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“Because we all trust and care about each other”: Exploring Tensions Translating a Theater-based HIV Prevention Intervention into a New Context

Mary Sherwyn Mouw, MD, MPH,

Postdoctoral Research Fellow, Cancer Control Education Program, UNC Lineberger Comprehensive Cancer Center, 135 Dauer Drive, 302 Rosenau Hall, CB# 7440, Chapel Hill, NC 27599-7440, University of North Carolina at Chapel Hill

Arianna Taboada, MSW, MSPH,

Art & Global Health Center, University of California, Los Angeles, 120 Westwood Plaza, Glorja Kaufman Hall, Suite 188, Los Angeles, CA 90095-1608

Scarlett Steinert, MS,

Coordinator of Healthful Living & Athletics, Student Services, Chapel Hill-Carrboro City Schools, 750 S. Merritt Mill Rd., Chapel Hill, NC 27516

Stephanie Willis, MPH, and

Coordinator of Health Services (Retired), Chapel Hill-Carrboro City Schools, 750 S. Merritt Mill Rd., Chapel Hill, NC 27516

Alexandra F. Lightfoot, EdD

Director, Community Engagement, Partnerships & Technical Assistance (formerly CBPR) Core, Center for Health Promotion and Disease Prevention, Adjunct Assistant Professor, Health Behavior, Gillings School of Global Public Health, Center for Health Promotion and Disease Prevention, University of North Carolina at Chapel Hill (UNC)

Mary Sherwyn Mouw: sheri_mouw@med.unc.edu; Arianna Taboada: ataboada@arts.ucla.edu; Scarlett Steinert: ssteinert@chccs.k12.nc.us; Stephanie Willis: skwillis1@gmail.com

Abstract

Background—A theater-based HIV prevention intervention developed in urban California was piloted with a new partnership in North Carolina.

Objectives—To describe the experience of translating a complex program with an enhanced partnership approach; barriers and facilitators of implementation in the new setting; and challenges and benefits of interdisciplinary, collaborative interventions.

Methods—We gathered perspectives of local stakeholders involved in program implementation through process evaluation interviews and focus groups with undergraduates, a college instructor, school district administrators, and high school teachers.

Corresponding Author: Mary Sherwyn Mouw, 135 Dauer Drive, 302 Rosenau Hall, CB# 7440, Chapel Hill, NC 27599-7440, sheri_mouw@med.unc.edu.

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Results—Implementing the intervention in a new setting proved feasible and successful; however, mistaken assumptions and unrecognized similarities about teaching priorities, philosophies, and values produced latent tensions amongst stakeholder groups, and were a limiting factor in partnership functioning.

Conclusions—Implementing a cross-disciplinary intervention in a new setting is best achieved through a local community-engaged process, with active involvement of relevant stakeholders. We suggest strategies to strengthen community partnerships cooperating in implementation of complex, context-tailored interventions.

Background

Partnerships operate within socio-ecologic contexts comprised of culture, place and history, organizational factors, disciplinary epistemologies, group dynamics, and individual beliefs. We describe our experiences with these contextual layers in piloting Arts-based, Multiple-Component, Peer-Education (*AMP!*) in North Carolina in a new community-university partnership. This theater-based HIV prevention intervention was originally developed in urban California. Our experience implementing a complex intervention in a very different geographic and socio-cultural setting provides practice-based evidence about working with partnerships to translate interventions. We explore two findings from our process evaluation: inherent tension between the processes of participatory work with communities and the practicalities of program implementation; and latent tension amongst stakeholder groups in the partnership. We describe lessons learned, particularly about engaging local collaborative partners.

Intervention History

AMP! was developed in 2009 through a collaboration between the University of California at Los Angeles Art & Global Health Center (UCLA AGHC) and the HIV/AIDS Prevention Unit of the Los Angeles Unified School District. *AMP!* is comprised of a theater piece, a condom negotiation workshop, and panel discussions with persons living with HIV/AIDS. The content of these three intervention components (Table 1) is developed by undergraduates and delivered by them to local high school students. *AMP!* provides information and prevention strategies to increase HIV knowledge, decrease stigma, and improve self-efficacy around sexual health communication.

New Context and New Partnership

Improving school-based sex education delivery is particularly important in the United States (US) South, a region that consistently ranks lower than the national average in sexual health indicators, and has the highest regional incidence rate of HIV. North Carolina (NC) has the eighth highest HIV incidence rate amongst states. Between 2007 and 2011, the percentage of new HIV cases diagnosed in adolescents (ages 13–24) increased from 18% to 23% of all incident cases in the state. NC health and educational policies that affect prevention efforts, meanwhile, are shaped by cultural and political conservatism. The state legislature, for example, opted against Medicaid expansion offered through the federal Patient Protection and Affordable Care Act; and in 2012 NC voters passed a Constitutional Amendment banning same-sex marriage. This influences the climate in which NC public schools operate, and

health education curricular content. For example, NC's School Health Education Act of 1996 required school districts to hold public hearings for approval of comprehensive sex education, or else teach premarital abstinence only. Most districts had abstinence-only programs until the 2009 Healthy Youth Act, which allowed for a more comprehensive, although still abstinence-focused, curriculum. In contrast, the Los Angeles school district where AMP! originated has operated its own HIV/AIDS Prevention Unit since the mid-1980's.

In 2011, AGHC initiated a partnership with UNC researchers and a NC school district. The pilot district had been an early adopter of the comprehensive approach to sexual education, and was selected because of its relatively progressive curriculum and history of engaging with university researchers. Table 2 compares demographics of the original and pilot counties.

With UCLA AGHC providing seed funding, guidance and oversight, we at UNC established a local multi-disciplinary partnership to guide implementation. We built ties with faculty, staff, and graduate students in public health, communication studies, student wellness, and public service. A student wellness faculty member with expertise in applied theater and HIV prevention designed and taught a semester-long course for undergraduates. This class, which trained undergraduates as near-peer health educators, was offered for credit, and fulfilled UNC's community service-learning requirement. The instructor trained the undergraduates enrolled in the course (n=10) in interactive theater techniques, and public health graduate students led them in a short course on sexual health and HIV prevention. Beyond the university campus, our collaboration involved two school district administrators who oversaw health programs and curricula. They coordinated logistics with schools, connected us with the teachers to whose students *AMP!* would be delivered, and facilitated buy-in from the teachers. They also ascertained *AMP!* aligned with state curriculum standards for the reproductive health and safety unit, and suggested edits to make the theater piece fit within the school's time constraints. For example, they suggested cutting a scene which duplicated material which would be covered in a more interactive fashion in the workshop.

AMP!'s three components (e.g., theater piece, workshop, discussion sessions) were not changed in the NC pilot; however, the *content* of each component was determined locally by the UNC undergraduates, eight of whom had grown up in NC and all of whom were products of abstinence-only education. The undergraduates based the performance piece on what they wished they had known about HIV and sexual health when they were in high school. For example, one satirical sketch in the performance depicted an abstinence-only classroom where the teacher essentially shut down any questions her students (two of whom had babies on their laps) had about sex. Another scenario raised issues about religion and students' struggle to understand how their faith influences their sexual health decision-making. A series of three-line scenes depicted difficult conversations with parents and partners about sex, showing how vulnerable and challenging sexual health communication can be. The undergraduates also developed the workshop scenarios, and local HIV-positive persons were recruited for the facilitated discussion sessions.

AMP! was pilot tested in Spring 2013. We enrolled 317 ninth grade students in the study to evaluate intervention effect. Participants had statistically significant changes in HIV knowledge and attitudes towards safe sex and persons living with HIV/AIDS as compared to the control group who did not receive the intervention. In addition to outcome data, we also collected process data, which is the focus of this article.

Methods

In the process evaluation, our primary research questions were: 1) What do the experiences of local stakeholders tell us about barriers and facilitators of implementation in the new setting?; and, 2) What do their experiences tell us about challenges and benefits of interdisciplinary, collaborative intervention research? We used multiple data sources to maximize consistency and to increase credibility, dependability, and trustworthiness of findings. We sought perspectives of several stakeholder groups: undergraduate students, university course instructor, district administrators, and classroom health teachers. We conducted three focus groups with undergraduates delivering the intervention (total n=10) over the course of the semester; and, after the intervention was delivered, we conducted key informant interviews (n=6) with the college theater course instructor and community school partners, including the two district administrator collaborators and three health teachers whose students had received the intervention. The interview guide covered their work history in health education, attitudes toward sex education, and their experiences with *AMP!*.

The study protocol was approved by the Institutional Review Board at UNC- Chapel Hill. Interviews and focus group discussions were recorded and transcribed verbatim. To provide a degree of objectivity, a researcher who had not been involved in implementation worked alongside the Project Manager and Principal Investigator in this analysis. We iteratively developed a thematic codebook, starting with topical codes drawn from the interview guide and adding inductive codes from participants' reflections. We managed transcripts and coding with ATLAS.ti (Version 7.1.8) qualitative data analysis software. We considered transcripts collectively and also compared across stakeholder groups for a more nuanced understanding of facilitators and challenges, advantages and disadvantages of implementing *AMP!* with a partnership approach, and in a new setting.

Results

Examining barriers and facilitators of implementation in the new setting, we found several layers of local context – including teachers' values, broader community norms and political climate – were important in partners' experiences in NC. The course instructor, a public university employee, mentioned possible political backlash from lawmakers offended by the theater piece. An administrator believed the way premarital sex and homosexuality were addressed would probably offend some parents and school employees, African-American parents and school employees in particular, because of religious beliefs. Teachers and administrators expressed doubts *AMP!* would be welcome in more conservative neighboring school districts. However, these concerns were anticipated socio-contextual issues, rather than barriers they had experienced. Although they were cognizant of the possible backlash,

participants expressed there were no reports of negative community feedback. Administrators felt *AMP!* was generally well-received by schools, and teachers said students were enthusiastic. Good long-standing relationships between administrators and health teachers, and administrators' past experiences with university research projects facilitated program implementation.

In addressing our second research question, issues of partner engagement emerged as both challenges and benefits of interdisciplinary, collaborative intervention research. The process evaluation uncovered latent tensions between stakeholder groups, but also how much they had in common. We found three important mistaken assumptions and unrecognized similarities between high school educators, district health coordinators, undergraduate participants, and the theater instructor: 1) Shared priorities and aims for comprehensive sexual education were not fully recognized; 2) Undergraduates and their theater instructor did not know the teachers' philosophies and strategies had much in common with activist theater; and, 3) Across groups, participants' descriptions of what makes teaching sexual education to adolescents especially challenging were strikingly similar. We discuss each of these below.

1. Priorities and aims for comprehensive sexual education

The three teachers expressed different beliefs and comfort levels with teaching sexual education. This theme was corroborated by a school district interview in which one administrator said she had long seen variation in specific content delivered by individual teachers throughout the district, depending on attitudes toward the comprehensive curriculum. However, we found commonalities in the teachers' classroom priorities: They tended to emphasize facts (e.g., STI symptoms, steps in correct condom use). They prioritized character-building, good choices, and seeing consequences of decisions. College students, in contrast, aimed to normalize talking about sexuality, reduce stigma associated with homosexuality and HIV, and provide practical information on HIV/STI testing. Teachers' goals were shaped by personal values, social norms, and the need to teach testable material, while college students' goals reflected what they learned in the *AMP!* course, and what they wished they had known in high school.

Looking deeper, however, a fundamental message teachers and undergraduates both aimed to communicate was that teens need not feel alone. (See Table 3). Teachers' and college students' goals centered around the idea that knowledge and dialogue reduce isolation in facing feelings about sexuality and emotionally-fraught decisions about sex. Both groups prioritized improving communication skills in talking with parents and partners. Both aimed to convey the message that choosing not to be sexually active is normal and acceptable. Both stressed that learning about healthy relationships is key. Undergraduates felt teenagers gain more from sex education when the focus is on relationships and communication, in addition to the physiological facts. Although emphases, rationales, and values differed, both groups wanted high school students to reflect on relationships, how emotions affect decision-making, and emotional dimensions of sex and sexuality.

2. Shared teaching philosophies: the effectiveness of participatory methods

College students and their instructor expressed some negative opinions about the quality of high school health education. The theater instructor referred to “dry, uninteresting” teaching and “adults talking...all day long.” One student even referred to *AMP!* as a way “to overthrow the system” of traditional sex education. A classroom scene in the performance reflected these assumptions. An abstinence-only teacher was portrayed in caricature, flustered and ignoring students’ questions about sex.

In contrast to these assumptions, teachers and district administrators favored strategies very much in line with activist theater. (See Table 3). All groups emphasized the importance of going beyond entertainment to engage students in discussion, participation, and reflection. Teachers and college students said stories based in lived experiences help teens see that sexual health education applies to *their* lives. Teachers said the workshop and discussion sessions were especially effective because they offered true stories, interaction, and hands-on skill-building. In fact, both an administrator and a teacher suggested *AMP!* had not gone far enough to incorporate participatory methods into the theater piece. In a focus group conducted with undergraduate students after they delivered the intervention, a different appreciation for challenges of teaching emerged. One student found teaching done during the workshops more difficult than putting on the scripted show, and compared it to theatrical improvisation.

3. Teaching challenges, being vulnerable, and the importance of a safe space

High school health teachers and the *AMP!* undergraduate students experienced similar challenges in the classroom. The material was complex and sensitive, and sometimes they just did not know what to say. Both groups at times felt uncertain of teaching boundaries in terms of what was acceptable within social norms of high school and what they could and could not effectively address within a classroom context. These challenges contributed to feelings of vulnerability, described as a significant part of the work of teaching sexual health. A district coordinator reflected that, in her professional experience, teachers are not generally invited to discuss these challenges.

In contrast, the theme of creating a safe space was prominent both where the college students talked about their experiences in the theater class, and where health teachers talked about their approaches to teaching sexual health. (See Table 3). Teachers aimed to provide a “safe zone” for their students, where no question is stupid, and nobody is belittled because of race, gender, or sexual orientation. The safe zone facilitated effective teaching, and came from establishing rapport, being nonjudgmental, and having good classroom management skills. Of note, one teacher talked about how being inclusive and non-judgmental in the classroom superseded her personal feelings about homosexuality.

Fostering a safe zone also meant holding space for what a district administrator called “awkward moments,” which she said were important for learning. Similarly, comfort with discomfort was a major focus of the undergraduate course. Because they developed the performance piece around what they wished they had known about sexual health when they were in high school, sharing stories about their personal experiences was an integral part of

their creative process. Creating a safe space is in fact a tenet of activist theater. The instructor guided undergraduates to shape a class environment conducive to sharing and hearing others' experiences and ideas. One undergraduate said "being vulnerable" went with "a wonderful wedding open of [the] mind with ideas."

For the undergraduates, creating the safe space resulted in a cohesive, effective group dynamic. Feeling supported while being vulnerable made learning and personal growth possible, and they described *AMP!* as a transformative experience. The elements of trust and caring that made the program a success are equally applicable to creating a strong partnership. In retrospect, this finding reinforced for the research team how important it is to create those spaces for all stakeholders.

Lessons Learned

We successfully established a partnership with local school district administrators and this facilitated pilot testing *AMP!* in the schools. The pilot was successful overall and we plan to continue and expand into new districts. However, our findings provide instructive insights about the roles of local stakeholders in translating interventions, and highlight the benefits of shaping a safe space for a partnership.

First, we learned about addressing the inherent tension between values of partnership development on the one hand and, on the other, a traditional project implementation and funding timeline. We expected contextual factors would provoke tensions in a setting so different from that in which the program was originally designed, and assessing these tensions was a primary aim of the process evaluation. However, in the key informant interviews, NC stakeholders talked less about actual difficulties arising from the regional conservative setting, than they did about potential future difficulties based on assumptions about others' beliefs and attitudes. Not having the structure and space to discuss these assumptions was a limiting factor in the partnership. For example, we did not tap into teachers' wealth of experience and local knowledge early on, or focus on making connections between college students and high school teachers. Understanding the teachers' perspectives and engaging them as partners is a key strategy needed for scale up of the intervention.

The expected barriers associated with regional political and cultural conservatism were likely attenuated by our piloting within a relatively liberal college town school district. Moving into new districts, *AMP!* will seek to include teachers early in the implementation process and attend to intrinsic partnership relationships through ongoing discussion of goals and experiences teaching sexual health. Dedicating both time and funding to gathering local input, as well as engaging in reflexivity will be important going forward. It is hardly surprising to conclude that community input is a key component in designing a community partnership-based program. However, the critical lesson learned is that translating complex interventions like *AMP!* into new settings will benefit from an even more inclusive approach, engaging diverse stakeholders (in our case beyond school district administrators) in a local partnership.

Secondly, we recognized during this analysis that our interviews and focus group discussions had essentially provided a safe space in which to address project challenges. Albeit belatedly, the process evaluation interviews pulled teachers into the implementation process. Their insights highlight the benefits of providing a safe space for a partnership. In their interviews teachers spontaneously offered suggestions, for example, about how to engage learners in discussions, invite questions with minimal embarrassment, and handle personal/professional boundaries, all of which were brought up as concerns in the undergraduates' focus group discussions. Teachers also shared ideas of adaptations they believed would make *AMP!* more participatory for high school students, and more acceptable to less progressive school districts.

Conclusion

We were struck by the potential of applying the concept of safe space to other university-community collaborations: The challenge of HIV prevention for youth demands creative approaches and strong collaboration across diverse disciplines. *AMP!* brings together expertise of artists, scholars, teachers, and youth to forge effective, context-specific programs. Co-creation of knowledge from across disciplines improves programs, and partnership dynamics influence outcomes and sustainability. Key ingredients of effective partnerships include reflexivity, shared philosophy, shared goals, and the compelling notion of partnership synergy, a coalescing of partners' perspectives, knowledge, and skills toward creative, effective, community-connected solutions.¹⁷ We suggest designing team processes to: 1) Ask where partners experience discomfort in the project; 2) Find shared aims and values; and, 3) Make assumptions transparent. Other partnerships might address these three issues through formal process evaluation, as we did, or by integrating these conversations into team meetings. Using these strategies even retroactively has clarified ways in which we can better engage with community partners and connect them with one another. Had *AMP!* applied these strategies in team meetings early in the academic year, teachers and undergraduates could have shared ideas directly with each other while program components were being designed, and undergraduate students could have built ties with teachers and learned from their experiences. We look forward to using these strategies to design a safe partnership space from the beginning of the next *AMP!* implementation. Deliberately and *proactively* addressing discomfort, aims, values, and assumptions will promote reflexivity, facilitate team-building across groups of diverse stakeholders, and spark synergy in our community-university partnerships.

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Table 1*AMP!* Intervention Components^a

Component	Description
Sex Ed Squad Performance	A 30-minute show delivered by college students weaving together humor, personal narrative, and medically accurate information to promote HIV prevention knowledge and strategies.
Condom Demonstration and Negotiation Workshop	An interactive forum theater workshop facilitated by college students to teach about how to properly use a condom, negotiate using condoms with a potential partner, or discuss condom use with a parent.
HIV+ Speakers	HIV+ advocates visited intervention school classrooms to share personal stories of what it's like to live with HIV, how/when they learned about their diagnoses, behaviors that put them at risk, issues of disclosure, and medication routines.

^aSource: Adapted from Lightfoot, et al.

Table 2 Demographics of California and North Carolina counties and school districts^a

	North Carolina	California
School district demographics		
K-12 student enrollment	12,206	643,000
Qualify for free/reduced lunch	32.2%	80%
Race		
White	52.3%	8.8%
African American	11.4%	10.0%
Asian	15%	6.1% ^b
Multiracial	6.4%	1.0%
American Indian	0.5%	0.04%
Hawaiian/Pacific Islander	0.1%	0.04%
Ethnicity		
Hispanic/Latino ^c	14.3%	73.4%
County-level demographics		
Population	140,420	10,116,705
Median household income	\$55,569	\$55,909
Per capita money income	\$34,465	\$27,749
Below poverty level	17.8%	17.8%
Children below poverty level	13%	27%
Uninsured (under age 65)	15%	25%
High School graduate	91%	76.6%
Bachelor's degree or higher	55.8%	29.7%

^aSources: References 13–17;^bThis figure collapses 3.9% Asian and 2.2% Filipino;^cTerm *Hispanic* used in NC data, *Latino* in California data

Table 3

Emerging Themes from Stakeholders

Theme	Exemplary Quotes	Participant Profile
Shared priorities: Knowledge and dialogue reduce isolation.	<i>They might be thinking, "Okay I'm the only one or why is it just me?" But a lot of that is just never talked about, even in friends' circles. People just need to be more open in general and I think this is a great space.</i>	Undergraduate student
	<i>I still haven't grasped or have accepted same-sex...It's still been a big wrestle for me, and it's basically from a religious point of view; but I also have to know that my students may be like that, so I am not in a position to judge. I can just kind of listen...like the skit...for those kids who are...in that situation...it kind of lets them know that they're not alone or by themselves.</i>	High school health teacher
Shared priorities: Focus on relationships and the emotional dimensions of sex and sexuality.	<i>My biggest thing is...the relationship part, because I think if there's some sort of respect, then boundaries won't be crossed...You'll know when it's time to have sex.</i>	High school health teacher
	<i>Instead of just focusing only on just the physical aspects of diseases and things like that...also focus on the emotional side because that's a really big deal...in high school with everything going on...I think in my experience or from friends that was more of a main focus then than the dangers or the physical aspects.</i>	Undergraduate student
Shared teaching philosophies	<i>What I think was challenging was essentially being the teacher. On stage you can stand up in front of the kids but you don't really have to interact with them...But in the classroom it was hard because you had to interact... You were improv'ing the whole time.</i>	Undergraduate student
	<i>They were playing roles but, you know, the situations were real... That little nugget helps to make the connection, you know, for how this impacts, how this could potentially impact me.</i>	High school health teacher
	<i>The only better way would be somehow getting the kids involved in the presentation...somehow getting them to act...some of our teachers do that.</i>	District administrator
Experiencing vulnerability and the importance of a safe space	<i>Nobody's asked me how I feel about it...Nobody has ever asked me, you know...that's where teachers have a real hard time...because it's very hard when you talk about sensitive issues...you know that's a tough piece.</i>	District administrator
	<i>You really hit home when kids start to open up to you...It all boils down to...if you've got your classroom environment established, you can really start to make an impact on kids.</i>	High school health teacher
	<i>Because we all trust and care about each other, it makes it possible to really delve deep into material that has made this show what it is.</i>	Undergraduate student