89 to 1.31 respectively.

Table 7: Effects of the intervention on mean HIV/AIDS knowledge score

Control		Intervention	
Pre (N=169)	Post (N=167)	Pre (N=148)	Post (N=133)
Mean (95% CI)	Mean (95% CI)	Mean (95% CI)	Mean (95% CI)
7.33 (7.05, 7.60)	8.64 (8.40, 8.89)	7.08 (6.82, 7.35)	8.97 (8.75, 9.19)

Post performance what did you learn?

"The only way you can get HIV is through semen, vaginal fluids, blood, pre-cum, and breast milk."

We used a subset of surveys with matching pre- and post-test identification numbers in order to determine if the observed differences in mean HIV/AIDS knowledge scores between the control and intervention conditions were statistically significant. This subset was used as a result of students not using the same identification number for pre and post-tests (discussed in the methodology section of the report on page XX). Our findings from this analysis indicates that the mean difference in HIV/AIDS knowledge scores is highly statistically significant t-test= 60.14 (*P*=.001).

HIV/AIDS Attitudes and Awareness

The Mantel-Hansel chi-square test was used to determine if there was a significant difference between the control and intervention conditions in the trend of ordinal responses (Table 8). There is a trend toward agreeing more with the statements "I am familiar with how I can affect international HIV/AIDS policy issues as a student" and "I am familiar with HIV/AIDS treatment available to people within the United States" on the post-intervention assessment among those in the intervention group, relative to the control group.

Table 8: Frequencies for statistically significant trends in post-test ordinal response to HIV/AIDS Attitudes and Awareness

I am familiar with how I can affect international HIV/AIDS policy issues as a student *P*=.0416				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
Control	19	61	61	25
Intervention	8	41	69	14

I am familiar with the HIV/AIDS treatment available to people within the United States *P*=.0263				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
Control	18	75	59	16
Intervention	10	67	56	11

Post performance what did you learn?

"Consent is sexy."

Condom Use and Communication

The Fisher's exact test was used to accommodate for small cell sizes in order to determine if there was a significant difference between the control and intervention conditions in the trend of ordinal responses to questions assessing future intention to use a condom and partner communication (Table 9) among sexually active participants. There is a trend toward agreeing more with the statements "I am likely to use a condoms or latex barriers with my partner when I have sex" and "I feel confident discussing safer sex with my partner" on the post-intervention assessment among those in the intervention group, relative to the control group.

Post performance what did you learn?

"Any age to buy a condom."

Table 9: Frequencies for statistically significant trends in post-test ordinal response to Condom use and communication

I am likely to use a condoms or latex barriers with my partner when I have sex *P*=.0037				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
Control	1	2	6	9
Intervention	0	2	10	18

I feel confident discussing safer sex with my partner *P*=.0032				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
Control	2	0	9	7
Intervention	0	0	15	15

Post performance what did you learn?

"I learned to be ok with talking about sex and safety."

High School Participants Focus Group Results

In answering the overall research question of how *AMP!* may have impacted the high school participants, four overarching themes were identified: duality of knowledge and misperception, change of perception toward people living with HIV/AIDS (PLWHA), integration of HIV/STD awareness, and relevancy of comprehensive sex education. The main themes are presented with narrative quotes.

The "Boogie Man": Intersection of knowledge and misperception

Although participants reported knowing the facts about HIV/STDs or discussing HIV/STDs in their health classes, the predominant sentiment among the participants was that misperceptions about HIV/STDs are still perpetuated in society. Furthermore, despite existing knowledge of HIV/AIDS, the knowledge does not always translate to an understanding of how HIV/AIDS fit into their immediate world.

> "Well, a lot of people say "oh don't do this, don't do that, you'll contract AIDS" or whatever it is that they believe that will happen. And they'll threaten you with it. So it becomes kind of a "don't let the boogie man get you" type of thing."
>
> Participant, Focus Group 1

The same student described HIV/AIDS as being a "mystery disease" and a "ghost thing" that people cannot understand. Having the facts was not enough to relate the topic back to their own lives. When asked whether talking about HIV is relevant to their school, participants of the first focus group thought it was important to discuss HIV but neither felt as if anyone in their school had STDs. The contradiction was recognized:

> "I feel like we are both proving a point that I've made earlier and not in a specifically good way. It was a negative point that not to make assumptions. So putting HIV into a certain group or it can't be this certain group. . . It's not set for a type of lifestyle; it's not set for a certain group of people."
>
> Participant, Focus Group 1

Underlying their beliefs about HIV/STDS is the contention between what they perceive as facts and what they perceive to be socially constructed assumptions and myths. A few students raised the issue of not being able to touch HIV+ individuals as a stigmatizing reaction to people who are living with HIV/AIDS, along with the belief that certain types of behavior are attached to getting HIV/AIDS.

> "And then most of the time, because of our culture, we think HIV, we think they did something nasty to get HIV."
>
> Participant, Focus Group 3

In addition to recognizing social myths about HIV/AIDS, students were able to reflect on their personal beliefs when asked what words they associated with HIV+ individuals prior to the HIV+ speaker sessions:

> "'Death,' probably. There's a really negative connotation that comes with HIV. And you just assume that person is gonna die."
>
> "And also sometimes when you think of people, sometimes when you think of people having HIV, you think that it also means AIDS."
>
> "I agree with both of them. When I'm thinking of someone having AIDS or HIV, I eventually thought it would turn into AIDS which they, of course, would die then after that, so that was my thought on it."

Participants, Focus Group 3

The consequences of HIV are believed to be serious and fatal. As a participant in the second focus group noted, "everybody else thinks about STDs and stuff because they don't want to have STDs that aren't curable." Although there is the belief that talking about HIV/AIDS is important among the participants, the conversation about HIV/AIDS is ambiguous. Participants admitted that they did not know anyone with HIV/AIDS but that it is "out there." Two participants commented specifically on the absence of HIV/AIDS in communicating with peers:

> "Well no, I've never met anybody with HIV. These were the first people so that's why I was a little bit shocked when they came in here and told us about their stories. . . We don't really talk about HIV and AIDS and stuff. . . well, in health class and so, we do, but not like, friends and stuff. We don't really talk about stuff like that. Not really."
>
> Participant, Focus Group 3

> "I like to think that my friends and I talk about not being stupid when it comes to sexual activity . . . I don't know if we directly talk about, like "oh this is HIV, this happens to a lot of people but you can prevent it by doing this," but I think there's kind of a knowledge that if you don't want to get HIV, you need to wear a condom or whatever, and just don't be stupid about it and take precaution."
>
> Participant, Focus Group 3

Overall, students demonstrated a very abstract understanding of HIV/STDs that combines both fact and misperception. They were unable to place HIV in the context of their lives or to talk about HIV/STDs with their peers.

A "normal" person: Change of perception towards PLWHA

Many of the students had never met HIV+ individuals before *AMP!*. The students indicated their surprise that HIV+ individuals could be as healthy as a "normal" person. They were able to recall the speakers' stories in detail and touch on the various aspects of living with HIV: the difficulty of telling family, the different circumstances leading up to diagnosis (i.e. long-term relationship, using drugs), and the maintenance of care after the diagnosis.

> "It really opened up my eyes because we always talked about HIV and stuff [in class], [but] we've never had like speakers and stuff. . . It was just really different and so it will always be in my mind and stuff about it."
>
> Participant, Focus Group 3

Meeting the HIV+ speakers gave the students the opportunity to address misperceptions about PWLHA and simultaneously to understand that the risk of HIV is not attached to only certain types of people. It revealed the face of the "Boogie Man" to be someone real and "normal" like them. It resituated their textbook understanding of HIV into the real world. One student explained,

> "I know that anyone can get HIV and you can get it from different ways and I – you know, we've learned that since fifth grade. But to me, it seemed a lot scarier to see

> someone who's completely healthy who had lived an absolutely normal life, telling that he was HIV-positive because it kinda makes it more real that absolutely anyone can get it, and it doesn't matter who you are. It doesn't matter your sexual orientation. It doesn't matter, you know, if you've gotten into college, if you have a Master's degree. . . It doesn't matter. You can get HIV and. . . it doesn't discriminate, and you may look fine but you still have it."
>
> Participant, Focus Group 3

This quotation exemplifies the students' increased perceived susceptibility to HIV as a result of meeting someone who appears normal but has HIV. It also reiterates the theme of fact and misperception coinciding with one another, in which knowledge about HIV/AIDS doesn't automatically negate misperceptions about HIV/AIDS. They consistently expressed an "anything could happen" mentality and understood the importance of using protection, namely condoms, as a strategy to prevent HIV/STDs.

Anybody can make mistakes: Integration of HIV/STI awareness

In addition to reducing stigma toward PLWHA, participation in *AMP!* had an impact on attitudes and beliefs about sexual health among the high school students. Across the focus groups, the students identified key take-away messages that alluded to their increased perceived susceptibility to HIV/STDs and endorsed beliefs about practicing safe sex. They integrated this greater HIV/STDs awareness into their overall understanding of HIV/STDs. For example, during the final focus group that addressed the overarching program goals and components, two participants discussed one important thing they took away from *AMP!*:

> "I'd say the last one, the third one [HIV+ speaker session]. Pretty much saying anybody can get HIV or AIDS . . . because like, I was asking them – I asked them what they'd do when they first found out and they were like all in shock, and they didn't know how they could have gotten it. And it just kinda shows you that it can happen to anybody, and you just have to be aware and everything. And like, you – you need to get tested and stuff."
>
> Participant, Focus Group 4

> "Um, yeah, was also like Participant1's. If you're gonna have sex, then you should do it responsibly."
>
> Participant, Focus Group 4

Others echoed similar sentiments about practicing safe sex and getting tested, but only two students mentioned it in context of having a partner.

> "So don't assume that just because you're with somebody [who] knows what they are doing that you can just let them take care of themself because they can still make mistakes."
>
> Participant, Focus Group 1

> "Well I think that the talking about a condom conversation with a partner is really important because you want to make sure that everybody is protected if you want to be protected."

Participant, Focus Group 2

Students appreciated when *AMP!* showed that anyone can make mistakes but their views still primarily revolved around individual responsibility over one's sexual health rather than shared responsibility with potential partners. Nevertheless, all students reported telling either friends or family about one or more components of *AMP!*. In particular, one participant felt confident speaking to her friend about getting tested:

> "Actually before this last one [HIV+ speaker session], when we were first like talking about getting tested and stuff like that, I have a friend and told him, 'cause I knew that he was just being all around, so I told him that he needed to make sure that he was getting checked regularly so if something happened, he could know about it. . . He told me that he did get checked regularly and stuff like that. So I felt like that was good, that I at least told him to make that he was."
>
> Participant, Focus Group 3

Be smart: Relevance of comprehensive sex education

Accompanying the shift in attitudes and beliefs about sexual health was the perception of increased sexual health knowledge and relevancy of comprehensive sex education among high school students. Specifically, students named the five fluids that could transmit HIV, the steps to how to put a condom on and properly dispose of it, and the efficacy of medication for HIV/AIDS care. Quantitative high school findings indicate a change in HIV/AIDS knowledge scores as well.

Throughout the four focus groups, the students related *AMP!* to other aspects of their sex education courses. A few identified gaps in their sex education courses that *AMP!* was able to cover:

> "Well, we talked about condoms and stuff [in class] but we talked about it briefly, but we never actually did learn how to put a condom on and stuff."
>
> Participant, Focus Group 2

> "I feel like at least my teacher does a good job of presenting it [HIV] without stigma. Because he just gives us statistics and information, but I don't really think we've talked about it in class how the stigma comes along with it isn't really true. . ."
>
> Participant, Focus Group 3

The above examples highlight how *AMP!* helps to address potential gaps in their current curricula for sex education. Students contrasted *AMP!*'s interactive and "humorous" approach to the traditional method that included "worksheets" and "lectures," with one participant describing *AMP!* as the fun teacher that still gets work done. Overall, students considered *AMP!* as a medium from which they could learn about sexual health. Although a few participants expressed that they could not relate to the characters in the scenarios that were presented in the performance and workshop, they shared the perception that what they were gaining would be relevant.

> "There's a maturity level and difference in middle school. Like, everything is funny and they don't really take anything serious. And then in high school, everything is actually serious because people might actually be sexually active."
>
> Participant, Focus Group 2

> "I think ninth grade is the best time to have it because going up until tenth grade, eleventh grade and twelfth grade, you probably need to know most of the stuff. So it'd be like, if it's sophomore year, it might be a little too late. . . but if it's anything more than that, it's definitely probably too late. . . This is like the best time to have it in ninth grade."
>
> Participant, Focus Group 4

The quotations illustrate the relevancy of comprehensive sex education among high school students. Students did not always directly relate to the presented information, but they reflected on the belief that teenagers are becoming sexually active and so it's "better to have knowledge" to keep safe. Furthermore, a few students expressed appreciation for sex education that does not stress an abstinence-only approach. As the following student reports:

> "And I think it was nice, even when the speakers came in about HIV, they never said "don't have sex," they just said "be smart about sex" which is, I think, a much better message and it's more important to teach "be smart and this is how you be smart" rather than "just never have sex" because that's not really practical."
>
> Participant, Focus Group 3

Undergraduate Participants Focus Group and Open-ended Survey Results

Under the umbrella of our guiding research questions this section of the evaluation report seeks to better understand the experience of the university students involved in *AMP!* Our two evaluation questions address effectiveness and feasibility specifically among the undergraduate student participants:

1. *How does participation in AMP! impact sexual health knowledge among undergraduate students?*
2. *How does participation in AMP! impact the sense of advocacy and empowerment of undergraduate students?*

This section responds to these questions and presents salient themes identified during the qualitative analysis of the open-ended surveys and focus groups conducted at three time points throughout the Sex Ed Squad course in Spring 2013 (See Methodology section on page 19 for data collection details). Participants were enrolled in a special topics service-learning course in the Department of Communication Studies at the University of North Carolina at Chapel Hill, and reflected a racially and ethnically diverse group, most of who were from North Carolina.

Table 10: Undergraduate Participant Demographics

Gender	Race/Ethnicity	Year at UNC	Home State
Female	South Asian	Senior	Tennessee
Female	Hispanic/Latino	Freshman	North Carolina
Female	Caucasian/White	Senior	North Carolina
Female	Caucasian/White	Sophomore	North Carolina
Female	Caucasian/White	Junior	North Carolina
Female	Caucasian/White	Freshman	North Carolina
Female	Black/African-American	Senior	North Carolina
Female	Hispanic/Latino	Junior	Puerto Rico
Male	Black/African-American	Freshman	North Carolina
Male	Caucasian/White	Senior	North Carolina

Participation in *AMP!* had an impact on the sexual health knowledge of undergraduate students in several important ways. Their involvement in the program enabled them to reflect on prior knowledge or recognize lack of knowledge about the topic, appreciate the importance of acquiring basic knowledge, and critically explore the role of knowledge in their personal lives and lives of others. These salient themes are described in detail, with key examples, below.

Joining the Sex-Ed Squad: Reflecting on prior knowledge and motivation for continued information-seeking

Students shared varied experiences they had had with school-based sex education and discussed other settings where they acquired sexual health knowledge prior to the course. Students grew up in an abstinence-based era, and many commented on the lack of information that they were given in school.

> "I felt like there was a lack of sexual education throughout my experience with sex end in high school…after having real sexual education in the program with [non-profit organization] I saw how much information was being left out and how inadequate abstinence only sex-education is in the schools."
>
> Participant, Focus Group 1

The student quoted here reveals that exposure to comprehensive sex education, when it happened, occurred outside of the school setting. Other students echoed this experience, sharing that they learned accurate information about sexual health in after-school settings, informal social networks, and at home, but rarely in school. Some students recalled learning basic anatomy and "general things" in high school sex education, but no student viewed their experience as ideal. They were critical of the education they received and aware of how a lack of knowledge affected them as high school students.

> "I wish I had had some place where I felt like [sex] was safe to talk about…there was just this pressure to know, to be experienced, to have all the answers."
>
> Participant, Focus Group 1

"Knowledge is power. That's what I'm looking to achieve."

In fact, increasing knowledge was a significant motivating factor in why students chose to enroll in the course. While they were inspired by the opportunity to engage high school students and provide them access to information, the undergraduates were also driven by the opportunity to educate themselves and gain knowledge for their own sexual health.

> "I've always told myself I need to research and look into it more. But I haven't and I feel like this is finally the time to get the information."
>
> Participant, Focus Group 1

While they sought general information and access to resources, the undergraduate students identified several areas of specific interest or concern. Some students wanted to learn the basics of HIV and testing, while others wanted to explore the biological and emotional complexities of sexual health. Several also expressed interest in learning more about health disparities and how to intervene. The following quote highlights wanting to know about HIV testing resources:

> "I think one of the most important things that I would like to know more about, especially even in this community when people come to me and they are like 'so, what about testing?'…they were asking about insurance, like 'my parents don't need to know' and things like that. I want to know more about that because personally I only know a little bit and I would love to know more."
>
> Participant, Focus Group 1

All students identified the Sex Ed Squad course as an opportunity to improve their own sexual health knowledge. Despite coming into the course with varied levels of existing knowledge, all were committed to leaving the course knowing more than they did at the outset.

The power of new knowledge: Perceived increase in knowledge and motivation to continue learning

Analysis revealed that students did perceive an increase in their own knowledge, yet also highlighted their commitment to continued learning. Many students came into the first day of class knowing relatively little about HIV. Following the HIV 101 training, which was developed by the Health Behavior graduate student Capstone Team and delivered the first day of class, the students indicated they gained increased sense of knowledge. For students that came in with limited knowledge, the exposure to in-depth information about sexual health and HIV was paramount. For students that came in with a

"Already in the past two days I've learned more than I have all through high school or my four years in college."

significant background in the topics addressed, the information prompted them to continue to expand their knowledge base. These two types of student experiences are juxtaposed in the following quotes.

> "After the first day of class and reading these documents, I feel like my knowledge doubled at least."
>
> Participant, Focus Group 1

> "I think I knew a lot about sexual health coming into this class, but I have also since learned many new things I didn't know. I don't feel like I can ever stop learning new things"
>
> Respondent, Survey 2

The documents mentioned in the first quote above refer to the materials provided in class and during their HIV 101 training, suggesting that these played a significant role in the students' knowledge gain. By engaging with the materials, they learned about the history of HIV and explored transmission mechanisms, prevention strategies, and social justice issues associated with the illness. While both statements represent a clear perception of increased knowledge, we did not formally assess what concepts students mastered and retained after the training. Furthermore, they clearly identified feeling more familiar with key sexual health topics and HIV in particular, yet the second quote also illustrates the student's awareness of the abundance of information they had yet to learn. The quotes also suggest that the *AMP!* program was effective in meeting students where they were in terms of their knowledge of HIV and sexual health and helping all course participants, whatever their level of knowledge at the outset, deepen their knowledge and understanding.

> "I feel confident saying I'm knowledgeable…I know that there is a lot out there that I still don't know but that keeps me driven to keep learning more."
>
> Participant, Focus Group 3

Students' focus group reflections supported findings from the individual survey data. While the students perceived their knowledge as high by the end of the course and felt more knowledgeable than their peers, they also recognized they had more to learn. They also acknowledged that increased knowledge did not necessarily translate to behavior change. As one student put it,

> "I think I know a lot more than some of my friends, but a lot less than I should to make good decisions."
>
> Respondent, Survey 3

Many students expressed the sense that the course touched the tip of the iceberg – it helped them become more familiar with basic facts and comfortable with sexual health topics, but they felt they still had more to learn about the complex issues that impact sexual health, healthy relationships, and social justice issues related to HIV and sexual health. They did find themselves more confident in sharing what they did know, including how to access resources or direct peers to accurate information when they did not know the answer.

> "I actually feel really confident about what I know or at least I know how to begin answering and if I don't know exact details I know where I can direct the person for more information."
>
> Respondent, Survey 2

Making meaning of the impact of new knowledge: Self-empowerment, self-advocacy, and communication

Undergraduate students made sense of their learning in different ways, including how increases in HIV knowledge was related to their own sense of empowerment and ability to communicate with peers and providers. An explicit goal of one student, expressed in the first focus group, included, "I would like to know more in order to be empowered."

> "I didn't know very much before this course and now I am fired up and ready to speak up about erasing the stigma associated with [sexual health and HIV]."

Many of the undergraduates perceived their increased knowledge as contributing to a heightened sense of empowerment. They described this empowerment as exemplified by enhanced awareness and, in some cases, changes in sexual health decision-making and improved communication with their peers and sexual partners (for those who were sexually active at the time of the study). It is important to note that this differs from what the undergraduate students reported at the beginning of the semester, when what was most important to them was learning in order to empower the high school students. Their perspectives shifted over the course of the semester as they began to reflect on their own experience. Many students described that simply learning how much they did not know was a step towards their self-empowerment. As they increased their own knowledge and gained access to resources and information provided through the course, the students gained a sense of empowerment which enhanced their willingness and ability to speak up about sexual health when communicating with peers. Students consistently brought up their gain in confidence and ability to convey accurate sexual health information within their social networks.

> "When I am talking with friends and someone says something that is not true, or misunderstood facts about sexual health, I feel that I can inform them of the truth, or just provide more accurate information without causing tension."
>
> Respondent, Survey 2

Beyond gaining knowledge about basic facts, questions, and where to find resources, undergraduate students expanded their understanding of the current state of HIV/AIDS in North Carolina and the United States. They also referenced the power of sharing their stories as a tool to de-stigmatize talking about sexual health. They were proud to be able to share the experiences they had within the course and *AMP!* program activities and to spread the messages they had learned. This sense of self-efficacy helped them incorporate the new knowledge and skills acquired into their interactions, for example with health care providers and peers. By the end of the semester, students began to report increased ability to advocate for themselves during doctor visits and willingness to share their stories with

peers as a tool to de-stigmatize talking about sexual health. They also reported seeking out opportunities for HIV testing, which they viewed as an important step in self-advocacy for sexual health. Their increased sense of confidence related to sexual health communication was identified repeatedly as a significant factor in this newfound self-advocacy.

> "I think I am very able to speak up for myself and I know what questions to ask. I understand what the doctors are saying and they are happy to explain further. I think doctors and health professionals appreciate when people know about themselves and about how to take care of themselves and are eager to engage more with someone who can communicate back with them."
>
> Respondent, Survey 3

In addition to feeling empowered at the individual level to communicate with their intimate partners and within their social networks, students described gaining a sense of advocacy at a community level. Through their increased understanding and knowledge, they gained a larger sense of advocacy and willingness to speak out against stigma, as this student describes,

> "Before taking this course I had trouble unpacking what it meant to be HIV positive. I was guilty of essentializing people with HIV. It is still something I am working through but able to confront. I have a red notebook that says HIV neutral, sometimes in class people ask what it means or just google it on their own. I think a few months ago I would have been afraid to carry around a notebook like that but now I have grown a lot as an advocate and an ally."
>
> Participant, Focus Group 2

Focus group findings provide strong evidence of the impact *AMP!* had on university student participants' HIV/AIDS knowledge, self-empowerment, and communication. However, the data did not reveal any salient themes related to change in behavior and decision-making related to sexual activity. Students recognized that taboo social norms around sexual health, testing, and talking about sex impacted their own behaviors and that it was difficult to "practice what they preach."

Recognition of limitations: teaching capacity and professional development

While participants reported improved communication with their doctors, and confidence in discussing sexual health in general, they struggled with advocating for healthy behavior among the high school students when few among them were able to make concrete changes. Furthermore, students were aware that their sense of empowerment and newfound knowledge did not directly translate to being strong teachers and facilitators for high school students. From the very beginning of the course, students voiced a deep concern about how effective they would be in the high school setting given their limited knowledge.

> "There will be questions that are thrown to us that are difficult to answer or we won't immediately know the answer to…we'll seem uncertain of ourselves."
>
> Participant, Focus Group 1

Observations of the high school performances corroborated this student's fear. Performers excelled at answering questions about what brought them to the course or how they built

the show, but were often unable to answer complex technical questions about sexual health or detailed questions about HIV. When such questions were asked students would defer to the course instructor, but voiced wishing that they were more capable of handling complex questions.

> "So when they asked a question and we are supposed to just write it off because we are not qualified to answer that – I want to be qualified to answer that! That was probably the most challenging for me is that I didn't feel as prepared as I could have been…that really bothered me"
>
> Participant, Focus Group 3

The limitations of the university students' ability to serve as health educators was noted by the course instructor and school district officials as an opportunity for program improvement, and will be further discussed in the feasibility findings section of the report. Despite the limitations noted above, many of the students expressed motivation to include sexual health advocacy in their future career goals.

As students reflected on the strengths and limitation of their increased knowledge and sense of advocacy and empowerment, they drew conclusions about their future engagement with sexual health education. In addition to a desire to continue learning, they wanted to continue to advocate and educate. While many made references to continuing the work "in the future" meaning after college or pursuing sexual health advocacy professionally, there was also an awareness of their continued involvement as students,

> "It's not a class as much anymore but a passion now."

> "I'm still in college and this is an amazing way to still be active and see an issue that is happening here, and a way to be active in that right now."
>
> Participant, Focus Group 1

Students characterized their involvement in sexual health activism as important and necessary both now and in the future. They recognized that they had been introduced to tools to utilize in sexual health education, and needed further training to be effective educators. However, they highlighted that there were so many competing academic demands which presented barriers to their full commitment to the Sex Ed Squad. These barriers, as well as facilitators, were identified as important considerations as the course and program evaluate their structure and will be addressed more fully in the section below discussing feasibility findings.

Feasibility Results

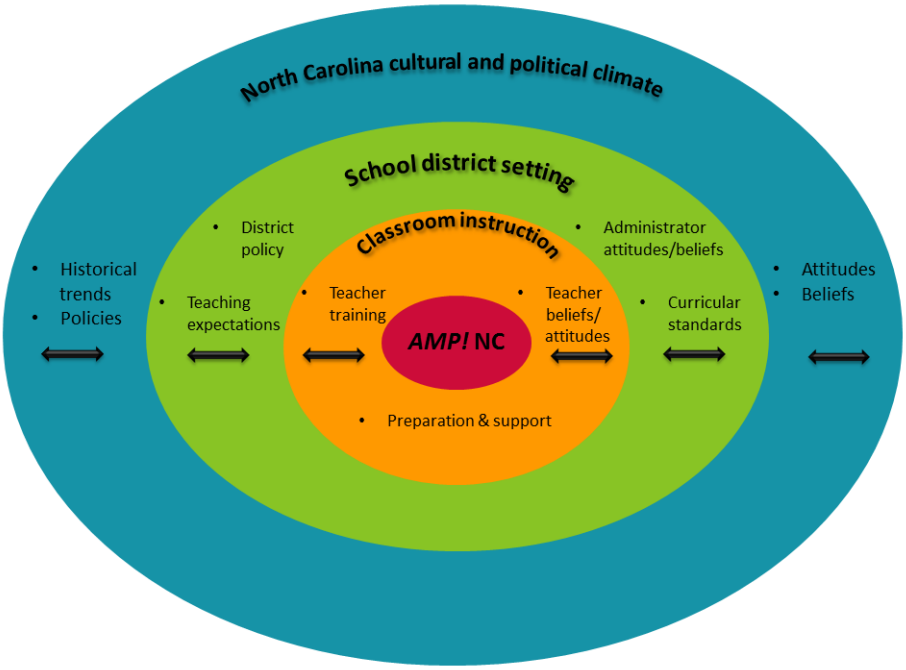
This section of the evaluation report addresses the third overarching evaluation question: *What is the feasibility of AMP! in North Carolina public high schools?* This was a broad question that we sought to answer by triangulating data from in-depth interviews conducted with key program stakeholders, including district health coordinators (N=2),

health teachers in the intervention school, (N=3), and the university course instructor (N=1) with field notes and evidence from the university and high school student data. As initial impressions emerged, we refined our questions to be more specific:

- What are the identified strengths and challenges from the pilot program?
- What do stakeholders perceive as barriers and facilitators to implementation?
- What are the key elements needed for effective implementation and sustainability?

Through careful analysis of evaluation data, we highlight program strengths and challenges, barriers and facilitators to effective program implementation, and key elements for program sustainability in detail (beginning on page 42). This section also reports on the lessons learned from successful implementation of *AMP!* in one progressive school district in North Carolina From our analysis of the data, we have generated key recommendations for improvement related to program content and delivery mechanisms. (See Recommendations on page 47). Finally, our analysis of the data prompted us to build a framework to shed light on the larger question of feasibility.

Feasibility Map: Illustrating the complex factors of successful program implementation



We present this feasibility map and its components below as a way to understand the multiple layers that both enrich and complicate the implementation of *AMP!* in North Carolina. As the team member leading the feasibility analysis undertook the coding process, reading and re-reading transcripts, memo writing and discussing emerging themes with team members, and moved from thematic analysis to conceptual analysis, she was inspired to develop the diagram as a way to visually describe the complex interactions that emerged from the data.

Each layer contains important barriers and facilitators to consider in the planning and execution of future iterations of *AMP!*. Similar to how a socio-ecologic model is constructed,

these layers work from the macro or structural level down to the micro, classroom interactions. At the center of the map is the *AMP!* Program, which as illustrated is nested within the complex layers which interact and often contradict with each other. Our findings suggest that *AMP!* must respond and engage with these complex layers in order to be successfully implemented, as opposed to successful implementation occurring in spite of these layers. Just as *AMP!* must interact with the different layers, the layers also interact and inform one another. The following describes each layer and provides examples of how they engage with each other and with the *AMP!* Program.

North Carolina cultural and political climate

At the macro level lie the historical and current trends for sex education in the state. As described on pages 2 and 3 in the introduction, North Carolina's conservative cultural and political views have influenced policies, as well as attitudes and beliefs, regarding sex education. For the most part, statewide policies on sex education as well as local school district policies in counties across the state have reflected a conservative agenda with the standard for all school age children remaining Abstinence Until Marriage (North Carolina Department of Public Instruction (NCDPI), 2013). Yet with the passage of the Healthy Youth Act in 2009 and General Statute (G.S.) 115C-81 Basic Education, the NC Healthful Living Essential Standards now requires that schools cover components of comprehensive sexuality education, including instruction in the use and/or demonstration of condoms in the 9th grade (NCDPI). The degree to which the curriculum is implemented, however, varies from county to county based on local board policy. In assessing the feasibility of the *AMP!* pilot, stakeholders repeatedly referenced the conservative climate within the state during their interviews, as illustrated in the following quotes:

> "This is a conservative state and there's a lot of barriers to, you know, sexual education"
>
> "You just kind of never know when something's gonna rear its ugly hear around in North Carolina with conservative, you know, opinions."
>
> "…they call themselves I guess "the Bible belt"…and unfortunately I think it's always gonna be that way until the state, the Department of Public Instruction, demands it."

School district setting

North Carolina's cultural and political climate directly translates to school district policy and standards for teaching sex education, an important consideration for potential expansion of *AMP!* into other school districts. Many NC districts continue to provide abstinence-based education, despite the statewide policy that permits comprehensive sex education. This decision is reflective of the socio-cultural norms and historical political trends mentioned above, as well as the attitudes and beliefs of district-level administrators. However, school districts do have autonomy, as exemplified by the district where *AMP!* was piloted. In many ways, however, the CHCCS district is an outlier and the strong embrace of *AMP!* in this district may be hard to replicate elsewhere. Because the CHCCS district has long supported a comprehensive sex education policy, all of their schools are

expected to deliver comprehensive curriculum through the Reproductive Health and Safety Unit. Even with this mandate, however, stakeholder interviews made clear the variation in classroom implementation in terms of teacher approach, comfort level, and content emphasis. Stakeholders described the dynamic that leads to such variation.

> "Even though we are a comprehensive school district, what happens in the classroom really depends on the teacher."

The quote above and statements like it were repeated multiple times. The expectation to teach comprehensive sex education is clearly supported within the district, yet a salient theme that emerged from the data is that, despite this mandate, teacher comfort levels differ and many are uncertain about where 'the line" is in discussing sexuality and sexual health topics and seek further clarity on how to stay within bounds, as made clear in the stakeholder quotes below.

> "They're always scared they are gonna say something wrong. As I've always told them, you know, as long as you stick to the facts, you know, you don't have to answer any questions."

> "You can really talk about anything, and I know teachers have asked me that, 'well, what can I say and what can't I say?' We're a comprehensive sex ed program. There's really not anything you cannot say."

Classroom Instruction

Teachers' ability to deliver comprehensive sex education in the classroom is influenced by numerous factors beyond district mandate, such as prior training, their own personal or religious beliefs and comfort levels, concern about parent reactions, and uncertainty about how to best teach sensitive information. Teachers described experiencing mixed messages from previous districts where they had taught, where they recalled being told "we're comprehensive, but don't do this. Don't say that and don't do this." In contrast, they noted that the CHCCS district truly embraced a comprehensive sex education approach.

> "It's the first time I've been in a school system where they actually took out a condom and put it on…they're just so progressive."

The comment above was spoken with a tone of amazement from a teacher who had taught health for 12 years prior to working in the CHCCS district without ever having done a condom demonstration, even during his tenure in districts with comprehensive sex education policies. The *AMP!* program was the first time he had a condom demonstration in his classroom.

> "I think it's more about the fear thing about what you can and can't say, to be honest with you. You know, there's always the apprehension, especially working in the South, about you know, what parents might view as appropriate, inappropriate, and obviously in this day and age of job security, that might actually be brought to the forefront."

The data revealed that fear of parental objection may influence what teachers teach or do not teach, an important element to consider for potential future expansion. On the other hand, teachers expressed a sense of irony that parents seem increasingly dependent on them to shoulder the burden of teaching adolescents about sexual health, a difficult conversation for many parents to initiate. Teachers are keenly aware of the potential of parent objection throughout their teaching of the Reproductive Health and Safety Unit, yet interestingly, none have received parent questions or complaints about unit content or about the *AMP!* program. Nevertheless, these concerns are important to consider in future iterations of *AMP!*.

This layer of the feasibility map is particularly important to consider in terms of the *AMP!* program. The intervention is delivered within the classroom context, where teachers' own knowledge, experience and comfort with the topic directly impact the quality and depth of information that students receive. As the data illustrate, the classroom experience is in some ways shaped by the school district setting, but the complexity between those two layers is heightened. The teachers themselves are also affected by North Carolina's political and cultural climate in terms of their own beliefs and attitudes and those of the community in which they teach. Thus, while adoption of *AMP!* is a step over which teachers may not have significant decision-making power, it is critical to engage them in a discussion of how best to incorporate the program into their classroom space and make it relevant for the students they teach. Issues of fear, parent pushback, and content are particularly important to address in preparing to implement *AMP!* in other potentially less receptive settings. Involving teachers in each district in a conversation about these issues may lead to clearer instructional goals and learning objectives that can help increase their sense of ownership as well as help tailor program components to varied cultural contexts.

Barriers and facilitators

Only by carefully considering and engaging with all layers in the feasibility map discussed above will *AMP!* truly be able to adapt to local settings and climate and become a program that responds to community needs and local context. During the pilot program, several facilitators were identified across the different layers that contributed to successful implementation in CHCCS:

- Trust between district level Health Coordinator, Curriculum Coordinator and teachers
- Trust between top-level district administrators (Superintendent, Assistant Superintendent) and Health Coordinator/s
- Trust/history of research partnerships between district/teachers/University
- Progressive district and parents within the state of NC
- Long-time proponents of Comprehensive Sex Ed (now called Reproductive Health and Safety)
- District Health Coordinators serve as "champions" and draw in other stakeholders
- Written description of *AMP!* content alignment with state essential standards

However, we recognize that these facilitators may not be present in other settings, and thus several challenges should be expected in other districts, including:

- Conservative administration and parents
- Logistics of larger districts and larger high schools

- Differences in adherence to recommended comprehensive guidelines
- Perceived parent backlash; fear of any type of controversy

The challenges listed above are in addition to those identified during the pilot program. Challenges specific to the *AMP!* pilot program in North Carolina are reported below.

Pilot program strengths and challenges

Data from the key informant interviews showed that there was a significant amount of enthusiasm about the *AMP!* program. Key informants felt that *AMP!* was a good fit for the CCHCS because the program presents information in an entertaining and humorous way, is powerful for students, and aligns well with the comprehensive approach supported by the district. *AMP!* is seen as a strong educational tool because it creates an environment which encourages youth to ask questions about sensitive and often "taboo" topics and addresses both the factual and emotional aspects of sex and HIV. Administrators and teachers both believed that the art/theater format of the program engaged students, made the information memorable, and addressed "real" issues in a way that "put a name and face on them." They also valued "bringing in different people and different perspectives" to help their students gain a deeper understanding of sexual health issues.

All key informants recognized the strengths in a near peer model, and thought personal stories were very effective, which was corroborated by findings from focus groups conducted with high school participants. From an educational perspective, the stories helped diverge from a lecture format. Interviewees found that multiple intervention components with diverse, interactive ways of delivery led to information retention and rapport building with the high school students. The possibility of getting students involved and interacting with the topics in a more participatory manner was noted as an important next step.

The data also revealed significant challenges faced during the pilot program. The challenges fell along several major areas, including logistical, content/curriculum, and organizational. Many of these challenges are addressed by a recommendation for developing program structure, curriculum, and learning objectives. This recommendation can be found on page 49, the specific challenges as described in detail below.

Logistics

Logistical challenges were mentioned most frequently by all informants as a significant barrier to program implementation, given the time intensive and details-oriented nature of planning the intervention. Stakeholders identified the amount of work that was asked of teachers and noted that a full time program staff was an essential component of managing the school-based implementation of both the program and the study. A major hurdle for the program was in navigating the conflicting schedules of the undergraduate students and the school district. The schedules simply do not mesh well. Spring breaks do not align, the university semester ends in late April, and the time frame of university student availability does not match well with the high school class schedule.

On top of the program components, the research components (particularly the consent process) were burdensome to teachers because they necessitated a significant amount of class time and teacher attention. Stakeholders understood the importance of rigorous

evaluation research, but also believed it would be a major barrier to dissemination and implementation of *AMP!* to other sites. Stakeholders in the CHCCS district, home to the University of North Carolina, are accustomed to the demands and rewards of participating in research projects. They suggested that administrators and teachers in other districts might be less willing and able to accommodate the time intensive requirements of research. "Periodic evaluation" or more of a program monitoring approach was suggested.

The many "moving parts" of the program was also identified as a major challenge. Stakeholders commented that the program as implemented in this pilot year with three distinct components with weeks of lag time in between sessions felt fragmented. Stakeholders suggested that a more streamlined or condensed version would benefit student learning as well as make the logistics and evaluation pieces more feasible and the program, possibly, more effective. The concept of a three-day cluster of the intervention components was recommended by multiple individuals, as was delivering the performance, in addition to the workshop components, in a classroom, rather than auditorium setting.

The logistics at the university level were also challenging. Undergraduate student schedules limited us to rehearsals within the once a week, 3-hour seminar, which is not enough time to develop and polish a show. The university course began with the two-week intensive, and undergraduate participation only increased from there, with many of them experiencing burnout and expressing this in the course evaluation. Student focus group and survey data corroborate the finding that the intensity and level of commitment expected of the undergraduate students was too strenuous to fit into a one semester-long course. In the same fashion, the course instructor role was more demanding than anticipated with the time pressures of matching university and school district schedules and fitting the performance and workshops into limited time frames. It was recommended that the AGHC develop a job description for the course instructor detailing the full extent of the role and ensure adequate compensation in future iterations of the program.

Content and Curriculum

High school teachers and the university course instructor believed having clear learning objectives for each program component would facilitate *AMP!*'s alignment with the curriculum as well as varied high school classroom teaching styles. These learning objectives should be presented throughout the program and reiterated by teachers during other, non-*AMP!*, class time. From an educational perspective, teachers were concerned about framing *AMP!* as a learning opportunity that had skills and content for students to master but did not provide any tools or follow up to assess student learning. Without these tools, they feared that *AMP!* would be perceived solely as an activity that got students out of regular class time. Teachers suggested the program could be improved by some pre-program planning, such as making sure students were aware of the information that was going to be presented to them, and post-program follow up, such as including an activity to reinforce what was taught. A warm up activity (i.e. "set induction") and follow up activity were specifically identified as strategies to help students process content and improve comprehension of material.

In addition, there were some specific content areas that were identified as problematic. Stakeholders discussed one performer's assertion that she was maintaining her virginity because she was not having vaginal sex. This seemed ambiguous to stakeholders, who felt

this message was confusing for high school students and needed more clarification. In addition, it became clear that the undergraduate students needed more than a two-hour HIV 101 training if they were to address high school students' questions adequately in the post-performance discussion. Additionally, the time spent on the topic of sexual health and HIV (3 class sessions) through the delivery of the *AMP!* components involved more than teachers typically spend on any one topic in the health curriculum. Teachers were forthcoming about how the content of *AMP!* did not always align with how they personally approached their classroom teaching. For some, the content focused too much on casual sexual intercourse, not enough on relationships, highlighted "alternative lifestyles," and did not go into depth or provide an opportunity to practice decision-making. Use of slang was also viewed by some as not appropriate for the classroom/educational context.

Larger organizational and partnership context

Organizational challenges are an important element that emerged from the data. The relationship between the UNC-based team and UCLA was identified as a source of inspiration but also a major challenge, namely that being across the country required a structure for communication, support, and accountability that had not been developed prior to the start of the project. Another challenge that became evident during the pilot was how the political and cultural context of each school district influenced the barriers and facilitators faced during program implementation in different settings Although UCLA was aware of the conservative climate within NC, their ability to strategize about how to realistically implement and oversee a program in such a setting was limited by their geographic location and disconnect from the on-the-ground work. Discussions about context, climate, and vulnerabilities are identified as critical steps for future partnership and we strongly recommend they take place before implementation during a planning phase. Given its prior history with the program, UCLA should take a leadership role in developing MOUs, scopes of work, payment schedule – none of which happened during this pilot year and was identified by on-the-ground collaborators as a major drawback. Adopting a set of principles for working in partnership is a viable solution for strengthening current and future collaborations and a first step in solidifying the UCLA-UNC partnership.

Conclusion & Recommendations

Conclusion

"I think it is a good program. I just, like I said, think it needs to be more combined and, um, a little bit more clarity so kids can comprehend what the main points are and I think you have a very successful thing here."

In assessing these comprehensive data, our team concludes that the *AMP!* program was successfully piloted in North Carolina and achieved significant outcomes in terms of increased high school student knowledge. In addition the program made an impact on the undergraduate students involved in developing and delivering the performance and workshops, and was well-received within the intervention school and by district level administrators. Our analysis of the evaluation data and careful consideration of program facilitators and barriers helped us generate the recommendations described below. We believe these will be critical to consider if we are to strengthen the existing program and facilitate future expansion into other school districts in North Carolina.

" I loved it and I think, um, you know, having college kids do it I think do it . . . it's just a different message than their teachers, you know . . . in this situation the kids are the performers, um, and, but it's such a unique way of presenting material. That is something the kids don't see every day, so I think it's a wonderful, um, a wonderful way to present the information. And sensitive inform- being sensitive information."

Research Recommendations

The recommendations in this section are to enhance validity, reliability, and transferability of the quantitative and qualitative results in addition to enhancing intervention effectiveness.

Instruments

1. Use more pre-validated scales to measure intervention concepts such as condom use self-efficacy scale (CUSES) or partner communication scale (PCS). Additional constructs to consider measuring include HIV/STD stigma and parent communication.

2. Social desirability scale: Since we are relying on self-reports to assess HIV knowledge, attitudes, and sexual behaviors, including a measure for social desirability would help determine if respondents are answering questions in a biased way by under-reporting "deviant" behavior and over-reporting socially acceptable behavior

3. Administer the same survey instrument administered to intervention participants during pre- and post-intervention to university students (i.e. UNC Sex Ed Squad students). An additional HIV/AIDS empowerment and advocacy measure should be included in the undergraduate student survey.

Methods

4. Greater efforts should be made to reduce participant burden for the consenting and data collection procedures. Recommendations include: Send all study related consent forms to parents at once; Collapse focus groups so that there is one pre- and one post-intervention focus group; Select brief scales when available to keep the survey short.

5. Use consistent time points for follow-up across conditions. Further, to observe a significant change in behaviors with a low sexually active group, we recommend that a scaled up research project conduct follow-up tests immediately after the intervention and at 6-, 12-, and 24-months post intervention.

6. Incorporate a Community Based Participatory Research (CBPR) approach to enhance relevance and fit. For example, working with a coalition or youth group to better tailor the survey instrument to the intended audience may enhance survey readability. Methods such as pre-testing the entire instrument or a subset of survey items with a small sample from the intended audience would allow for an evaluation of the appropriateness of the survey language and question type.

Intervention Planning and Implementation Recommendations

The recommendations in this section are to strengthen the intervention itself, and improve the planning and implementation process so that the intervention is delivered in a manner that is both effective and feasible

1. Model the intervention after the CDC's Diffusion of Effective Behavioral Interventions (DEBI) program by identifying core elements and key characteristics for the *AMP!* intervention. Core elements are intervention components that must be done and cannot be changed. These elements should be generated from the behavioral theories used to create *AMP!*. Key characteristics are components of the intervention (activities or delivery methods) which can be changed to suit the needs of the target population. We recommend using behavioral theory, pilot data, and empirical evidence to identify core elements and key characteristics. Following the core elements without change or addition is essential to intervention effectiveness.

2. Extend the course for university students to be a two-semester course to allow for more time to learn about HIV/STDs and to develop and modify performances.

3. Integrate HIV 101 training into the college course throughout the semester(s) as opposed to a one two-hour training to provide a longer period of engagement with material, the opportunity for college students to ask questions as they arise over the course of the semester, and to further develop facilitation skills once concepts are mastered.

4. Separate college students into different (smaller) performance groups to reduce college student performance burden and to increase performance ownership among actors. Creating smaller performance teams may also be a way to reach more schools or districts.

5. Deliver program components in a compact cluster (i.e. over three days) in high schools to reduce teacher burden and to enhance high school student engagement.

6. Expand opportunities for high school students to interact with program content, such as "freeze" moments during the performance, where they could practice decision-making in "real" scenarios.

7. Consider involving high school students in the creative process of developing skits and performing for their peers or near peers.

8. Develop instructional materials with health teachers that help facilitate uptake of program components post-intervention within the health classroom. These materials may include follow up activities for the teacher to lead, assessment sheets, or supplementary information.

9. Administer a brief feedback survey to intervention participants immediately after an intervention component to test retention and appropriateness. Questions would ask about learning objectives from each intervention component such as "What are the five fluids?" or "How much did you enjoy the session presented today?"

Project Management and Partnerships Recommendations

The recommendations in this section are geared toward project oversight and highlight key strategies for the lead organization (UCLA) to promote transparency and equity with collaborators.

1. A full time project manager is needed to oversee program management and research activities at the North Carolina *AMP!* site. In addition, funding for research assistants is essential to collecting, managing and analyzing data.

2. Key informants noted the importance of identifying district or school level program champions early in consideration of expansion of *AMP!*. Program champions should also be involved in the decision-making process via regularly scheduled stakeholder meeting.

3. As mentioned earlier, a CBPR approach to budgets and finance is recommended. School district and organizational/institutional partners should be factored into project budget and compensated accordingly.

4. Policies and expectations for regular communication between UNC, UCLA, and other partners should be established prior to any further planning or implementation in order to facilitate clear guidelines for collaborating across distance

5. We recommend that UCLA, as lead organization, document roles and responsibilities via MOU or other contractual agreements to enhance transparency of expectations with collaborators.

6. Expand partnerships to find other natural allies, such as the NC Department of Public Instruction whose mission is to provide age appropriate, medically accurate HIV/STD and teen pregnancy prevention education to all school-age children with an emphasis on minority populations whom are disproportional impacted, through a collaboration of the Department of Public Instruction, local school systems, higher education, state and local health departments, and community-based organizations.

Dissemination Recommendations

The recommendations in this section suggest ways to share research findings.

1. Plan early for dissemination. We recommend that for each research project a dissemination plan is developed that sets goals for presentations/publications, identifies appropriate conferences and events, and drafts a budget for what dissemination efforts will cost.

2. Develop standard fact sheets that succinctly and clearly share research findings with audiences such as school administrators and parents.

3. Develop concise research summaries of each of the studies conducted to share with scientific colleagues and audiences.

4. Plan a community forum to share results with the school communities in which you have collected data so they can learn about the findings.

5. Make all research reports, fact sheets, and summaries available for download on the AGHC website.

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Appendices

A. University Course Syllabus
B. Quantitative Survey: High School Participants
C. Open Ended Survey: Undergraduate Participants
D. Focus Group Guide: High School Participants
E. Focus Group Guide: Undergraduate Participants
F. In Depth Interview Guide: High School Health Teachers
G. In Depth Interview Guide: Key Stakeholders

A. University Course Syllabus

COMM STUDIES 390 (Special Topics):
Performing Sexual Health: UNC Sex-Ed Squad
Communication Studies in conjunction with the APPLES Service Learning Program
UNC Chapel Hill, Spring 2013

Amy Burtaine (Instructor)
Bobby Gordon (Co-Instructor)
Arianna Taboada (Co-Instructor)
Course Meeting Time/ Tour: Fridays 9-12
Location: Bingham 203

REQUIRED script building intensive: Jan. 13-Jan.24
Sunday January 13th: 5-9 pm
Monday January 14th - Thursday January 17th: 6-9 pm
* no class Friday January 18th *
Saturday January 19th and Sunday January 20th: 10am-4 pm
Monday January 21st – Thursday January 24th: 6-9 pm
* no class Friday January 25th *

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Course Description:
This intensive course will explore the history, theories and strategies behind activist sexual health education theatre as it has been used both locally and globally. The course will begin with an intensive training on sex, sexuality, HIV/AIDS and the powerful history of artists' interventions to open urgent dialogues on these taboo topics. We will study the work of several socially engaged theatre practitioners and examine how humor, personal narrative and non-judgmental, sex-positive approaches have been utilized to open empowering and educational dialogues about sexual health by and for a diverse range of communities. We will then turn theory into action and form our own theater collective known as the "UNC Sex Ed Squad." As an ensemble of artist-educators we will write, rehearse, produce, and tour an engaging and challenging piece of activist theater aimed at educating ninth graders in the Chapel Hill-Carrboro City Schools about HIV/AIDS.

Course Methods:
This course will be, by its very nature, hands-on and experiential. Students will work as writers, performers, directors, and facilitators. The primary methods used in this course are based in collaborative group work: creating an original show (using participatory research to create theatrical material that is appropriate to the local context, personal writing, and improvisation); experimenting with various acting techniques and exploring social change and activist theatre; touring the performance to local high schools; evaluating performances and audience response; leading follow-up workshops with high school

students giving them the opportunity to explore the issues through art and theatre making; discussion, reflective writing, feedback, and critical analysis of work created.

APPLES Service Learning Credit:
This course is an APPLES Service Learning Course and also fulfills requirements for EE (experiential education). As such, you will be required to complete and document 30 hours of service outside of regular classroom time and academic work related to the course. For these service hours you will be developing a theatrical piece on HIV/AIDS during the January intensive and performing it at local public schools. Because you will be interacting with high school students about sensitive topics, you are required to know and follow the state mandated reporting and AMP! referral policy posted on Sakai. We will review it in class, and you can download a copy for your own records.

Controlled Enrollment: Permission of the instructors required.

Attendance/Participation:
A given and required. Being in theatre means being committed to the members of a theatrical ensemble or group (this class), the work, the community, the idea of using theatre for social change, and yourselves. We expect each other to be on time, wholly present, and ready to work, play, and create.

There are no unexcused absences from this class. Each student will be allowed one excused absence per semester. The excused absence must be a university approved absence (appropriate documentation is required) will be evaluated on a case-by-case basis, and the final decision rests with the instructor. After that a full letter grade will be deducted from your final course grade for each absence.

Furthermore, your active participation in the ensemble and class is assumed ahead of time. You must be in the room or at the service site, ready to work, and fully present when class begins. If you are not, your grade will suffer accordingly. If you have questions about this, please come talk to me. Your "Participation" also applies to the 30 hours of academically related service.

Student Learning Outcomes:

- Demonstrate an understanding of HIV, sexual health, and how artists are in a unique position to affect tangible change in both of these areas.
- Identify the unique sexual health challenges facing North Carolina adolescents
- Develop an effective and engaging original theatre piece to educate NC teens about HIV/AIDS, using humor and personal narrative
- Perform and tour the show to local high schools and facilitate follow-up workshops with high school students
- Evaluate the impact of the touring show and workshops
- Critically reflect on the course and service experience
- Synthesize the theoretical foundations of community-based theatre and health education

Required Course Texts:

Boal, Augusto. *Games for Actors and Non-Actors* (2nd Edition). Routledge. New York, NY. 2005.
Rohd, Michael. *Theatre for Community, Conflict, and Dialogue: The Hope is Vital Training Manual.* Heinemann. Portsmouth, NH. 1998.

****All other course reading will be listed in the week-by-week schedule and posted on Sakai. Please see syllabus breakdown by date(s).**

Course Assignments and Evaluation:

GRADE BREAKDOWN:

Script Devising Intensive / Tour Service Hours	=	300 pts
Weekly Response Postings (15 weeks x 10 pts)	=	150 pts
Reflection Papers (2 papers x 150 pts)	=	300 pts
Final Synthesis Paper	=	250 pts
TOTAL POINTS	**=**	**1000 pts**

Service Work (Script Development Intensive, Rehearsal, and Tour Service Hours): (300 points) (Elements Involved: Participatory Research; Personal Writing and Improvisation as Prompts for Scripted Material; Rehearsal Sessions, Tour to Schools)
For this pilot tour, we will tour to Carrboro High School. UNC students will have 2 separate contacts with Carrboro HS 9th graders: initial performance and post-performance dialogue (for 100-200 students); follow-up condom skills workshops (to multiple health classes of 15-40 students each).

Weekly Response Postings (15 weeks x 10 points each = 150 points) Each week students will be required to post on Sakai in response to a given prompt. Some weeks, students will be asked to respond to the assigned readings with observations and questions, dialoguing with other students about the themes from the reading on the Sakai discussion boards. Other weeks, students will be given a prompt such as: writing a monologue, researching videos on the web and posting and responding to them, writing an Op-ED piece for the DTH, responding to our experiences in the schools etc. Specific prompts will be given out on a weekly basis.

Reflection Papers (2 papers x 150 points each) These will be 3-5 page papers that give students an opportunity to reflect upon topics we address in class and experiences that arise from our work. The theme for each reflection paper will be decided and a detailed description of each assignment will be posted on Sakai.

1. CRTICIAL ANALYSIS OF INTENSIVE
2. ON SERVICE LEARNING AND THE ETHICAL ISSUES THAT ARISE

Final Synthesis Paper (250 points): A 6-8 page synthesis paper discussing how, after the arc of the course and tour, students are making sense of discussions, readings, and practical applications of the course. (Assignment details will be posted on Sakai).

OTHER IMPORTANT INFORMATION:

Office Hours (By Appointment): We are available and want to help you any way we can. I encourage you to come see me in my office whenever you need or want to. Please email me, call me, or see me before or after class to set up a time.

Communication: If something/anything comes up, please communicate the problem/issue to me as soon as possible, and we will try to remedy the situation as best we can. But, we can't even attempt to help you if you don't talk to us and let us know!

Help with Writing and The Writing Center: I am available and willing to help you with your writing. Feel free to contact me! You are also encouraged to utilize the Writing Center on campus. They advertise: "The Writing Center is a free service available to students, faculty, and staff at UNC-Chapel Hill." Their hours are Monday-Thursday 9am-7pm and Friday 9am-4pm. They are located in the lower level of the new Student and Academic Services Building (SASB), located on the corner of Manning Drive and Ridge Road, near the Ramshead complex and the Morrison dormitory. Their phone number is (919) 962-7710 and their web address is http://www.unc.edu/depts/wcweb/

Accommodations: UNC-CH is committed to making its classes, programs and facilities accessible to students with disabilities. If you think you may require accommodations for a disability or another medical condition please contact the Department of Disability Services (DDS), located in the Student Academic Services Building (SASB), Suite 2126; 450 Ridge Road; Phone: (919) 962-8300; Website: http://disabilityservices.unc.edu or Email: disabilityservices@unc.edu

Honor Code: All students of the University of North Carolina at Chapel Hill are responsible for knowing and adhering to the Honor Code. Information on the Honor Code can be found at: http://honor.unc.edu/honor/index.html

WEEKLY SCHEDULE

Week One - Jan 11: Intro to Course + HIV/ AIDS 101 (CAPSTONE graduate students give some background on HIV/AIDS - biological, historical, sociological)

Guiding Questions: What do we know about HIV? What don't we know? (A brief review of history, biology, facts and figures.) What is the landscape of HIV in our country and in our state? What questions still remain (on a macro level and on a personal level)?

DUE before 1st day of class: FILL out the survey at the link provided to you via email / on Sakai

READING: ***(have reading completed by the first day of class)***

1. CDC fact sheet: HIV in the United States at a Glance . Centers for Disease Control and Prevention.
2. CDC fact sheet: North Carolina 2010 Profile. Centers for Disease Control and Prevention.

3. North Carolina State Report (SHARP Report): An analysis of the successes, challenges, and opportunities for improving healthcare access. (Read: Part 2.1 Overview of the HIV/AIDS epidemic in NC and Part 3.2 HIV-related stigma)
4. Whetten-Goldstein K. and Nguyen T. Q. *You're the first one I've told: New Faces of HIV in the South.* Rutgers University Press, August, 2002.(Read Chapter 2, on description of the epidemic)

ASSIGNMENTS: (***due by 5:00 on Sunday the 13th***)
Weekly Posting: After having heard the capstone students' presentation and done the readings, what burning questions remain for you? On the Sakai discussion board post: 3 urgent questions that remain for you and 3 observations that you have from the readings

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January 13-24: SCRIPT DEVISING INTENSIVE
Immediately following the Friday classroom session we will launch into the first week of the script building INTENSIVE. Over the course of the week, we will identify key sexual health topics and respond creatively to these topics with humorous, dynamic and educational skits. By the conclusion of the first week of the intensive, we will have created material for a rough first draft of a 45-minute performance piece.

Note: Any extra rehearsals needed later in the semester will be scheduled outside the regular class meeting time.

Guiding Questions: What are teenagers in this region of North Carolina learning? What are they not learning? In order to effectively use our own narratives to educate, we will hone in on what exactly makes narrative such an effective teaching tool. In other words, what "work" can stories accomplish? What can't they accomplish? And how can you use your own story to connect with an audience that has lived a different experience than you?

READING DURING THE INTENSIVE: Reading will be assigned as appropriate throughout the 2 week intensive. All readings can be found in required texts or uploaded to Sakai.

More Background and Context (HIV and Youth, HIV and the South)
- Sexual Health of Young People in the U.S. South: Challenges and Opportunities (*for reference and review*)

2 CDC Fact Sheets:
- HIV Among Youth 2011
- HIV Related Risk Among High School Students

For Presentation by HIV speakers on Jan. 17th
- HIV and African Americans in the Southern United States: Sexual Networks and Social Context

From NC Department of Public Instruction – Reproductive Health and Safety:
- Skills and Strategies for Abstinence Power Point

- Saying "No" to Pressures to Have Sex Power Point
- Abstinence Lesson Plan
- Reducing Risks for STDs: Correct and Consistent Condom Use Power Point

Scripts:
- UCLA Sex Squad – *What Would Sex Squad Do?* Script. 2012.
- Interactive Theater Carolina script from HIV/AIDS course

Reading from Course Texts: (*will be assigned during the Intensive as relevant)*
- Boal, Games for Actors and Non-Actors (Translator's Intro: pgs. Xxii-xxvii, Preface pg. 17, pgs. 241-276.)
- Rohd, Hope is vital (Preface, pgs. Xv-xix; pgs. 1-9, pg. 71-75) Rohd, Hope, "Activating Material" (pgs. 97-111)

Week ONE of Intensive
Location: Swain Hall
Sunday, Jan. 13: 5-9
Monday, Jan. 14: 6-9
Tuesday, Jan. 15: 6-9
Wednesday, Jan. 16: 6-9
Thursday, Jan. 17: 6-9

Week Two - Jan 18: CLASS DOES NOT MEET (COMP TIME) DUE TO INTENSIVE

ASSIGNMENTS: Weekly Posting (*prompt will be given out during intensive)*

Week TWO of Intensive
Location: Swain Hall
Saturday, Jan. 19: 10-4
Sunday, Jan. 20: 10-4
Monday Jan. 21: 6-9
Tuesday Jan. 22: 6-9
Wednesday, Jan. 23: 6-9
Thursday, Jan. 24: 6-9

Week Three - Jan 25: CLASS DOES NOT MEET (COMP TIME) DUE TO INTENSIVE

ASSIGNMENTS:
-Weekly Posting
-Response paper #1 guidelines will be given out.

Week Four - Feb. 1: The Artist as Activist – The Shoulders We Stand on (some more history) and Theatre for HIV

DUE: Response Paper #1
In Class: RUN and Tweak Show

Guiding Questions: Whose shoulders do we stand on in the field of applied theatre / theatre for social change? (Some of the heavy hitters.) Why are the arts a particularly effective teaching tool? And because of that, what is the role of the artist (or really artist-activist) in the fight against HIV and for sexual health? How does this work look different in different cultural and regional settings?

Critical analysis of the history of performance, humor, and narrative being used as a sexual health teaching tool. What works and why? What does not work and what caused it to fall flat?

READING DUE: *(Read or review – if already read during the intensive) – the following selections from Boal and Rohd.*

1. Boal, Games for Actors and Non-Actors (Translator's Intro: pgs. Xxii-xxvii, Preface pg. 17, pgs. 241-276.)
2. Rohd, Hope is vital (Preface, pgs. Xv-xix; pgs. 1-9, pg. 71-75) Rohd, Hope, "Activating Material" (pgs. 97-111)

Reading on Examples from the Global South

3. Durden, Emma. "Participatory HIV/AIDS Theater in South Africa" in *Acting on HIV: Using drama to create possibilities for change.* Francis D.A. (ed). Rotterdam: Sense Publishers, 2011. Pg. 1-14.

Other HIV/AIDS Theatre Reading:
Possibly: Glik et al. Youth Performing Arts: Entertainment-Education for HIV/AIDS Prevention and Health Promotion: Practice and Research. *Journal of Health Communication: international Perspectives. 2002; 7(1), 39-57.*

ASSIGNMENTS:
-Weekly posting

Week Five - Feb. 8: More on Sex / Sexuality / Stigma

In Class: Run & Tweak Show
CHECS Counselors on STI's etc.
Looking at Stigma

Guiding Questions: What other questions do we have about STD's and the complex terrain of human sexuality? What do we talk about and not talk about? What is the role of stigma in maintaining silence or opening dialogue?

READING:

1. Lorde, Audre. "Uses of the Erotic: The Erotic as Power" in *Sister Outsider: Essays and Speeches.* Crossing Press: 1984.
2. Watch UNC AIDS Course Lecture 2 (Prevention 101; Youth and Teens at Risk with Peter Leone - 1/17/2012): On-line link: http://vimeo.com/37272927

ASSIGNMENTS:
-Weekly posting

Week Six - Feb. 15: Going Out Into the Community (Service Learning and Ethical Dilemmas)

In class: Tweak and Run Show
Saturday, Feb. 16: Triangle Dance Festival for AIDS

Guiding Questions: Who are we to "help" / educate anyone? What are the inherent problems of going into a community (even with "noble intentions") as an outsider? Can theatre work to un-do some of these problems?

What is the role of critical reflection? In what ways does service learning and /or theatre reinforce the "us vs. them?" Who are "we" the performers (and how might we be "read")? Who are "they" our audiences (and how can be inclusive and inviting without reinforcing stereotypes or making assumptions?)

READING:
1. Barnes, Hazel. "Mapping Ethics in Applied Drama and Theatre" in *Acting on HIV: Using drama to create possibilities for change.* Francis D.A. (ed). Rotterdam: Sense Publishers, 2011.Pg. 131-144.
2. Bickford, Donna and Nedra Reynolds. Activism and Service-Learning: Reframing Volunteerism as Act of Dissent. *Pedagogy: Critical Approaches to Teaching Literature, Language, Composition and Culture. 2002; 2(2):229-252.*
3. Chipatiso, Remo and Eric M. Richardson. "Understanding Role in HIV/AIDS Interventions: A Case Study of Themba Interactive" in *Acting on HIV: Using drama to create possibilities for change.* Francis D.A. (ed). Rotterdam: Sense Publishers, 2011. Read Section on "Questioning" (pg. 32-34)

ASSIGNMENTS:
-Weekly posting

Week Seven - Feb. 22: PREVIEW for Stephanie Willis , CFAR staff, LGBTQ center staff and others (on campus showing for feedback)

In class:
SHOWING TO COMMUNITY + FEEDBACK - We will perform the created skits, scenes and monologues for invited guests, get their feedback, and hold a discussion about what kind of issues the show will raise for ninth graders.
VIEWING OUR WORK WITH A SOCIAL JUSTICE LENS (multiple and intersecting identities) - Our group will explore Dan Savage's *It Gets Better* campaign to understand how non-artists have been engaged to fight LGBT bullying and teen suicides. We will examine our own work to make it less hetero-normative, and revise what we've made to speak to the LGBT teen community.

SENSITIVE TOPICS ON TOUR - what to do if a HS student discloses something to you. What we can do. What we shouldn't do. (*Will be addressed more in-depth later in the course.)*

Guiding Questions: (For our invited audience). What feedback do you have for us (from the place where you "sit"? What is clear and what is less clear in our performance? What did most enjoy or least enjoy? Why? Is there something critical that we have left out?

What do we make of this feedback? How do we incorporate it (where appropriate and possible) as we continue to revise the show? How do we not personalize feedback on our creative process?

READING: *no assigned reading this week*

ASSIGNMENTS:
-Weekly posting (on the experience of the preview)
-YouTube / Google: Watch "It Gets Better" testimonials. Find one that speaks to you and post it on the discussion board. Watch another clip posted by a fellow student.

Week Eight - March 1: PREVIEW of show for Mike Irwin's class – Chapel Hill High School (w/feedback from students)

Guiding questions: Same as Week 7 – Same questions as above, asking the HS students "Does this show speak to you? In what ways? Why or why not?"

In class: After the HS preview, assess: What's working? What should we tweak?

READING: No assigned reading this week

ASSIGNMENTS:
-Weekly posting (*on experience in the school/ classroom*)

Week Nine - March 8: Begin to create Condom Skills Workshop
**NOTE- spring break starts at 5:00 pm on Friday, March 8. Students are not permitted to leave for spring break early.

In Class: Work on Condom Skills Workshop / Run Show (w/ any tweaks added from HS showing)

Guiding Questions:
Why are we still talking about condoms? Why are condoms and barrier methods important? Why do people NOT use them / not want to use them?

What do we want our condom skills workshop to look like? What do we want HS students to practice, think about, take away? What do we know now that we wished we had known in HS? How are we incorporating theatre techniques in this follow-up workshop?

READING:

1. Crosby, Richard and William Cates Jr. Condom use: Still a sexual health staple. *Sexual Health*; 2012, 9, 1-3.
2. Francis, Dennis. "Using Forum Theatre to Engage Youth in Sexuality, Relationship And HIV Education" in *Acting on HIV: Using drama to create possibilities for change.* Francis D.A. (ed). Rotterdam: Sense Publishers, 2011. Pg. 15-28.

ASSIGNMENTS:
-Weekly posting *(Prompt TBA)*
--Response paper on service-learning and ethical questions – assignment guidelines on Sakai

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Week Ten - March 15 : SPRING BREAK (*Friday March 8 - Monday March 18*)- no rehearsals, no class on Friday, March 15

Week Eleven: March 22: TOUR DATE #1 to Carrboro HS

DUE: Response Paper #2 (on service-learning and ethical)

READING: *No Reading Due*
ASSIGNMENTS:
-Weekly posting (*on experience in the school or other prompt TBA*)

Week Twelve: March 29 : Develop Condom Skills Workshop
***** NOTE: NO visits to schools on this date b/c it is a district Teacher Workday***

In-Class: Training for Follow-Up Workshops and Facilitation
If Possible: Initial Evaluation of Course Tour. Now that we have performed at a school, let's evaluate: How was the show received by the audience(s)? What seemed to work? What didn't work as well? Where did you feel the audience engage or disengage? What feedback have we heard from the schools, students, community partners?

Guiding Questions: Same set of questions from week nine. Also address: Difference between theatre and therapy. What we can and cannot do. What we should not do. What to do if a student discloses anything that requires reporting by law?

What makes a good facilitator?

READING: Rohd, Hope is Vital, pgs. 112-140 (Chapters on Facilitation and Peer Education). Review mandated reporting policy on Sakai.

ASSIGNMENTS: Weekly posting (*prompt TBA*)

Week Thirteen: April 5: Run-through show with Notes/ Rehearse Teams for Condom Skills Workshop

In-Class: Rehearse Workshop and Facilitation – Final Prep for School Tour
****NOTE: NO visits to schools on this date b/c April 1-5 is the school district Spring Break**

****REQUIRED: ON-CAMPUS PERFORMANCE OF THE SHOW 7-8:00 PM (Actors call time: 6 PM)**

READING: No Reading Due
ASSIGNMENTS: Weekly Posting *(prompt TBA)*

Week Fourteen: April 12 TOUR to Carrboro High School

READING: no reading due
ASSIGNMENTS: Weekly Posting *(on experience touring in schools)*

Week 15: April 19: Return to Carrboro HS for follow-up workshops

READING: no reading due
ASSIGNMENTS: Weekly Posting *(on experience touring in schools)*

Week 16: April 26 – Return to Carrboro HS for follow-up workshops
FINAL DAY OF CLASSES AT UNC

DUE: Final Synthesis Paper
READING: no reading due
ASSIGNMENTS: Weekly Posting *(on experience touring in schools)*

B. Quantitative Survey: High School Participants

This survey asks questions about your knowledge of HIV/AIDS, sexual behavior, and use of drugs and alcohol. The information you give will be used to develop better health education about HIV/AIDS for young people like yourself.

Please do not type your name in this survey. The answers you give will be kept private. Your name and identity will never be linked to your answers or reported to your parents, teachers, or classmates. This is not a test, and there are no right or wrong answers. Your answers will not affect your grade in this class.

Completing the survey is voluntary, and you do not have to answer any question that makes you feel uncomfortable. When you are finished, tell the person who is administering the survey that you are done. To help keep your answers private, please work by yourself.

Thank you for your thoughtful responses and careful completion of this survey. We appreciate your time and effort!

Please click on the circle to the left of your choice:

Q1 HIV is the virus that leads to AIDS.
- ❍ True (1)
- ❍ False (2)
- ❍ I Don't Know (3)

Q2 HIV can be transmitted through blood.
- ❍ True (1)
- ❍ False (2)
- ❍ I Don't Know (3)

Q3 HIV can be transmitted through pre-cum.
- ❍ True (1)
- ❍ False (2)
- ❍ I Don't Know (3)

Q4 HIV can be transmitted through semen.
- ❍ True (1)
- ❍ False (2)
- ❍ I Don't Know (3)

Q5 HIV can be transmitted through vaginal fluids.
- ❍ True (1)
- ❍ False (2)
- ❍ I Don't Know (3)

Q6 HIV can be transmitted through breast milk.
- ❍ True (1)
- ❍ False (2)
- ❍ I Don't Know (3)

Q7 HIV can be transmitted through saliva.
- ❍ True (1)
- ❍ False (2)
- ❍ I Don't Know (3)

Q8 HIV can be transmitted through touching.
- ❍ True (1)
- ❍ False (2)
- ❍ I Don't Know (3)

Q9 HIV can be prevented by wearing a condom during sex.
- ❍ True (1)
- ❍ False (2)
- ❍ I Don't Know (3)

Q10 I know where to get an HIV test.
- ❍ True (1)
- ❍ False (2)

Q11 Please click the circle below that is closest to how you feel now:

	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)
I feel comfortable discussing HIV/AIDS with my peers. (1)	❍	❍	❍	❍
I am informed about how HIV/AIDS affects people in other parts of the world. (2)	❍	❍	❍	❍
I am familiar with how I can affect international HIV/AIDS policy issues as a student. (3)	❍	❍	❍	❍
I understand how the United States influences international HIV/AIDS issues. (4)	❍	❍	❍	❍
I am familiar with the HIV/AIDS treatment available to people within the United States. (5)	❍	❍	❍	❍
I feel compassionate toward people with HIV/AIDS. (6)	❍	❍	❍	❍
I speak up when I hear someone tell a myth about HIV/AIDS. (7)	❍	❍	❍	❍

The next questions ask about HIV and sexual behavior. Please click on the circle to the left of your choice:

Q12 Have you ever been taught about HIV or AIDS in school?
- Yes (1)
- No (2)
- I Don't Know (3)

Q13 Have you ever taken an HIV test?
- Yes (1)
- No (2)
- I Don't Know (3)

Q14 Have you ever met someone who has HIV/AIDS?
- Yes (1)
- No (2)
- I Don't Know (3)

For the purpose of this survey, "sexual intercourse" is defined as having oral, anal, or vaginal sex.

Q15 Have you ever had sexual intercourse?
- Yes (1)
- No (2)
- I Don't Know (3)

SKIP PATTERN Answer If "Have you ever had sexual intercourse?" Yes Is Selected

Q16 How old were you when you had sexual intercourse for the first time?
- 11 years old or younger (1)
- 12 years old (2)
- 13 years old (3)
- 14 years old (4)
- 15 years old (5)
- 16 years old (6)
- 17 years old or older (7)

SKIP PATTERN Answer If "Have you ever had sexual intercourse?" Yes Is Selected

Q17 During your life, with how many people have you had sexual intercourse?
- ❍ 1 person (1)
- ❍ 2 people (2)
- ❍ 3 people (3)
- ❍ 4 or more people (4)

SKIP PATTERN Answer If "Have you ever had sexual intercourse?" Yes Is Selected

Q18 The last time you had sexual intercourse, did you or your partner use a condom?
- ❍ Yes (1)
- ❍ No (2)
- ❍ I Don't Know (3)

SKIP PATTERN Answer If "Have you ever had sexual intercourse?" Yes Is Selected

Q19 The last time you had sexual intercourse, what method(s) did you or your partner use to prevent pregnancy? (Select all that apply.)
- ❑ No method was used to prevent pregnancy (1)
- ❑ Condoms (2)
- ❑ Birth control pills (3)
- ❑ An IUD (such as Mirena or ParaGard) or implant (such as Implanon) (4)
- ❑ A shot (such as Depo-Provera), patch (such as Ortho Evra), or ring (such as NuvaRing) (5)
- ❑ Withdrawal (or "pulling out") (6)
- ❑ Some other method (7)
- ❑ I am not sure (8)

SKIP PATTERN Answer If "Have you ever had sexual intercourse?" Yes Is Selected

Q20 Did you drink alcohol or use drugs before you had sexual intercourse the last time?
- ❍ Yes (1)
- ❍ No (2)

SKIP PATTERN Answer If "Have you ever had sexual intercourse?" Yes Is Selected

Q21 Please click the circle in the box below that is closest to how you feel now:

	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)
I feel confident discussing safer sex with my partner. (1)	❍	❍	❍	❍
I am likely to use a condoms or latex barriers with my partner when I have sex. (2)	❍	❍	❍	❍

Q22 Please click the circle in the box below that is closest to how you feel now:

	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)
I know at least one place in my community where I can find condoms. (1)	❍	❍	❍	❍
I am likely to take an HIV test by the end of the year. (2)	❍	❍	❍	❍

The next questions ask about drinking alcohol. This includes drinking beer, wine, wine coolers, and liquor such as rum, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of wine for religious purposes. Please click on the circle to the left of your choice:

Q23 Have you ever had a drink of alcohol, other than a few sips?

❍ Yes (1)

❍ No (2)

SKIP PATTERN Answer If "Have you ever had a drink of alcohol, other than a few sips?" Yes Is Selected

Q24 How old were you when you had your first drink of alcohol other than a few sips?
- ❍ 8 years old or younger (1)
- ❍ 9 years old (2)
- ❍ 10 years old (3)
- ❍ 11 years old (4)
- ❍ 12 years old (5)
- ❍ 13 years old (6)
- ❍ 14 years old (7)
- ❍ 15 years old (8)
- ❍ 16 years old (9)
- ❍ 17 years old or older (10)

The next questions ask about marijuana use. Marijuana also is called grass, pot or weed.

Q25 Have you ever used marijuana?
- ❍ Yes (1)
- ❍ No (2)

SKIP PATTERN Answer If "Have you ever used marijuana?" Yes Is Selected

Q26 How old were you when you tried marijuana for the first time?
- ❍ 8 years old or younger (1)
- ❍ 9 years old (2)
- ❍ 10 years old (3)
- ❍ 11 years old (4)
- ❍ 12 years old (5)
- ❍ 13 years old (6)
- ❍ 14 years old (7)
- ❍ 15 years old (8)
- ❍ 16 years old (9)
- ❍ 17 years old or older (10)

The next 3 questions ask about other drugs.

Q31 Have you ever used any form of cocaine, including powder, crack, or freebase?
- ❍ Yes (1)
- ❍ No (2)

Q28 Have you ever sniffed glue, or breathed the contents of spray cans, or inhaled any paints or sprays to get high?
- ❍ Yes (1)
- ❍ No (2)

Q29 Have you ever used steroid pills or shots without a doctor's prescription?
- ❍ Yes (1)
- ❍ No (2)

Q30 During your life, how many times have you used a needle to inject any illegal drugs?
- ❍ Never (1)
- ❍ 1 time (2)
- ❍ 2 or more times (3)

The last five questions provide us with demographic information. Please click on the circle to the left of your choice:

Q31 What is your race? Select one or more responses.
- ❑ American Indian or Alaska Native (1)
- ❑ Asian (2)
- ❑ Black or African American (3)
- ❑ Native Hawaiian or Other Pacific Islander (4)
- ❑ White or Caucasian (5)
- ❑ Other (6)

SKIP PATTERN Answer If "What is your race? Select one or more responses." Other Is Selected

Q32 What is your "other" race? Please describe.

Q33 Are you Hispanic or Latino/a?
- ❍ Yes (1)
- ❍ No (2)

Q34 How do you describe your sex?
- ❍ Male (1)
- ❍ Female (2)
- ❍ Transgender, female to male (3)
- ❍ Transgender, male to female (4)
- ❍ Refuse to answer (5)

Q35 How do you describe your sexual orientation?

- ❍ Straight/heterosexual (1)
- ❍ Bisexual (2)
- ❍ Gay/homosexual (3)
- ❍ Lesbian (4)
- ❍ Other (5)
- ❍ Refuse to answer (6)

SKIP PATTERN Answer If "How do you describe your sexual orientation?" Other Is Selected

Q36 What is your "other" sexual orientation? Please describe.

Q41 Do you receive or qualify for Free Lunch or Reduced Lunch at your school?

- ❍ Yes (1)
- ❍ No (2)
- ❍ I Don't Know (3)

Finally, we'd like to ask you a few questions that will help us create a special code for your survey. This code will be used to tell your survey apart from everyone else's without having to know your name, address, or other information that would give away who you are.

Q42 What is the FIRST LETTER of your street name? For example, if your street name is Willow, then you will write "W". If your street name is a number, such as 33rd Ave, you would spell out thirty-third and write "T".

Q43 What are the first TWO DIGITS of your home address? For example, if your address is 123 Willow St. you will write, "12".

Q44 What is the TWO DIGIT NUMBER that describes your birth order? For example, if you are the third born in your family, then you will write, "03".

C. Open Ended Survey: Undergraduate Participants

Instructions

Please take a few quiet minutes to provide answers to the following questions. Do not write your name on this form. Instead, when you've completed all of the questions, fold the form, place it in the attached envelope and seal it. You should return the envelope to the Sex-Ed Squad classroom where it will be collected without being opened. Your responses will be transcribed by a third party so that your handwriting is not identifiable and then your responses will be shared anonymously with the Sex-Ed Squad program leaders in order to inform the training process throughout the semester.

Please do not write your name or provide any other identifying information on this survey. The answers you give will be kept private. Your name and identity will never be linked to your answers or reported to your teachers or classmates. Your answers will not affect your grade in this class. Answering the questions is voluntary, and you do not have to answer any question that makes you feel uncomfortable.

Thank you for your thoughtful responses. We appreciate your time and effort!

Questions for Survey 1

1. Have you ever been tested for HIV? STIs? Why or why not?
2. Do you know your HIV status currently?
3. What do you talk about with your partner before a sexual experience?
4. Have you ever had sex without a condom? If so, was it with a main partner or a casual partner?
5. In the last 3 months have you had sex? If so, was it with a main partner or a casual partner? Did you use a condom?
6. How would you rate your sexual health knowledge on a scale from 1-7 with 1 indicating very little knowledge and 7 indicating very extensive knowledge. Comment on your response.
7. Do your friends ask you questions about sex, or sexual health?
8. How good are you at thinking clearly when you're turned on? Comment on your response.
9. How would you rate your ability to speak up for yourself about your sexual health on a scale of 1-7 with 1 indicating very little ability and 7 indicating very high ability. Comment on your response.
10. What does joining this group mean to you?

Questions for Survey 2

1. Since you became a member of the UNC Sex-Ed Squad have you been tested for HIV? STIs? Why or why not?
2. Do you know your HIV status currently?

3. What do you talk about with your partner before a sexual experience?
4. Since becoming a member of the UNC Sex-Ed Squad have you had sex? If so, was it with a main partner or a casual partner? Did you use a condom?
5. Since becoming a member of the UNC Sex-Ed Squad have you had sex without a condom? If so, was it with a main partner or a casual partner?
6. How would you rate your sexual health knowledge on a scale from 1-7 with 1 indicating very little knowledge and 7 indicating very extensive knowledge. Comment on your response.
7. Since becoming a member of the UNC Sex-Ed Squad have your friends asked you questions about sex or sexual health?
8. Has anything changed about your communication with sexual partners since becoming a member of the UNC Sex-Ed Squad? If so, what?
9. How would you rate your ability to speak up for yourself about your sexual health on a scale of 1-7 with 1 indicating very little ability and 7 indicating very high ability. Comment on your response.
10. What does being a member of the Sex Squad mean to you?

Questions for Survey 3

1. Since you became a member of the UNC Sex-Ed Squad have you been tested for HIV? STIs? Why or why not?
2. Do you know your HIV status currently?
3. Since becoming a member of the UNC Sex-Ed Squad have you had sex? If so, was it with a main partner or a casual partner? Did you use a condom?
4. Since becoming a member of the UNC Sex-Ed Squad have you had sex without a condom? If so, was it with a main partner or a casual partner?
5. If you are sexually active what do you talk about with your partner before a sexual experience?
6. At this point in time how would you rate your sexual health knowledge on a scale from 1-7 with 1 indicating very little knowledge and 7 indicating very extensive knowledge. Comment on your response.
7. Since becoming a member of the UNC Sex-Ed Squad have your friends asked you questions about sex or sexual health?
8. Has anything changed about your communication with sexual partners, or the way you may communicate in the future, since becoming a member of the UNC Sex-Ed Squad? If so, what?
9. At this point in time how would you rate your ability to speak up for yourself about your sexual health on a scale of 1-7 with 1 indicating very little ability and 7 indicating very high ability. Comment on your response.
10. After taking the class, what does being a member of the Sex Squad mean to you?
11. This is the final question in this survey. What are some elements of the course that did not work well for you? What would you change?

D. Focus Group Guide: High School Participants

Introduction

The goal of this focus group is to have an open and honest discussion about the ___ (*UNC Sex-Ed Squad Performance/Positively Speaking/Condom Negotiation Workshop*) you saw ___ (*today, last week, etc.*). Your participation in this activity is completely voluntary. Whether or not you choose to participate will not affect your grade in this class.

Has anyone here ever participated in a focus group? Let me tell you a little more about how it works. A focus group is a type of research in which a group of people are asked about their perceptions and attitudes toward a program or idea. I'll ask several questions to facilitate our discussion, but you should feel free interact and respond to each other too. Remember that there is no right or wrong answer, and it's ok to disagree or to have different opinions. Does anyone have questions?

I also want to let you know that I am recording this focus group. However, your responses will be used only for research purposes, and any transcripts of the recording will not include your name. Your responses may be shared with parents, teachers, and administrators, but they will not hear the recording and your name will not be connected with anything you say. Does anyone have questions? Ok, let's get started!

Session 1: UNC Sex-Ed Squad Performance

1. What did you like most about the performance?
2. What did you like least about the performance?
    a. What could the actors have done better?
    b. Did any of the topics covered in the performance make you feel uncomfortable?
3. What are the main take-away messages that you remember from the Sex-Ed Squad performance?
4. Do you think it is important to talk about HIV at your school? Why or why not?
5. Could you relate to any of actors or situations in the performance? Which ones? In what ways?
6. Did you talk with anyone about the performance?
    a. Who did you talk to? (Friends, parents, teachers, siblings, etc.)
    b. If so, what did you talk about?
    c. If not, why?
7. We're almost out of time, but I'd like to be sure we've covered everything you want to talk about. Would anyone like to share anything else about the Sex-Ed Squad performance?

Session 2: HIV-positive Speakers

1. Before you heard the speakers, what are some words that you might have associated with someone who is HIV positive?
    a. After participating in Positively Speaking, have any of those words changed?
    b. Now what words do you associate with someone who is HIV positive?
    c. Can you tell me more about why those words have changed?

2. What stories do you remember most from the person you met?
    a. How did his/her story make you feel?
3. Before the panel, had you met someone living with HIV?
    a. If so, can you tell me more about that experience?
    b. If not, how do you think you might have reacted?
4. Did you talk with anyone about the HIV-positive speakers?
    a. Who did you talk to? (Friends, parents, teachers, siblings, etc.)
    b. If so, what did you talk about?
    c. If not, why?
5. Do you think it is important to talk about HIV at your school? Why or why not?
6. We're almost out of time, but I'd like to be sure we've covered everything you want to talk about. Would anyone like to share anything else about the HIV-positive speakers?

Session 3: Condom Skills Workshop

1. What did you like most about the workshop?
2. What did you like least about the workshop?
    a. What could the presenters have done better?
3. What did you learn at the condom skills workshop?
    a. Did you already know how to use a condom? If so, how did you learn?
    b. What do you think is the best way to learn about how to use a condom?
4. Do you have any concerns about using a condom in the future?
5. What did you learn about how to communicate with a partner about using a condom?
6. Are there any condom skills that weren't covered in the workshop?
7. Do you think it is important to talk about condom skills at your school? Why or why not?
8. We're almost out of time, but I'd like to be sure we've covered everything you want to talk about. Would anyone like to share anything else about the Condom Skills Workshop?

Session 4: Overall Program Feedback

1. What connections did you see between the UNC Sex-Ed Squad Performance, the HIV-positive speakers, and Condom Skills Workshop?
    a. Were you aware that they are part of the same program?
2. What was most memorable aspect of these three presentations for you?
3. What is the most important thing you learned in these three presentations?
4. Is there anything that you would change about these presentations in the future?
    a. What would you delete?
    b. What would you add?
5. We're almost out of time, but I'd like to be sure we've covered everything you want to talk about. Would anyone like to share anything else?

E. Focus Group Guide: Undergraduate Participants

Focus Group #1: Introduction

The goal of this focus group is to have an open and honest discussion about what brought you to the Sex-Ed Squad Program, what you'd like to gain from the program throughout the course of the quarter, and how you're thinking about sexual health and sexual health programming prior to engaging in the Sex-Ed Squad performance development process. Your participation in this activity is completely voluntary. Whether or not you choose to participate will not affect your grade in this class.

Has anyone here ever participated in a focus group? Let me tell you a little more about how it works. A focus group is a type of research in which a group of people are asked about their perceptions and attitudes toward a program or idea. I'll ask several questions to facilitate our discussion, but you should feel free interact and respond to each other too. Remember that there is no right or wrong answer, and it's ok to disagree or to have different opinions.

I'd like to ask you to keep confidential all information that you are about to hear from your peers in this group today. We will be using a recorder to make sure we hear and record all your responses. However, your responses will be used only for research purposes, and any transcripts of the recording will not include your name. All of your responses will be anonymous (i.e., no names will be recorded or linked to any of the responses to my questions) – we are interested in what the entire group has to say. Your responses may be shared with parents, teachers, and administrators, but they will not hear the recording and your name will not be connected with anything you say. Before we start, do you have any questions? Ok, let's get started!

Focus Group #1: Questions

1) What were your reasons for wanting to join the UNC Sex-Ed Squad?
2) Are there any other reasons that you know of why students join the UNC Sex-Ed Squad?
3) What are you excited about? What are you nervous about?
4) What are the content areas that you feel most comfortable talking about with your peers and with high school students?
5) What are the content areas in which you feel that you could use additional information, support, etc?
6) Are there any content areas that you feel uncomfortable or anxious talking about with your peers and/or high school students? If so, what are they? What would help you feel more comfortable with these content areas?
7) If you think back to when you were a high school student, what are the things about sex that you wish you had been told?
8) How would you describe your knowledge about sexual health issues?
9) Were any of you part of a sexual health promotion program, like the UNC Sex-Ed Squad, in high school? If so, what was your experience like?
10) What do you hope to gain by being a member of the UNC Sex-Ed Squad?
11) This concludes our conversation. Are there any other things that you would like to mention or say about the questions you were asked or about the study in general?

Focus Group #2: Introduction

Hello again! Our discussion today is meant to be a continuation of the informal conversation we began at the beginning of the school year. Today our focus group is going to center on your experiences since becoming a member of the Sex Ed Squad. Your participation in this activity is completely voluntary. Whether or not you choose to participate will not affect your grade in this class.

Just like last time I'll ask several questions to facilitate our discussion, but you should feel free interact and respond to each other too. Remember that there is no right or wrong answer, and it's ok to disagree or to have different opinions. I would also ask all of us to refrain from offering advice or from trying to convince others to agree with our opinions or views.

I'd like to ask you to keep confidential all information that you are about to hear from your peers in this group today. We will be using a recorder to make sure we hear and record all your responses. However, your responses will be used only for research purposes, and any transcripts of the recording will not include your name. All of your responses will be anonymous (i.e., no names will be recorded or linked to any of the responses to my questions) – we are interested in what the entire group has to say. Your responses may be shared with parents, teachers, and administrators, but they will not hear the recording and your name will not be connected with anything you say. Before we start, do you have any questions? Ok, let's get started!

Focus Group #2: Questions

1) What are you most enjoying about being part of the UNC Sex-Ed Squad this semester?
2) What has been the most challenging part of being a member of the UNC Sex-Ed Squad this semester?
3) What are the content areas that you feel were most beneficial to you personally? Why?
4) How did you feel about your first showing? What worked? What would you like to do differently going forward?
5) What changes have you noticed in yourself as a result of being a member of the UNC Sex-Ed Squad this semester?
6) What changes have you noticed in your peers as a result of being a member of UNC Sex-Ed Squad this semester?
7) Have you changed any of your own sexual behaviors over the course of the semester?
8) How would you describe your knowledge about sexual health issues?
9) How would you describe your comfort talking about sexual health issues with your peers?
10) How did you feel about the performance in the Triangle Dance Festival for AIDS? What worked? What would you like to do differently going forward?
11) What do you hope to gain by bringing the performance and workshops into high schools later this semester?
12) This concludes our conversation. Are there any other things that you would like to mention or say about the questions you were asked or about the study in general?

Focus Group #3: Introduction

Hello again! Our discussion today is the third and final part of the conversation we began at the beginning of the school year. Today our focus group is going to reflect on the Sex Ed Squad experience. Your participation in this activity is completely voluntary. Whether or not you choose to participate will not affect your grade in this class.

Just like last time I'll ask several questions to facilitate our discussion, but you should feel free interact and respond to each other too. Remember that there is no right or wrong answer, and it's ok to disagree or to have different opinions. I would also ask all of us to refrain from offering advice or from trying to convince others to agree with our opinions or views.

I'd like to ask you to keep confidential all information that you are about to hear from your peers in this group today. We will be using a recorder to make sure we hear and record all your responses. However, your responses will be used only for research purposes, and any transcripts of the recording will not include your name. All of your responses will be anonymous (i.e., no names will be recorded or linked to any of the responses to my questions) – we are interested in what the entire group has to say. Your responses may be shared with parents, teachers, and administrators, but they will not hear the recording and your name will not be connected with anything you say. Before we start, do you have any questions? Ok, let's get started!

Focus Group #3: Questions

1) Reflecting back on the semester, what did you enjoy about being part of the UNC Sex-Ed Squad?
2) What was the most challenging part of being a member of the UNC Sex-Ed Squad this semester?
3) What are the content areas that you feel were most beneficial to you personally?
4) What changes have you noticed in yourself as a result of being a member of the UNC Sex-Ed Squad?
5) What changes have you noticed in your peers as a result of being a member of the UNC Sex-Ed Squad?
6) Have you changed any of your own sexual behaviors over the course of the semester?
7) How would you describe your knowledge about sexual health issues?
8) How would you describe your comfort talking about sexual health issues with your peers?
9) What did you most enjoying about bringing the UNC Sex –Ed Squad to high schools this semester?
10) What was the most challenging part about bringing the UNC Sex –Ed Squad to high schools this semester?
11) If you could change any part of the program – the course itself or the intervention – what would you change and why?
12) This concludes our conversation. Are there any other things that you would like to mention or say about the questions you were asked or about the study in general?

F. In Depth Interview Guide: High School Health Teachers

Demographics Questionnaire

We are collecting demographic data to report in the aggregate but your individual responses will not be associated with this data.

Gender: _____

Race: _____

Years taught (any subject, any district):_____

Years taught (health): _____

Years taught (in district): _____

Have you taught outside of North Carolina?

___Yes ____No

If yes, please list other states:_____

In North Carolina, have you taught outside of Chapel Hill-Carrboro City Schools?

___Yes ___No

If yes, please list other districts:_____

Introduction

The goal of this interview is to better understand your perspectives on what aspects of *AMP!* worked well, what aspects did not work well, and how the intervention can be modified or improved. We are also interested in what impact *AMP!* may have on your own motivation to teach sexual/reproductive health in an innovative manner. Your participation in this interview is completely voluntary, and all information will be de-identified and kept confidential.

We will be using a recorder to make sure we hear and record all your responses. However, your responses will be used only for research purposes, and any transcripts of the recording will not include your name. Your responses may be shared with parents, teachers, and administrators, but they will not hear the recording and your name will not be connected with anything you say. Before we start, do you have any questions?

Ok, let's get started!

Questions

Teaching background

1. Can you tell me a little bit about your professional background and role?
2. What have been some experiences that helped prepare you for teaching health?

3. I'd like to learn about your experience in teaching the reproductive health and safety unit.
    a. Why do you think teaching these topics are important for youth today?
    b. What kinds of challenges do your students face that are relevant to this unit?
    c. What are the most challenging topics to teach in this unit? Why?
    d. What factors would make teaching these topics easier? (probe: parent support, more time, district support).
    e. What material do you enjoy teaching? Why?
    f. When do you observe your students most engaged? Most uncomfortable?

I'd like to hear about your thoughts on the content and impact of the *AMP!* program.

4. Please describe your response to the performance. The follow up workshop? The HIV + Speakers? (probe for "appropriate vs. inappropriate")
5. What aspects of *AMP!* worked well? What was your favorite moment?
6. What kinds of responses have you observed from the students who have seen the *AMP!* performances?
7. What kinds of responses, if any, have you had from parents regarding *AMP!* activities?
8. What have you told others (teachers, parents, others) about *AMP!*?
9. What were the key messages that you think students will take away?
10. What were the key messages you took away?
11. Did the *AMP!* program influence your teaching for the unit? If so, how? If not, what kind of support would be useful in teaching the unit?
12. In what ways could the AMP! program be improved to better support the curriculum? To impact student learning?
13. Is *AMP!* appropriate for the school setting? If yes, why? If no, why and what other setting(s) do you think would be more appropriate?

I'd like to hear your thoughts on some of the facilitators and challenges of implementing a program like *AMP!* in the school setting.

14. What kinds of challenges or barriers did you experience in planning the logistics for *AMP!*?
15. What kinds of challenges or barriers did you experience in regards to implementing *AMP!* in the high school?
16. If you could change any part of the *AMP!* activities (performance, follow up workshop, HIV + Speakers), what would you change and why?
17. How do you think your colleagues in other high schools in the district would view this program?

I'd like to hear how you think *AMP!* would be received in other districts where you have taught.

18. How do you think health teachers in other districts would perceive *AMP!*?
19. How do you think *AMP!* could be adapted to meet other districts' needs?

Is there anything you'd like to add that we have not yet discussed?

G. In Depth Interview Guide: Key Stakeholders

Introduction

The goal of this interview is to better understand your perspectives on what aspects of *AMP!* worked well, what aspects did not work well, and how the intervention can be modified or improved.

We will be using a recorder to make sure we hear and record all your responses. However, your responses will be used only for research purposes, and any transcripts of the recording will not include your name. Your responses may be shared with parents, teachers, and administrators, but they will not hear the recording and your name will not be connected with anything you say. Before we start, do you have any questions?

Ok, let's get started!

Questions

1. Can you tell me a little bit about your professional background and role?
2. How did you get involved with *AMP!*?
3. In what ways does the *AMP!* program support the district's goals for teaching about sexual health?
4. Is *AMP!* appropriate for the school setting? If yes, why? If no, why and what other setting(s) do you think would be more appropriate?

Tell me a little bit about your thoughts on the *AMP!* program

5. Please describe your reactions when viewing the performance? The follow up workshop? The HIV + Speakers? (if applicable)
6. What were the key messages you took away?
7. From your perspective, what aspects of *AMP!* worked well? What was your favorite moment?
8. What kinds of responses have you observed from audiences who have seen the *AMP!* performances?
9. What were the key messages that you think students will take away?
10. What were the key messages that you think teachers will take away?
11. If you could change any part of the *AMP!* activities (performance, follow up workshop, HIV + Speakers), what would you change and why?
12. In what ways could the *AMP!* program enhance its approach to better support the curriculum? Impact learning of students?

Tell me a little bit about challenges that have come up in your work with *AMP!*

13. What kinds of challenges or barriers did you experience in planning the logistics for *AMP!*?
14. What kinds of challenges or barriers did you experience in regards to the performance itself?
15. What kinds of challenges or barriers did you experience in regards to implementing *AMP!* in the high schools?
16. Overall what did not work well or could be improved? How could it be improved?

Program Sustainability

17. What do you think are the key components to developing strong relationships with community partners?
    a. What kinds of things are helpful when working with universities?
    b. What kinds of things are helpful when working with high schools?
18. How do you think health teachers in other high schools in the district would view this program?
19. How do you think *AMP!* could be improved to meet your district's needs?
20. How do you think *AMP!* would be received in other districts?
    a. What kinds of barriers do you anticipate the program would face?
    b. How do you think colleagues in other districts would perceive *AMP!*?
21. How do you think *AMP!* could be adapted to meet other districts' needs?
22. What would you like to see from *AMP!* in the future?
23. Is there anything else you would like to add?

Additional questions for Course Instructor

24. How does your previous theater experience connect to your experience with *AMP!*?
25. Can you talk about what the process of developing the performance and workshops is like?
26. How do you think the *AMP!* components were received in the high school?
27. How would you describe the experience of teaching the Sex Ed Squad?
    a. What kinds of changes have you noticed in the students?
    b. What kinds of students are interested in being in the Sex Ed Squad?