Hip Hop and Health Project

Evaluation Report

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Contents

Executive Summary

This report summarises the findings of the evaluation of the *Hip Hop and Health Project* (HHHP)[1].

The project aimed to reduce the risk of transmission of BBV and STI amongst young people of African and Arabic-speaking backgrounds.

The *Hip Hop and Health Project* (HHHP) was conducted by the Multicultural Health and Support Service (MHSS), a program of the Centre for Culture, Ethnicity and Health, in partnership with the Anti-Racism Action Band (A.R.A.B.), a program of Victorian Arabic Social Services. The HHHP was funded through the Health Promotion Funding Initiative of the Department of Human Services.

The project aimed to reduce the risk of transmission of blood-borne viruses (BBV) and sexually transmissible infections (STI) amongst African and Arabic-speaking young people by increasing their knowledge of these conditions and promoting preventative behaviours. It intended to achieve this aim through the provision of interactive workshops and outreach support.

Health education sessions were conducted by the HHHP male community worker and an MHSS female community worker. These sessions covered basic information about STI and BBV, how to practice safe sex, where to get tested and some information on treatment. Each session was followed by a performance by A.R.A.B. that included beat boxing and dancing.

The project evaluation was conducted between March and June 2008 by independent evaluator Cara Brough. It included both impact and process elements and two key questions were asked:

I. Did the project meet its objectives?
II. Were the strategies implemented effective in meeting these objectives?

Hip hop was an effective medium for the delivery of sensitive information to the target groups.

The project successfully met both its objectives: 13 workshops were provided with young people from a range of African and Arabic-speaking backgrounds, and outreach services were provided to more than 100 young people.

Some of the key learnings were that hip hop is an effective medium for the delivery of sensitive information but the material performed needs to be culturally appropriate to the target group. Time is needed to engage with African and Arabic-speaking communities, and outreach activities are most effective when rapport and trust are first established with target groups.

[1] Known previously as *Rapping and Beat Boxing on HIV and STI: An educational and outreach support project for African and Arabic-speaking young people*

It is recommended that the Department of Human Service continues to fund the HHHP as an ongoing activity.

If the project is re-funded, it is recommended that MHSS adapt the program structure to incorporate key learnings, including:

- Prioritising under-represented communities
- Developing a strategy to increase the participation of young women in performances and outreach work
- Market-testing the content of workshop performances and education sessions with young people from target groups
- Involving young people from target groups in the Reference Group, and using the group to resolve issues as they arise
- Expanding the peer education component and training more young people to be peer educators
- Exploring a range of options to make the workshop schedule fit into existing youth programs and events

Introduction

The *Hip Hop and Health Project* (HHHP) was conducted by the Multicultural Health and Support Service (MHSS), a program of the Centre for Culture, Ethnicity and Health, in partnership with the Anti-Racism Action Band (A.R.A.B.), a program of Victorian Arabic Social Services. The HHHP was funded through the Health Promotion Funding Initiative of the Department of Human Services.

The project aimed to reduce the risk of transmission of blood-borne viruses (BBV) and sexually transmissible infections (STI) among African and Arabic-speaking young people, by increasing knowledge of these conditions and promoting preventative behaviours.

The project had two objectives: providing interactive workshops using principles of peer education; and providing outreach support to the target population.

This aim would be achieved through:

- The provision of interactive workshops about BBV and STI that utilise the principles of both peer education (communicated through hip hop) and adult learning
- The provision of outreach support to the target population to assist them to access appropriate information, prevention, testing and treatment services

The HHHP was evaluated between March and June 2008 by independent evaluator Cara Brough.

The evaluation combined elements of an ***impact*** evaluation (evaluating objectives and impacts) and a ***process*** evaluation (evaluating the strategies and interventions used).

Key evaluation questions

The key *process* evaluation questions were:

Reach[2]

1. Did the project achieve its intended reach?

2. Were the groups and individuals accessing the program representative of the target population?

Quality and appropriateness

3. Were the workshops culturally, gender and age appropriate to the participants and the target population?

[2] The number, proportion and representation of individuals who participated in the project

Partnerships and collaboration

4. How did the project partnerships and interagency collaborations contribute to achieving the project's objectives?

The key *impact* evaluation questions were:

5. Did the program achieve its intended impact of:
    - Increasing the knowledge of BBV/STI and the intention to practice preventative behaviours within the target group?
    - Increasing access for the target group to appropriate information, prevention, testing and treatment services?
6. What were the barriers and enablers to achieving these impacts?
7. How did the mode of delivery contribute to promoting the intended knowledge and behaviours?

This evaluation includes both **impact** and **process** elements.

For more information on the evaluation framework see Appendix 1.

Data collection

Data for the evaluation was gained from the following sources:

- Individual and/or group interviews with project staff (A.R.A.B. and MHSS), participants, performers, the project's Reference Group members, and workers from organisations for whom the HHHP workshops were conducted
- Pre-workshop and post-workshop questionnaires (see Appendix 2) that tested participants' learning and attitudes
- Project reports and data
- Observation by the evaluator

Structure of this report

The following report is divided into five sections:

1. Program Description
2. Process Evaluation
3. Impact Evaluation
4. Project Learnings
5. Recommendations

Section 1: Program Description

1.1 Target population, objectives and impacts

Target Population
African and Arabic-speaking young people under the age of 25, with a focus on recent arrivals[3] to Australia, including both young people who attend secondary school and those who have left the education system

Objective 1
To increase the knowledge of BBV/STI and promote preventative behaviours amongst the target population, through the provision of interactive workshops that utilise the principles of both peer education (communicated through hip hop) and adult learning.

Impact
Increased knowledge of BBV/STI and intention to practice preventative behaviours amongst the target population

Intended Outputs
- 12-16 workshops[4] delivered to the target population, with 10-25 participants per workshop
- Four of these workshops delivered in regional or rural areas with a high number of African and Arabic-speaking migrants and refugees

Objective 2
To support the target population to access appropriate information, prevention, testing and treatment services through the provision of outreach services

Impact
Increased access for the target group to appropriate information, prevention, testing and treatment services

Intended output
Outreach support provided to 15 young people to access appropriate information, prevention, testing and treatment services

The project targeted African and Arabic-speaking young people under the age of 25, with a focus on recent arrivals.

[3] The Australian government defines 'newly arrived' as someone who has arrived in Australia in the previous five years. This five-year period is considered by the Australian government as the length of time it takes someone to effectively resettle in Australia. However, many workers who work with migrants and refugees have argued that it can take up to ten years for certain individuals and groups of migrants and refugees to effectively resettle.
[4] A HHHP workshop includes a beat box and dance performance as well as a health education session.

1.2 Program development and operation

This sub-section describes the program and its development. Analysis of the program is provided in sections 2 and 3.

The Multicultural Health and Support Service (MHSS), in partnership with the Anti-Racism Action Band (A.R.A.B.), applied for funding for the HHHP through the Health Promotion Funding Initiative of the Department of Human Services (DHS) in 2007.

The project utilised a community youth worker to deliver the workshops and provide outreach support.

MHSS and A.R.A.B. had previously collaborated on a number of workshops delivered to newly-arrived young people. Background information on the project partners can be found in Appendix 3.

DHS provided program funding to MHSS to conduct the HHHP for a 12-month period. The program commenced in July 2007 and was completed in July 2008. A.R.A.B. was sub-contracted by MHSS to collaborate on the design and delivery of the workshops.

MHSS employed a full-time community youth worker to:

- work with A.R.A.B. to design and deliver the *Hip Hop and Health* workshops
- provide outreach support to African and Arabic-speaking young people
- promote the workshop and identify and develop workshop opportunities

A Reference Group made up of project partners was also established to:

A reference group was created to provide advice and feedback, and to help promote the project.

- provide relevant information, advice and support
- receive reports on the project and provide feedback on their contents
- remain updated about the developments and activities of the project so that timely and informed decisions can be made when required
- assist in the promotion of the project and its achievements within each reference group member's networks or whenever other opportunities arise
- assist in monitoring the projected timeframes of the project
- ensure that processes were ethical and transparent at all times.

Workshop development

MHSS designed the health education component of the workshop. A health education session was then conducted for A.R.A.B. performers and project staff, to give the performers a context from which to develop the beat boxing and dance performance that would feature in the workshops. This session provided an excellent stimulus for the creative development process.

A.R.A.B. then developed a performance that conveyed, through dance and beat boxing:

- information on BBV and STI
- the importance of practicing safe sex
- the importance of looking after, and taking responsibility for, one's own sexual health and the sexual health of others
- the importance of accessing treatment and testing services

The project's Reference Group provided A.R.A.B. with feedback on the performance, which was then adapted accordingly. This feedback process is discussed further in the partnerships subsection of Section 2.

After attending a health education session, A.R.A.B. performers developed a beat boxing and dance performance to convey key project messages.

Networking

In order to engage with the target group and promote the project, the HHHP community worker attended numerous community events (such as the Eid festival), built extensive networks with community organisations working with the target group, and conducted outreach activities with young people, particularly at sports events such as basketball and soccer games.

Workshop delivery

Most workshops were delivered during the second half of the project. A typical workshop began with young men and young women meeting in separate groups for a health education session.

Separate health education sessions were conducted for young men and young women. Each session was adapted to the needs of a particular group.

Health education sessions were conducted by the HHHP male community worker and an MHSS female health educator. These sessions covered basic information about STI and BBV, how to practise safe sex, where to get tested and some information on treatment. While maintaining a core content, the education sessions were adapted to meet the needs of each group; they usually involved a presentation, activities and group discussion.

Each session was followed by A.R.A.B.'s performance, which included beat boxing and a play involving a dance performance. In some of the longer sessions, A.R.A.B. involved the participants in dance or beat boxing workshops. For a better sense of the performance see the project DVD ***Hip Hop and Health: Rapping and beat boxing on BBV and STI***.

Most workshops took place as part of an existing youth program such as a homework group, youth group or sports group. Several workshops were conducted at camps for refugee young people.

Outreach

The HHHP community worker visited many different youth groups to build rapport with young people, so that targeted information on BBV/STI prevention, testing and treatment services could be disseminated.

Information pamphlets and condoms were also distributed during youth programs and activities such as soccer and basketball practice games, and homework groups. Outreach work also involved one-on-one discussions with young people and support to access services and understand information.

Section 2: Process Evaluation

The following section discusses three aspects of the strategies employed to reach the HHHP objectives: reach; quality and appropriateness; and partnerships and collaborations.

2.1 Reach

Reach is defined as the number, proportion and representativeness of individuals who participated in the project[5]. The following sub-section discusses two aspects of reach: number of participants and representativeness. An analysis of the proportion component of reach is beyond the scope of this evaluation.

Participation targets

The HHHP successfully met most of its participation targets, which were:

- 12-16 workshops, with 10-25 participants per workshop
- four workshops in regional and rural areas
- outreach support to 15 young people

Workshops

As of June 2008, the HHHP has conducted 13 workshops in metropolitan Melbourne. These workshops were attended by over 395 young people from Sudanese, Somali, Eritrean, Ethiopian, Iraqi and Afghani backgrounds. Participants ranged in age from 15-25 years.

An additional workshop was conducted in Geelong through MHSS' *Africans in Regional Victoria Project*. Due to time constraints and difficulty engaging with regional groups of young people, the project has not been able to meet all of its regional and rural targets.

A critical success factor in ensuring participation was the way in which the HHHP community worker engaged with the target group. Engagement strategies included representation at community events, building networks with community organisations that were already working with the target group, and outreach activities at sports events.

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[5] RE-AIM.org 2006, Kaiser Permanente, viewed 14 February 2006, http://www.re-aim.org

Networking to build relationships with key people in the target group was a critical factor.

The HHHP community worker found that it took a considerable amount of time (approximately six months) to build demand for the *Hip Hop and Health* workshops. To successfully promote the program, the worker needed to spend time gaining the trust of organisations and individuals working with the target community. Similarly, he found that networking to build relationships with key people in the target group was a critical factor in widening access to the target communities.

Once a few workshops had been conducted, the target communities began to promote the program themselves through word of mouth. After six months, awareness of the project had grown and by early 2008 (during the second half of the project) demand for the *Hip Hop and Health* sessions was high.

Outreach

The HHHP far exceeded its target of 15 young people for outreach support.

The HHHP community worker visited many different groups in order to build rapport with young people so that targeted information on BBV/STI prevention, testing and treatment services could be disseminated.

Outside of the *Hip Hop and Health* workshops, information pamphlets and condoms were distributed to over 100 young people during outreach activities to soccer teams in Mitcham and Coolaroo and a basketball group in Braybrook. Outreach work also involved one-on-one discussions with young people about services and BBV/STI information.

The HHHP far exceeded its target of 15 young people for outreach support.

The HHHP community worker also received five calls from young people seeking more information about STI/BBV and accompanied two young people to treatment services. Information about MHSS and the HHHP community worker's role was provided to young people in *Hip Hop and Health* workshops and outreach activities.

MHSS initially envisioned that young people would access one-on-one outreach support by calling the HHHP community worker after they had participated in a workshop, or after meeting the worker at their sports or homework group.

However, very few young people called MHSS directly; most one-on-one outreach work was facilitated through face-to-face contact.

Focus group interviews with workshop participants suggest that reasons for the low number of calls are that young people:

- are sometimes not confident to access services (GP or sexual health services) without assistance from a worker. However, if young people do need to approach a worker for assistance it is more likely to be a worker they know and trust, such as a youth group worker
- are unsure about the kind of support MHSS offers and unsure about whether their contact with MHSS will be confidential

Both the HHHP community worker and evaluator observed that young people appeared more willing to approach the HHHP community worker after several contacts (through outreach or *Hip Hop and Health* workshops) rather than after a one-off workshop. The HHHP community worker also found that young people were more likely to ask him for support in person immediately after a workshop, rather than calling him a few days later.

Representativeness

<u>Cultural, ethnic and religious differences</u>

The target group is extremely diverse, encompassing different cultures, languages and religions as well as different refugee and settlement experiences. The category 'Arabic-speaking' includes many second and third generation young people.

The HHHP targeted African and Arabic-speaking young people who were relatively recent arrivals in Australia. Participants included young people from the Sudanese, Somali, Eritrean, Ethiopian, Iraqi and Afghani communities.

The HHHP has been particularly successful in engaging Sudanese young people. Over half the workshop participants and outreach recipients were of Sudanese background.

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There are two reasons for the over-representation of Sudanese young people amongst workshop participants. First, Sudanese groups were particularly enthusiastic in their uptake of the program. Second, MHSS specifically targeted Sudanese young people as they are a very recently arrived community and, as such, are likely to be disconnected from the service system and have limited access and exposure to information about BBV and STI.

The HHHP also targeted marginalised groups within the Sudanese community, particularly young people who were not connected with the school system. To engage these people, the HHHP community worker conducted outreach at venues where they normally gathered, and worked collaboratively with other youth workers to

engage this group. Unfortunately, a camp planned with this group of young people had to be postponed due to security concerns.

One of the key learnings to arise from this part of the project is that building trust and rapport with young people who are not connected with the school system is a slow process and seeking to engage them in education sessions requires persistence over time. This kind of engagement would be suited to a project with a timeframe of more than 12 months.

Building trust with young people who are not connected with the school system is a slow process, which requires persistence over time.

It was also more difficult to engage with other sub-groups within the target population, particularly Muslim communities, although it did deliver sessions to these sub-groups. The HHHP community worker found that some community leaders and community workers connected with these harder-to-engage subgroups were often concerned about the cultural relevance of the program for their communities. As a result, the HHHP community worker needed to negotiate content and approach with community leaders and workers, a process which was successful on a number of occasions. This issue is explored in more detail under the Quality and Appropriateness sub-section on p.15.

Gender

Participation in the *Hip Hop and Health* workshops was fairly balanced in terms of gender, with only slightly more young men accessing the Hip Hop and Health workshops than young women.

The outreach component, however, mostly involved young men. This was due to more young men's activities being targeted for outreach than young women's activities, and because the HHHP community worker was male (which may have made young men more comfortable than young women in seeking one-on-one support). This issue is explored in more detail under the Quality and appropriateness sub-section on p.15.

2.2 Quality and Appropriateness

Cultural responsiveness and appropriateness

The HHHP responded effectively and creatively to the cultural diversity within its target population. The HHHP community worker and the A.R.A.B. performers and project workers were particularly flexible and skilled in adapting their approach to the nuances of each group.

The HHHP initially planned to develop a single *Hip Hop and Health* session format that would be delivered to the target population. The A.R.A.B. project workers soon realised that the sessions needed to be adapted to be responsive to the cultural and religious differences amongst the target population.

The A.R.A.B. project workers needed to ensure that community elders and workers – who often facilitated youth programs – were comfortable with the workshop material and objectives. For example, community leaders were more comfortable with material that emphasised health rather than sex, was less sexually explicit, and treated abstinence and monogamy as viable preventative behaviours.

Community leaders were often more comfortable with material that emphasised health rather than sex, and treated abstinence and monogamy as viable alternatives.

The HHHP community worker and A.R.A.B. adapted the performances and workshops to be less sexually explicit and more sensitive to the values of the particular group in question. For example, where the female protagonist in the performance pulls out a string of condoms from her pocket, the performance was altered so that she pulled out a single condom. This change was made to avoid the suggestion that 'promiscuity was the norm' amongst young people.

The HHHP community worker also found that examples used during the health education sessions needed to accord with a particular group's values and norms. For example, some groups could relate better to safe sex messages when they were discussed in the context of a long-term relationship, rather than relying on scenarios that assumed casual sex as the norm. In one session observed by the evaluator, participants told the community worker that abstinence as a protective behaviour seemed to be under-explored within the session. In this instance, the community worker was quick to respond to the values of the group and incorporated abstinence, as one option, within his examples.

Some groups could relate better to safe sex messages when they were discussed in the context of a long-term relationship, rather than relying on scenarios that assumed casual sex as the norm.

All people interviewed for the evaluation believed that it was critical that the HHHP was sensitive to the cultural nuances of each group. There was some disagreement, however, over the extent to which the content should be adapted.

If participants saw the performance in a space that was culturally relevant, felt respected by the educators and felt confident that they could challenge the values implicit in the performance, a productive dialogue would ensue.

Some interviewees believed the adaptation of some of the performance content during the project was possibly over-cautious and responsive to older people's cultural values rather than younger people's cultural values. They felt that one of the roles of performance was to push boundaries, break taboos and challenge participants and that this was central to the transformative potential of the arts.

Others believed the adaptation of content was an important measure to ensure that different communities could engage with the information. This group suggested that if participants saw the performance in a space that was culturally relevant and accessible, felt respected by the *Hip Hop and Health* educators and performers, and felt confident that they could challenge and disagree with the values implicit in the performance, a productive dialogue would ensue.

Others believed that unless the performance and health education sessions were adapted, community leaders might be unwilling to allow the HHHP any access to their youth groups.

Moreover, those who favoured adapting the performance content argued that content that offended young people risked alienating them and hence discouraging them from talking about sexual health issues and accessing MHSS services. One worker gave an example in support of this view: *"When the sexually explicit aspect of the performance started after a basketball game* [which involved Sudanese young people] a *whole group of Somalis* [also attending the basketball game] *just walked out"*.

This difference of opinion was not a source of conflict within the HHHP. Most people interviewed by the evaluator raised it as an issue that might need further exploration should the project continue. All those interviewed agreed that the only way to test these different views was to market test the material with the young people in question. Market tests were originally planned with different groups of young people, but time restraints prevented this from happening. The material had limited testing with older members of different communities who supported the view that it should be adapted.

From the evaluator's perspective, this difference of opinion was productive because it occurred between people who have extensive experience working cross-culturally. In part, it arose from the different ways in which the primary health sector and the community arts sector see the value and purpose of their work, and will continue to form the basis of a productive dialogue should the project continue.

Gender

The HHHP employed several strategies to respond to gender differences.

One of these was to conduct single-gender health education sessions. These single-gender groups created an environment in which participants were comfortable asking questions and discussing issues.

Single-gender groups created an environment where participants were comfortable asking sensitive questions and discussing issues.

In one session observed by the evaluator, both young men and young women participated in a joint health education session because the female health educator was unavailable. In this session the young men talked frequently but the young women said very little. This was in sharp contrast to the lively discussions the evaluator witnessed in a women-only session. However, an interesting exchange did take place in this mixed gender session. Several young men raised a concern that if they suggested wearing a condom or getting tested within the context of a monogamous relationship, they would risk offending their girlfriends. Most of the young men agreed that in this situation young women would view testing and safe sex negatively. At one stage, a young woman interjected and said precisely the opposite; that young women would be happy to use condoms particularly because they had the added benefit of contraception. This young woman also added that she thought young women were just as concerned about STI/BBV as young men.

The evaluator related the above story to a group of young men at a later date, together with another story from a young women's focus group in which participants thought that it was young men who were resistant to safe sex practices. Apart from finding the story particularly funny, the young men were interested in the young women's perspective and thought that it might be productive to keep the sessions single-gender at the beginning of the *Hip Hop and Health* workshop, but to bring the two groups together at the end for a discussion about the different genders' perception of each other and their responses to negotiating safe sex.

Participants thought it might be useful to bring the groups together at the end for a discussion about their perceptions of each other and their responses to negotiating safe sex.

Some of the project staff and Reference Group members expressed concern to the evaluator that hip hop was a male-dominated medium and, as such, could alienate young women.

When this view was put to young women in an evaluation focus group, they did not agree that hip hop alienated girls; they said, however, that it was the dancing rather than the hip hop that they particularly enjoyed.

Strategy to better engage young women in future outreach work:

- Employ a female worker
- Involve more female performers
- Target young women's activities for outreach

While believing that *'dance and music is the language of young people'* regardless of which gender performs it, A.R.A.B. thought that, should the project continue, it may be useful to develop another performance that involved predominately female performers (as the current performance involves mostly young men). These performers would serve as positive role models for young women, specifically in relation to taking active responsibility for their sexual health.

As mentioned above, the HHHP's outreach work was particularly successful in engaging young men. This is a considerable achievement as young men are often very difficult to engage around sexual health issues. Should the project continue, the current strategies will provide an excellent model for engaging with young men from the target group.

HHHP should, however, develop a strategy for better engaging with young women in outreach. A strategy for better engaging with young women should consider measures such as employing a female worker, involving more female performers and targeting young women's activities for outreach.

2.3 Partnerships and Collaboration

A.R.A.B. and MHSS

In evaluation interviews both A.R.A.B. and MHSS were very positive about their partnership. Both agencies valued each other's flexibility, commitment to high quality workshops, and professionalism. Both believed that the different priorities and focus that each agency brought to the partnership was valuable and that the differences that arose, as in the example provided above about changing the content of the performance, were productive differences rather than differences that hampered the project.

A.R.A.B. project workers described the productive nature of the agencies' different roles in this way: "*We're not social workers…we are focused on the performance outcomes and performers and making a performance product that people enjoy…a space where* [participants] *can celebrate, share and belong...* [the MHSS Community Worker] *is focused on the community groups* [and their participation and learning]*…we respect each others' roles…because we are not social workers we are freer to challenge and confront…social workers can look after the participants in ways that we can't."*

The original performance, which utilised images of Africans dying of AIDS, was changed in response to suggestions from the Reference Group. This was a source of some creative tension.

One source of tension arose early in the project when A.R.A.B. first presented its performance to the Reference Group. The original performance utilised the dramatic power of images of Africans dying of AIDS. Many Reference Group members thought that the performance was using the fear of death and disease as a motivating force and that this may encourage inaction, fear and prejudice amongst participants. The Reference Group suggested a more positive message that focused on harm minimisation. Some of the performers found some of this feedback initially difficult because they felt attached to their creative product. As one performer put it, "*I was worried about my work and words being compromised"*. Subsequently though, these performers, having understood the disadvantages of fear-based messages, were happy to change the content.

On reflection, some Reference Group members thought that this conflict could have been avoided if the performers were better briefed on the kind of messages MHSS wanted to convey. When the evaluator put this suggestion to the A.R.A.B. project workers, they felt that extensive briefing could have put too many restrictions on the creative process: *"It was good they gave us few constraints in the beginning…creativity was allowed".* The A.R.A.B. project workers were also untroubled by the performers' initial protectiveness of the work, arguing that "*protectiveness is needed in order to create".*

Both partners agreed that the most difficult aspect of the collaboration was the scheduling of *Hip Hop and Health* workshops. The initial plan was to schedule workshops in a block so that performers could effectively 'go on tour'. This was not possible to organise because, in order to gain access to young people, the workshops needed to be delivered at pre-existing youth programs or events. Workshops were occasionally postponed and rescheduled due to changes in youth group schedules. This presented a significant logistical problem for A.R.A.B. as each workshop required scheduling 4-5 performers who had other performance commitments.

Both A.R.A.B. and MHSS identified scheduling as an issue that needed to be resolved should the project continue. Some suggestions made included:

- Conducting most of the performances at a series of camps on set dates over a 12-month period
- Returning to the original intention of conducting workshops in a block. This was seen as having more chance of working next time around as the HHHP project would then be well known and have a better chance of attracting participants
- Having a pool of performers so that the HHHP can be more flexible about fitting into existing youth group schedules

Workshops were sometimes postponed or rescheduled due to the need to fit in with pre-existing youth events. This presented a logistical problem in scheduling A.R.A.B. performers.

Reference Group

The Reference Group met six times and involved representatives from:

- Family Planning Victoria
- Young People's Health Service, Centre for Adolescent Health
- Centre for Multicultural Youth Issues
- A.R.A.B – Victorian Arabic Social Services
- Communicable Disease Control Section – Public Health Group – Department of Human Services
- MHSS – Centre for Culture, Ethnicity and Health

The Reference Group provided advice on health education session content and exercises, the performance and its message, and networking and engagement. However, members interviewed for the evaluation also identified a number of factors that impeded the group's function. These were:

- Changes in Reference Group representatives and HHHP project staff
- Sporadic attendance from some Reference Group members

- Reference Group members were able to give more meaningful advice and guidance at the beginning of the project than they were at the end. Some members believed that, towards the end of the project, they did not have enough information on issues arising to be able to give meaningful guidance

HHHP project staff and Reference Group members also thought the Reference Group could have been enhanced if consumer representatives had been involved.

Networks

Hip Hop and Health sessions and outreach support was conducted through the programs and activities of the following organisations:

- Diversitat in Geelong
- Chisholm College, Dandenong (ESL Classes)
- Southern Ethnic Advisory and Advocacy Council (SEAAC)
- South Eastern Region Migrant Resource Centre (language classes)
- Whittlesea City Council Youth Services (City Camp Group)
- Sudanese Australian Integrated Learning Program (SAIL)
- Migrant Information Centre (Eastern Melbourne) (soccer group in Mitcham)
- Victorian Arabic Social Services (VASS) (soccer group in Coolaroo)
- North Richmond Community Health Centre (dance group)
- NMIT Collingwood Campus (newly arrived students)
- City of Maribyrnong Council Youth Services (Street Surfer group in Braybrook)

Section 3: Impact Evaluation

The *Hip Hop and Health* Project was successful in achieving its intended impact: raising awareness of BBV and STI and promoting preventive behaviours amongst the target group.

The following section discusses the impacts of the Hip Hop and Health workshops and outreach work.

3.1. Impacts of the Hip Hop and Health workshops

Health education sessions

Quiz results showed an increase in both participants' confidence in discussing safe sex with a partner, and in their intention to practice safe sex.

To test whether the health education sessions created a change in knowledge and attitude amongst participants, the evaluator developed quizzes (see Appendix 2) that were conducted at the beginning and end of several health education sessions. Quiz results showed that participants' knowledge increased after participating in a session. Quiz results also showed an increase in both participants' confidence in discussing safe sex with a partner, and in their intention to practice safe sex.

In evaluation focus groups, participants reported that new knowledge they gained from the workshops included:

- location of treatment and testing services and other information about these services (bulk billing, confidentiality, waiting times, etc)
- how to practice safe sex
- information about transmission of BBV and STI

The extent of learning that took place in a workshop, however, was significantly influenced by the workshop's format and length.

Sessions sometimes took place in rushed and chaotic environments, with their length and format adapted to fit within the tight programs of existing youth groups. Evaluation quiz results showed that participants learnt less in rushed sessions than they did in longer sessions, and that learning was directly related to having time to discuss the issues. Some of the sessions were so rushed, and environments so chaotic, that it was a testament to the HHHP community worker's excellent group skills that participants learned anything at all.

When workshops were run in more controlled spaces and over a longer timeframe, the difference in learning outcomes was obvious. This was particularly the case in workshops that were conducted on camp. Film footage taken at these camps showed a high level of engagement from participants, and in-depth learning taking place through discussion and questions.

Discussion and questions appear to be a particularly important element in these sessions, because the language around sexual health is particularly bewildering to young people for whom English is a second language. The use of medical terminology like Chlamydia, clinical words like genital and pubic hair, and slang words to describe sex and anatomy, appear to cause confusion. Participants interviewed for the evaluation suggested that the workshops would be improved if more time was spent defining words and allowing participants to ask questions.

Discussion and questions are particularly important, because the language around sexual health can be bewildering to young people for whom English is a second language.

The technique used by the MHSS female community worker, in which the educator answered questions that participants had written down earlier and anonymously placed in a box, seemed to be a particularly good method for eliciting embarrassing questions and stimulating discussion around the answers.

Developing strategies on how best to manage rushed sessions is a key challenge for the HHHP. The project's flexibility to fit with existing programs allowed educators to have extensive access to the target group, but sometimes resulted in compromised learning.

The quizzes and focus group discussions also showed that young people who attended repeat sessions learned more than those who attended single sessions. Notably, those attending repeat sessions appeared much more confident to access treatment services, and more likely to say that they intended to practise safe sex in the future.

Should the HHHP continue, it should consider building more repeat sessions into its program. Some consideration should also be given to adapting the content of each session. In the HHHP community worker's view, the current amount of information delivered on BBV and STI was too much for a single session and that it would be better to cover less information in more depth.

Young people who attended repeat sessions appeared much more confident to access treatment services and more likely to say that they intended to practice safe sex.

The evaluator also observed that young people often raised issues to do with negotiating safe sex within interpersonal relationships (eg *What if I offend her by wearing a condom? What do I do if he says he won't wear a condom?)* but there was rarely enough time to discuss these issues. Perhaps space for this kind of discussion could be incorporated into a repeat session format.

The HHHP has continuously improved its health education session over the course of the project to enhance participants' learning. These changes have included:

- handing out show bags with leaflets of relevant services an condoms
- returning for a follow-up session where possible

- presenting information particularly relevant to newly-arrived young people. This includes knowledge about the service system and information about BBV (particularly HIV) and STI in an Australian context. This followed an observation by the HHHP community worker that newly-arrived young people had some knowledge about HIV but that this knowledge was often particular to an African context. For example, because HIV/AIDS is less visible in Australia than in Africa (public health messages on billboards, people who are on the streets and visibly sick and/or dying) young people are often unaware that HIV exists in Australia or that in Australia people with HIV can live for a long time with the assistance of medication.

Young people were much more receptive to health education messages when they were validated and promoted by a performance medium they loved.

Beat boxing and dance performance

The beat boxing and dance performance was integral to achieving the HHHP's intended impact. This impact was due not so much to teaching young people facts (the health education workshops did this) but, as one performer said, making 'an uncool subject cool'.

Young people were much more receptive to the health education messages when the messages were validated and promoted by a performance medium they clearly loved and performed by other young people they respected and idealised.

The transition from 'uncool to cool' was evidenced in the kind of banter young men had with the HHHP community worker. *"Initially the guys joked that they couldn't use condoms because they couldn't find one big enough. When I saw them again (months after the performance) they made jokes about how many condoms they carried."*

While participants were clearly energised, excited and inspired by the performance, they also listened to the performance's messages. Participants in evaluation focus groups said that the performance inspired them to take care of themselves and each other, and to take sexual health seriously. As one participant put it: "*It makes the information go into your brain easier*".

In post-evaluation quizzes, young people said they felt more confident to talk to a sexual partner about safe sex after having seeing the performance. They also said health messages delivered by other young people were easier to listen to.

At the end of most performances, the performers encouraged participants to join them as they danced. The performers showed remarkable skill in encouraging and inspiring young people to join in. These events contributed to the sense of sharing and celebration that seemed to underpin the entire Hip Hop and Health session.

All those interviewed for the evaluation (participants, performers, Reference Group members and project workers) believed that peer education through hip hop was essential to achieving the project's intended impact. The excitement, involvement and engagement achieved at these performances were not simply due to the medium (hip hop) and the agent (young people); they were achieved because the performers were skilled at involving participants and the performance itself was a high quality production.

All those interviewed believed that peer education through hip hop was essential to achieving the project's intended impact.

The performers

The performers, who also sometimes belonged to the target group, reported benefiting enormously from their participation in the project.

In evaluation focus group discussions, they said that the project increased their knowledge and changed their behaviour in relation to BBV and STI. The performers also said that before they began work on the project, BBV, STI and safe sex was not something their friends ever talked about: "*It was more likely you would joke about it rather than talk about it".*

After participating in the project, the performers said they felt more confident in talking about the issues with their friends. They also said that participation in the project had increased their confidence and that it felt "*great to do something good for people"*. In many ways the impact of the project on the performers was more extensive and deeper than its impact on participants. This is consistent with the benefits of peer education in which active, continued involvement in developing and communicating health messages to peers has a far-reaching effect on the peer educators themselves.

After participating in the project, the performers said they felt more confident in talking about the issues with their friends.

Both A.R.A.B. and MHSS project workers believed that if the project was to continue into the future, more young people should be involved in peer education. This could happen by:

- involving more young people as performers
- training young people who previously attended workshops to become peer educators, forming a continuing link between MHSS and a particular group of young people.

Part of the original proposal was for young people to devise their own messages in the HHHP workshop. This idea was abandoned due to lack of time within the current format, but could be worth revisiting in a repeat session format if the project is to continue.

3.2 Impacts of outreach

Impact: That young people are supported by the program to access appropriate information, prevention, testing and treatment services.

Interacting with young people at sporting events or youth programs was an effective way to build rapport, especially with young men.

Many young people were supported through outreach. Due to the fact that many of those provided with information accessed services independently, the project has no accurate data on how many young people accessed services as a result of information provided through outreach.

The community worker reported, however, that many young people asked him for directions to clinics and further information about how to access clinics.

Interacting with young people attending sporting events or youth programs was an effective way to build rapport, especially with young men. In these settings, young people had the opportunity to ask questions casually and privately, and the community workers could assist them to access information and services. Their confidence in approaching the community worker grew with repeated visits.

Section 4: Project Learnings

1. Promotion and engagement with African and Arabic-speaking communities takes time.

2. Networking to build relationships with key people in the target group was a critical factor in gaining access to target communities.

3. Word of mouth amongst community networks is a key way to promote the HHHP and build credibility.

4. Building trust and rapport with young people who are not connected with the school system is a slow process and seeking to engage them in education sessions requires persistence over time.

5. When community leaders and workers from the target communities are wary of the content of the *Hip Hop and Health* workshop, due to cultural and religious differences, it is important to explain the HHHP's approach and adapt the workshop content to respond to a particular group's values and practices.

6. Workshop content should be market-tested with young people from different sections of the target group. Strategies for adapting content should also be market-tested with these sections of the target communities.

7. Young people are more likely to ask for support and advice:
   - on a face-to-face basis
   - after meeting a worker on several occasions and having the opportunity to build rapport.

8. Different outreach strategies need to be explored to increase the participation of young women in outreach.

9. A successful partnership is based on respect for each other's distinct roles.

10. Participants learn more when they have time to discuss relevant issues and ask questions.

11. Newly-arrived CALD young people need assistance to understand the bewildering lexicon of sexual health language.

12. Participants learn more in repeat sessions.

Critical success factors include networking, relationship building and effective word-of-mouth promotion.

Young people are more likely to ask for advice or support when they can build rapport with a worker over time.

13. The young people who devise and deliver health messages also benefit from the process.

14. Young people are much more receptive to the health education messages when the messages are validated and promoted in a performance medium they love and that is performed by other young people they respect and idealise.

15. It takes skilled, experienced performers and a high quality performance to energize and involve a group of young people.

Section 5: Recommendations

It is recommended that DHS continue to fund the HHJP as an ongoing activity. Should further funding be provided, the following recommendations will further strengthen the project.

Reach

Develop a strategy to increase the participation of the sections of the target group who were under-represented in the first 12 months of the project. Under-represented groups should be prioritised in terms of need.

Develop a strategy to increase the participation of young women in HHHP outreach work.

Under-represented groups and women should be prioritised for future projects.

Appropriateness

Market-test existing and future workshop performances and education session content with young people from different sections of the target group.

Information

Improve the way the HHHP promotes MHSS services and MHSS confidentiality and privacy policies to young people. This will allow the service to be more easily understood and accessed by CALD young people.

Scheduling

Develop a strategy to resolve the scheduling issues identified.

Explore the feasibility of the following options:

- Conduct most of the performances at a series of camps on set dates over a 12-month period
- Return to the original intention of conducting workshops in a block
- Have a pool of performers so that the HHHP can be more flexible about fitting into existing youth group schedules

To resolve scheduling issues, explore the feasibility of conducting performances at camps, or have a pool of performers to draw upon.

Reference Group

Involve young people from the target group in the Reference Group and provide them with support and resource to participate in an active and meaningful way.

Ensure that the expertise of the Reference Group is used to its full capacity by keeping the group informed about issues as they arise, and using the group to help think through these issues.

Spread existing health education content over a series of sessions to increase depth of learning.

Health Education Sessions

Retain pre- and post-quizzes as an ongoing monitor of participants' learning and attitudes.

Increase participants' learning by:

- Ensuring that every session devotes at least half the time to discussion and questions
- Conducting repeat and multiple sessions
- Spreading existing health education content over a series of sessions so that in a single session participants learn less material in more depth
- Developing activities to assist participants to understand the language associated with sexual health. (Utilise, after market testing, the definition sheet developed at the beginning of the project.)
- Developing a minimum criteria for a successful health education session (eg minimum time-frame, must include at least x minutes for discussion and questions, etc) and only deliver sessions that will meet the minimum criteria
- Developing a session that incorporates a discussion on negotiating safe sex with a sexual partner (this session could incorporate single and mixed gender discussions)
- Expanding the workshop format so that participants can devise their own health messages

Involve more young people from target communities as performers or peer educators.

Peer education

Expand and develop the peer education component of the project to involve more young people as performers and peer educators.

Train peer educators from target communities to provide a continuing link between MHSS and different groups of young people.

Building the capacity of existing programs

Provide education about BBV/STI to workers and youth leaders who work with the target group.

Performance

Develop a performance that involves more young women and provides positive role models for young women.

Appendix 1: Hip Hop and Health Evaluation Framework

Aim: The aim of this project is to increase the knowledge of BBVs/STIs and promote preventative behaviours to reduce the risk of transmission among African and Arabic-speaking young people through a youth-friendly and culturally appropriate initiative.

Target Population: African and Arabic-speaking young people

Objective 1:	**Key Questions** (what do we need to know to decide if we have achieved this objective)	**How will we answer these questions?**
To increase the knowledge of BBV/STI and promote preventative behaviours amongst the target population, through the provision of interactive workshops that utilise the principles of both peer education (communicated through hip hop) and adult learning Impact: Increased knowledge of BBVs/STIs and intention to practice preventative behaviours amongst the target population.	**Process Evaluation:** *Reach:* Did the project achieve its planned reach: 12-16 workshops delivered to target population? Were the groups accessing the program representative of the target population? *Quality and appropriateness:* Were the workshops culturally, gender and age-appropriate to the participants and the target population? Was the mode of delivery (hip-hop/peer led/supported by a health educator) effective in engaging the target population? Were participants engaged and stimulated by the workshops?	Project Reports Interviews with project reference group and project staff Population data Focus Group interview with participants. Interviews with project reference groups, project staff and performers. DVD interviews Participant Surveys

	Impact evaluation Did the program achieve its target of increasing the knowledge of BBVs/STIs and the intention to practice preventative behaviours amongst workshop participants? What were the barriers and enablers to achieving this impact? What new skills and knowledge did participants gain from the workshops? What new skills and knowledge did performers gain from the workshops? Was the mode of delivery (hip-hop/peer led/supported by a health educator) effective in promoting the intended knowledge and behaviours?	Pre- and post-workshop participant quizzes. Focus Group Interview with participants. Interviews with project reference groups, project staff and performers. DVD interviews
Objective 2:	**Key Questions** (what do we need to know to decide if we have achieved this objective)	How will we answer these questions?
To support the target population to access appropriate information, prevention, testing and treatment services through the provision of outreach services Impact: That young people supported by the program access appropriate information, prevention, testing and treatment services	**Process Evaluation:** *Reach:* Did the project achieve its planned reach: 15 young people provided with support to access appropriate information, prevention, testing and treatment services? *Quality and appropriateness:* Was the outreach model effective in providing this support? Why or why not? Was the mode of delivering outreach support effective in engaging the target population? Why or why not?	Project reports Interviews with project reference groups and project staff.

	Impact evaluation Did young people access appropriate information, prevention, testing and treatment services? If so, what resources & or testing services did they access? What were the barriers and enablers to achieving this impact?	Interviews with project reference groups and project staff.
Overall Aspects of the Project		
Partnerships and reference group	What have been the critical success factors and barriers to working in partnership (A.R.A.B. and MHSS)? Has the reference group provided effective guidance, resourcing and support to the project? Have any new relationships/partnerships formed because of the project? If so, what are they? What have you learnt about the type of partnership required to implement this project? What kinds of collaborations have arisen from the project?	Interviews with project reference groups and project staff.
Adoption/ Networking	Which organisations, workers, and groups have been involved in the project?	Interviews with project reference groups and project staff
Supportive environments	What environmental factors have enabled, or been a barrier to, achieving the intended impacts of this project?	Interviews with project reference groups and project staff.
Future and Sustainability	**Project sustainability?** How should issues of sustainability be dealt with? What are the obstacles to sustainability for this project? **Sustainability of impact** What have you learnt that you would do differently next time in order to promote sustained behaviour change for the target audience? In the context of this work and project, what does sustainability mean?	Interviews with project reference groups and project staff.

Appendix 2: Quick Quiz

Put a circle around the correct answer.

1. You can tell if someone has HIV or AIDS because they look sick.

   True False Don't know

2. You can tell when you've got an STI because the symptoms are obvious.

   True False Don't know

3. Pain, itchiness and difficulty when urinating (pissing) or having sex can be a sign of a Sexually Transmitted Infection (STI).

   True False Don't know

4. The contraceptive pill (the one that stops you getting pregnant) protects you against Sexually Transmitted Infections (STIs) or Blood Born Viruses (BBVs).

   True False Don't know

5. Oral sex is safe sex.

   True False Don't know

6. Treatment for Sexually Transmitted Infections (STI) or Blood Born Viruses (BBV) will help you feel better. .

   True False Don't know

Put a circle around the answer that describes what you believe or feel.

1. In the future, I will practice safe sex by using a condom or a dam.

   Never Sometimes Always

2. I feel confident to talk with my boyfriend/ girlfriend about safe sex.

   Not Confident Confident Very Confident

3. I know where I can get treatment for a Sexually Transmitted Infection (STI) or Blood Borne Virus (BBV) .

   No Yes

Appendix 3: Project Partners

Multicultural Health and Support Service (MHSS)

MHSS is a statewide program of the Centre for Culture, Ethnicity and Health and was established in 2003 to work with and empower CALD communities, individuals and groups to achieve better health outcomes in relation to the diverse, highly complex and culturally sensitive issues relating to BBV and STI. It has a unique understanding and experience of cultural diversity through its work and its culturally diverse workforce.

MHSS works specifically with Southeast Asian and East African individuals, families and communities, as well as addressing needs across CALD communities and the broader community. MHSS also works with mainstream service providers in relation to access and culturally sensitive service provision.

MHSS takes a partnership and capacity building approach that incorporates three key programs:

1. *Client outreach support* – provided to individuals and families to assist them to access information, testing and treatment services in relation to BBV/STI
2. *Community education* – delivered to the targeted communities on HIV, hepatitis C and STI
3. *Community action* – in collaboration with relevant mainstream and multicultural agencies and groups to raise awareness of and provide more effective responses to meet the needs of CALD communities in relation to BBV/STI

Anti-Racism Action Band (A.R.A.B.)

A.R.A.B. is a youth performing arts project open to young people from diverse backgrounds. It is an initiative of the Victorian Arabic Social Services (VASS) who were concerned about the growing number of incidents of anti-Muslim racism in Australia that followed events such as September 11 and the Bali bombings. In particular, VASS wanted to give young people who had been feeling the brunt of racist abuse a chance to challenge some of the harmful stereotypes and to have fun in the process.

VASS was able to obtain funding from VicHealth at the end of 2003 and the work began in early 2004. VASS recognised that in order to deal with racism, they needed to open their doors to young people from all races and cultures. Two years later, A.R.A.B was able to employ two paid artistic directors and a project worker on an ongoing basis, along with 6 artist-tutors. By mid 2006, A.R.A.B members performed at over 130 events with a total audience of more than 25,000.

The young people in A.R.A.B include Muslims from African and Middle Eastern countries such as Lebanon, Assyria, Turkey, and Somalia as well as Christians from countries like Samoa and the Philippines. There are also Anglo-Australians who identify themselves as either Christian or non-religious, and some Kooris. Overall, A.R.A.B is a unique project fostering performing arts skills while challenging young people's views of themselves and those around them. A.R.A.B currently has close working relationships with five secondary colleges – Broadmeadows, Hillcrest, Lakeside, Box Forest and Lalor North – and has performed at many other schools across the north and west of Melbourne.

Other project partners

Centre for Multicultural Youth (CMY)

CMY is a community-based organisation that advocates for the needs of young people from migrant and refugee backgrounds. The Centre has a priority focus on culturally and linguistically diverse (CALD) young people from refugee and newly arrived communities. In supporting young people, CMY combines policy development and direct service delivery within a community development framework.

Family Planning Victoria (FPV)

FPV has been providing sexual and reproductive health services in Victoria for over 30 years. Its Action Centre provides free, low-cost information, education, counselling, medical services and referral for young people under the age of 25 with concerns about: contraception, sexuality and gender issues, pregnancy and unplanned pregnancy, sexual decision-making, sexual abuse, relationships and sexually transmitted infections.

Centre for African Australian Women's Issues (CAAWI)

CAAWI is a newly established African women's organisation that aims to link African women and their families to organisations and individuals with the capacity to provide them with greater opportunities, and offer information and support to strengthen their social connectivity. This work is supported by training workshops on various topics including skills and leadership development.[6]

[6] Due to a lack of resources and staffing, CAAWI was unable to actively participate in the implementation of the HHHP project.