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In Their Own Voices: Rural African American Youth Speak Out About Community-Based HIV Prevention Interventions

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Abstract

Background—The HIV epidemic is a major public health problem in the United States, particularly among rural African American adolescents and young adults.

Objectives—We sought to explore young, rural African American's perspectives about key programmatic components to consider when designing youth-targeted, community-based HIV prevention interventions.

Methods—We report data from four focus groups with adolescents and young adults aged 16 to 24 (n = 38) conducted as part of a community-based participatory research (CBPR) project designed to develop multilevel HIV risk reduction interventions in two rural North Carolina communities with high HIV rates. Analysis was performed by academic and community partners using a modified grounded theory approach to content analysis.

Results—Interventions should target preadolescents and early adolescents rather than older adolescents and young adults in an effort to "catch them while they're young." Intervention developers should obtain input from local young people regarding critical programmatic components, such as whom to employ as study recruiters and intervention leaders; intervention

format and delivery options, acceptable recruitment and intervention locations, and incentive structures. Participants believe selecting community collaborators representing varied community sectors is critical. Important barriers to address included limited transportation, discomfort communicating about sexual issues, lack of community interest in HIV prevention, and unwillingness to acknowledge and address sexual activity among adolescents.

Conclusion—When designing HIV/AIDS prevention interventions, targeting young people, it is important to form academic–community partnerships that ensure young people's perspectives are integral to the intervention development process.

Keywords

HIV prevention; youth; African American; rural; community-based participatory research

The HIV epidemic continues to be a major public health problem in the United States, particularly among African American adolescents and young adults age 15 to 24 (young people). African Americans represent 15% of the adolescent population[1] yet comprise 61% of new cases of HIV among persons under age 25.[2] Although many HIV prevention interventions have been developed for African Americans under age 25, few focus on nonurban residents or address the needs of those from the Southeast.[3,4] This is important given that the South has the highest number of young people living with HIV/AIDS (PLWHA)[5] and data suggest rural adolescents may be more than twice as likely as their urban peers to be sexually active.[6,7] Moreover, few interventions incorporate young people's perspectives into intervention development activities, despite claims that this approach may increase intervention effectiveness.[4] In this study, we explored the perspectives of rural, African Americans aged 16 to 24 regarding important issues to consider when developing youth-targeted HIV prevention interventions.

HIV EPIDEMIC IN RURAL SOUTHEAST

Since the mid 1980s, the South has reported more AIDS cases each year than any other region.[2,5,8] Rural communities in the Southeast are disproportionately affected by the AIDS epidemic, accounting for over half of AIDS cases in 2001.[9] In 2003, North Carolina reported the second highest number of AIDS cases from nonmetropolitan or rural areas.[10,11] Our target counties had some of the highest HIV/AIDS rates in the state and the most significant HIV/sexually transmitted infection disparities. Of North Carolina's 100 counties, Edgecombe and Nash counties ranked third and eighteenth in the 3-year average rate of new HIV cases for 2003 through 2005.[2,11]

CHALLENGES TO HIV PREVENTION PROGRAMMING

There are many challenges to the design and implementation of HIV prevention programs in rural African American communities. The rural HIV epidemic occurs within a social context often complicated by low literacy rates and high rates of unemployment, poverty, incarceration, and HIV-related stigma.[12,13] Structural challenges such as the lack of geographic concentration of populations, limited transportation, and few health providers and facilities also make the delivery of health prevention interventions challenging.[14] For

rural residents, boredom and lack of recreational facilities have also been identified as major issues influencing sexual initiation and behavioral patterns.[15] Rural adolescents, in particular, may be at higher risk for HIV infection compared with their nonrural peers owing to increased rates of early sexual debut, lack of condom use, and multiple sexual partners.[7]

HIV INTERVENTIONS FOR YOUNG PEOPLE

Although many HIV prevention interventions have been developed for young people, few address the needs of those residing in the Southeastern United States or rural communities. [4] In addition, few have undergone rigorous evaluation. The US Centers for Disease Control and Prevention (CDC) have identified 14 “youth-targeted” HIV prevention interventions with substantial evidence of their effectiveness.[3,4] Nine of the fourteen programs were tested in samples that were predominantly or entirely African American. Four targeted urban, high-risk African Americans[16–19] and four included multi-ethnic samples with large proportions of African Americans. [20–23] Only two included participants from the Southeastern United States[16,24]; none included participants from rural communities. Excluding the CDC-endorsed interventions, a literature review identified two HIV interventions for adolescents implemented in rural settings.[25,26] Only one of these studies included a significant number of African Americans. This was a peer educator training program that improved sexual knowledge, attitudes, and condom use behaviors.[26,27]

Traditionally, young people have played fairly restricted roles in HIV prevention programs. Commonly, HIV prevention interventions involve young people as peer educators.[28] Few interventions report involving young people in the intervention development and evaluation process.[16,26,27,29–31] Most of these studies fail to describe how young people were involved in the intervention development or systematically assess the effect of their participation. Studies that have done so report that inclusion of young people produced more refined questions, more effective recruitment, data collection/analysis procedures, and a more efficient research administration process.[30–32] In addition, participants reported a sense of empowerment that was transformative in ways that extended beyond the original research intentions.[30]

PROJECT GROWING, REACHING, ADVOCATING FOR CHANGE, AND EMPOWERMENT (GRACE)

Project GRACE is an academic–community partnership that utilizes CBPR methodology to develop feasible and sustainable interventions to address the disproportionately high rates of HIV among African Americans in rural North Carolina. CBPR is a collaborative research approach that equitably involves all partners in the research process recognizing the unique strengths each brings.[33] Some have argued that CBPR techniques represent a promising tool for involving young people throughout the intervention development process, thereby improving intervention success.[4] To date, no published studies describe using CBPR to allow the voices of rural African American young people in the Southeastern United States to inform the development of community-based HIV prevention interventions. In this paper, we report the results of our qualitative exploration of the perspectives of rural African

Americans aged 16 to 24 regarding how to successfully design and deliver effective community-based HIV prevention interventions.

METHODS

Setting

Project GRACE operates in Edgecombe and Nash, two contiguous rural counties in eastern North Carolina. The racial distribution in each county is predominantly White (42% and 61%, respectively) and Black (57% and 37%, respectively) with disproportionately high rates of poverty and sexually transmitted infections/HIV among African Americans. Eighty-five percent of HIV/AIDS cases in the region where both counties are located are among African Americans.[34]

Academic–Community Partnership Development

The Project GRACE partnership and its development has been described in detail elsewhere.[35] In brief, in 2005 university investigators initially reached out to the two communities through a series of community forums to discuss health problems of interest and to identify key community leaders and organizations to work collaboratively to address these problems. The community identified HIV as the primary problem that should be initially addressed and a consortium of 94 community leaders, organizations, and concerned citizens joined the project during the first 2 years, with equal representation from both counties. Consortium members represented diverse sectors such as the faith, government, arts, community-based organizations, and the business and political communities. Consortium members helped to write several grants that funded the community needs and assets assessment from which the data presented here are drawn.

Project GRACE used a staged approach to partnership development,[36–38] that included a cyclical and iterative process to strengthen the partnership.[35,39–42] The project utilizes a steering committee as its governing structure. The steering committee is composed of representatives from all contracting and subcontracting partner organizations and community leaders in each county and is charged with oversight of all project-related activities. We chose this structure because it maintains the integrity of the CBPR process by emphasizing equal partnership, collective decision making and active participation of all members. We use community forums and quarterly consortium meetings to raise community awareness about our research activities, provide information about the spread of HIV in the African American community, and allow community interpretation of research findings and commentary about interventions under development.

Study Design

Project GRACE chose a qualitative approach, using focus group methodology to conduct a community needs, assets, and resources assessment to inform the development of HIV prevention interventions in the two contiguous, rural counties in eastern North Carolina. The needs assessment was conducted during the spring and summer of 2006 and involved 11 focus groups (n = 94) and 37 key informant interviews. For the focus groups, we purposefully sampled three populations that our community partners identified as those at

greatest risk for HIV infection: young people aged 16 to 24, formerly incarcerated individuals, and adults over age 25. In this analysis, we report the results from the focus groups conducted with young people to specifically highlight their perspectives regarding how to successfully design and deliver effective community-based HIV prevention interventions.

Participants

We conducted four focus groups with young people between the ages of 16 and 24 (n = 38). Groups were stratified by gender and risk type. High-risk participants were defined as those who had dropped out of school or been involved with the juvenile justice system. Participants age 18 and older provided verbal consent; parental consent and participant assent were obtained for those under the age of 18. The study protocol was approved by the University of North Carolina Institutional Review Board.

Recruitment/Data Collection

A purposeful sample of participants in the target age range was recruited through local community-based organizations using flyers, print and radio advertising, and snow ball sampling. Focus groups were held at local youth centers, a church, and a county administration facility. Focus group moderators were experienced and matched participants' ethnicity. The discussion guide contained 12 open-ended questions that assessed perceptions about multilevel determinants of HIV (i.e., individual, interpersonal, social, economic, political, structural, and physical/environmental); perceived community needs, assets, and resources affecting local HIV rates; and key considerations for intervention development. Each focus group lasted approximately one and a half hours. Participants received a cash incentive of $20.

Data Analysis

Focus groups were audio-recorded, transcribed, and coded using Atlas. Ti,[43] a qualitative data management program. We used the following modified grounded theory approach to data analysis.[44] Three coders read each transcript to identify themes related to recommendations for HIV prevention interventions targeting youth. Two coders were Master of Public Health–trained university researchers with experience in qualitative data analysis and one was a community member who was trained in qualitative analysis techniques. This allowed triangulation of perspectives to ensure appropriate interpretation of the data. Coders read each transcript line by line to identify themes in a process called *open coding*. The three coders reconvened to discuss their broad list of initial themes and to group these themes into thematic categories in a process referred to as *axial coding*. This resulted in the development of a thematic codebook. Each transcript was recoded by two independent coders using the codebook. Coding discrepancies were resolved via consensus. Data were sorted and displayed in matrices allowing us to identify themes specific to individual focus groups, gender, or risk groups as well as to identify themes salient across all focus groups thereby indicating thematic saturation. Reported results represent consensus across all focus groups.

RESULTS

Sample Characteristics

The sample characteristics are shown in Table 1. In regards to gender, our sample was fairly evenly split (47% female; 53% male). The mean age was 18.1years (*SD* ± 2.0). Most had never been married and were currently in school.

Thematic Overview

Participants identified four key considerations when designing community-based HIV/AIDS prevention interventions targeting young, rural African Americans. They discussed key population groups to target, intervention approaches, key collaborators to involve, and potential barriers to intervention success. Although this section includes illustrative quotes, please refer to Table 2 for a complete list of quotes.

Target Population: "Catch Them While They're Young!"

Participants overwhelmingly agreed on the importance of providing HIV prevention information early and often. Sexuality and HIV education before puberty was felt to be critical for preparing children for the physical changes and sexual urges that accompany normal sexual development. Participants believed early education would improve decision-making skills critical for navigating the often confusing sexual development period. The following quotes support this theme:

> You need to come in elementary school and start teaching them early; if you can get it through their head early, when they grow up, then they'll know what to do and what not to do.

> 'Cause when you're in middle school, you start to get your hormones and all that stuff and you're looking around, like sex is like the new thing, and you're wanting to have sex with everybody and anybody.

Intervention Approaches: "Find Us and Try to Put Your Purpose in the Middle!"

Participants identified four recruitment and intervention delivery issues critical for success. The identity of recruiters and intervention leaders was of the utmost importance for engaging and retaining participants. Appropriate venues for recruitment activities and intervention delivery were suggested. Acceptable communication styles for intervention staff were described. Finally, participants delineated incentive structures necessary to facilitate hiring intervention staff from the community and attracting younger participants.

Participants identified three types of people ideally suited to be recruiters and intervention leaders: peer educators, respected community adults, and PLWHA. Participants believed young people were more likely to respond positively to prevention messages delivered by peer educators.

> Maybe young people should talk to young people, but some grownups act like they ain't even been through some stuff, like they never did wrong. And young people

> would more likely listen to another young person who's been through it, or knows about it.

Participants also reported that respected community adults who play positive roles in the lives of young people, could provide wisdom and experience about HIV and sexual health that peer educators might lack, as the following quote highlights: "The people in the neighborhood that are really trying to do things. They're trying to do positive stuff with the bad kids." Finally, participants believed that PLWHA could deliver the most powerful messages due to their experience living with HIV/AIDS.

> The people who already got it [HIV/AIDS]. They step [at you] like, 'I got it. Y'all don't want it.' And then they express what they go through. They'll make the next person think two or three times before they have unprotected sex.

Participants also acknowledged benefits of learning from all three perspectives within the context of one intervention. They suggested interventions targeting young people consider starting with peer education then later integrate the perspectives of adults.

> Adults won't be effective at speaking to youth; if you're like 17, 18 you don't want to hear somebody grown telling you [that] you can't do this and you can't do that. So, we think that in order to get the youth, we start with the youth but bring the adults in to educate us 'cause we don't know everything.

Participants suggested a variety of appropriate venues for recruitment activities and intervention delivery (Table 3). Most were sites where young people commonly socialize. As one participant said, "Find us, and then you try to put your purpose in the middle of it. I think that'll be a good thing." These results suggest the importance of recruiters becoming familiar with and comfortable participating in activities mimicking young people's daily lives.

Participants had specific opinions about appropriate communication behaviors intervention staff should employ such as how staff should dress, talk, and act. Staff should wear casual clothing and feel comfortable using local slang. The following quote highlights the participants' sentiments regarding staff clothing: "No suit! Man I ain't gonna listen to him." They wanted a mutually respectful communication style that fostered dialogue rather than lecturing. Participants shared: "You ain't gonna just walk up to nobody like that and go 'listen to this, son'." Participants preferred: "May I have some of your time to talk to you?" Participants also shunned prevention messages called "education" or "information" preferring the use of catchy "street words" such as "fun gatherings, rap sessions, jamborees, or a chat about AIDS." Participants reported that: "Boring programs won't catch people's attention."

Finally, given high poverty and unemployment rates, participants recommended both money and food as adequate compensation for staff and participants recruited from the community, particularly young people. This was perceived as a key step toward establishing credibility and demonstrating a commitment to improving the overall quality of life in the community. Participants shared:

> But y'all got to be paying something good. You know what I'm saying. Y'all got to be throwing out $11.15 an hour or something like that.
>
> Food is the thing that's gonna draw them out there.

Potential Collaborators: "It Takes Everyone in the Village to Reach the Youth!"

Participants identified three stakeholders as key collaborators: respected members of youths' social networks (e.g., family, friends, teachers/coaches, religious leaders), popular icons whose lives local young people try to emulate (e.g., television, music or sports stars), and negative role models (e.g., alcoholics, drug addicts) from whom young people could learn. Regarding the latter group:

> Like a wino or something, they talk sense but won't nobody listen to them. But they got more wisdom than half these people in school. Just 'cause they ain't got book sense, they still got sense. To me, they done messed up. So, they're gonna learn from their mistakes.

The underlying message regarding the selection of collaborators was that "it takes everyone in the village to reach the youth."

Barriers: "You Won't Hear Nobody Talking About AIDS!"

Participants identified four major barriers to the successful design and implementation of community-based HIV prevention interventions for young people. First, the lack of a local public transportation system would make accessing intervention programs difficult. Participants stated: "A lack of transportation, 'cause a lot of people ain't got no cars or nothing, [they] can't get around." Second, pervasive social stigma and discomfort discussing sex and HIV/AIDS among both adults and young people might hinder hiring of intervention staff, recruitment, and program acceptance by the broader community. One participant shared: "For young people, I think what stands in the way is that they're so, what's the word, they might be embarrassed and uncomfortable to talk about it." Third, perceived lack of involvement in HIV prevention efforts by key community stakeholders, such as politicians and law enforcement, was thought to present a major challenge. The following quotes highlight participants' frustration:

> They [stakeholders] don't care about us 'cause we live in the hood. This town ain't gonna do nothing for us.
>
> Ain't nobody we'll listen to 'cause ain't nobody going to talk to us.

Finally, the unwillingness of social institutions and other community organizations to collaboratively acknowledge and address sexual activity among adolescents was cited as a major barrier. One participant reported:

> They don't talk about it enough around here. They don't talk about it hardly. The only person you will probably hear it from most likely is from your parents. Unless you're with your parents, you won't hear about nobody talking about AIDS or nothing like that. And if you hear it in the streets, they talking bad. They taking bad about it.

DISCUSSION

Our findings provide insight on key issues to consider when developing HIV prevention interventions for young, rural African Americans, a population at risk for HIV infection. We identified four areas of focus: which population subgroups to target, acceptable recruitment and intervention delivery approaches, collaborators to involve in the intervention process, and barriers to intervention success. Participants noted a number of features either missing from existing interventions or perceived as critical to success in rural communities.

Research demonstrates effective HIV prevention interventions for young people include elements that are theory based, provide a combination of HIV knowledge and behavioral skills training, and enhance motivation to reduce HIV risk.[45,46] These tenets are unlikely to differ for interventions targeting rural versus urban youth. However, our data suggest several approaches not typical of many existing HIV prevention interventions. First, participants felt interventions need to start earlier, preferably in elementary or middle school. Although study participants were older adolescents and young adults, their lived experiences informed their beliefs regarding the need for interventions to begin much earlier, and this belief challenges current, local education policies as well as the approach of many existing interventions. Most existing interventions target older, usually sexually active adolescents, [3,4,44] despite evidence that sexual behavior interventions are more likely to be effective if implemented before sexual risk behaviors become established.[47–49] Second, participants wanted programs to incorporate multiple perspectives. They wanted didactic knowledge from peers or other respected experts and experiential learning through the eyes of PLWHA and high-risk groups such as drug users. Most existing programs use trained facilitators or peer educators, although recent programs have begun to incorporate the voices of PLWHA.[50] Finally, participants wanted interventions to blend seamlessly into their existing social lives. Although many existing interventions are implemented in community-based settings, these settings are often not the main social venues for the target populations, particularly high-risk young people. Participants recommended interventions be delivered on street corners, in beauty salons, and other local establishments already serving local young people.

Several study findings suggest HIV prevention efforts targeting young people in rural African American communities may require additional tailoring to be effective. Similar to other studies of challenges to health prevention in rural communities, participants highlighted the high prevalence of poverty and lack of transportation as important challenges.[14,51,52] Participants articulated three additional barriers salient for HIV prevention efforts in rural communities, including community social norms reflecting highly negative attitudes toward HIV/AIDS and a perceived lack of involvement by socially and politically influential community leaders. Others have noted that residents of rural communities hold more HIV-related stigma compared with urban communities.[53–59] Thus, HIV prevention interventions may need to both address the prevention needs of young people while simultaneously seeking to change community norms regarding HIV and AIDS. Participants reported significant denial within their communities regarding early adolescent sexual debut and controversy regarding discussing sexuality with adolescents, all of which they noted might hamper HIV prevention efforts. The Southeast, particularly rural communities, is more socially and politically conservative with regard to sex, which may

make program recruitment and implementation difficult or constrain the types of programs developed.[14,32]

Collectively, our findings suggest that youth and young adults are interested and willing to participate in all aspects of intervention development and execution including recruitment and serving as intervention staff. Their desire to be engaged in all phases of intervention development/implementation parallels the approach used in CBPR. CBPR ensures that interventions' target populations collaborate in every phase of research design and evaluation ensuring that key stakeholders' perspectives are articulated and integrated throughout the research process.[33] Few existing youth-targeted HIV prevention interventions have sought the perspectives of young people as part of the intervention development process.[4] Several national[16,27,50,60–62] and international studies[30,31] found their HIV prevention interventions were better conceptualized and more effective when young people's perspectives were integrated into the development and/or implementation process.

We have used our findings to shape both the expansion of our partnership as well as intervention development. We have added youth and young adult members to our steering committee to provide input into the broader management and operation of our CBPR partnership. A youth advisory board has also been added to help guide intervention implementation. Finally, we have collaboratively developed *Teach One Reach One*, a family-based, lay health advisor HIV prevention intervention that trains caregivers and their preadolescents and early adolescents (ages 10 to 14) to be peer educators.

There are several important considerations when interpreting the results of this study. First, the data from these two rural communities may not be generalized to populations with different sociodemographic characteristics. However, our findings may be applicable to other young African Americans residing in similar high-risk rural communities. Second, young people who participate in research studies likely differ from those who choose not to participate.[63–65] Thus, the essential intervention components articulated here may not be effective for all populations of young people. Our inclusion of both low-and high-risk participants was intentional to increase the validity of study findings within our target population. Third, participants articulated desired programmatic elements but, given that a number of their suggestions have not been incorporated into HIV prevention programs demonstrated to be successful, the impact of these suggestions on the effectiveness of interventions needs to be tested.

These findings provide critical insight regarding essential intervention components that should be considered when designing HIV prevention interventions for rural, African American young people. Interventions should begin early, broadly target young people, and incorporate multiple perspectives. For rural communities, interventions will need to address denial about early adolescent sexual debut and negative community social norms regarding HIV and PLWHA. The integration of young people's voices can enhance the development of culturally appropriate, youth-targeted HIV interventions in rural communities.

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Table 1

Characteristics of Youth and Young Adult Focus Group Participants (*N* = 38)

Characteristic	***N* (%)**
Female gender	18 (47)
Mean age, years	(*SD*) 18.1 ± 2.0
Education	
Less than high school	5 (13)
Some high school	27 (71)
Graduated high school/GED	3 (8)
Some college	2 (5)
Graduate degree	1 (3)
Marital status	
Married or living with a partner	4 (11)
Separated	4 (11)
Never married	30 (79)
Employment*	
Working full time	3 (8)
Working part time	9 (24)
Taking care of home or family	2 (5)
In school	27 (71)
Other	4 (11)
Family receiving public assistance	8 (21)

*Respondents were allowed to check all that apply.

Table 2

Themes and Illustrative Quotes Theme Subtheme Illustrative Quotes

Theme	Subtheme	Illustrative Quotes
Target population: Catch them while they're young!	Early education	You need to come in elementary school and start teaching them early; if you can get it through their head early, when they grow up, then they'll know what to do and what not to do. 'Cause when you're in middle school, you start to get your hormones and all that stuff and you're looking around, like sex is like the new thing, and you're wanting to have sex with everybody and anybody.
Intervention approaches:	Identity of recruiters and intervention leaders	What you need to do is get some real young kids on your team. Like you let some of us talk to them and they'll understand us better.
Find us and try to put your purpose in the middle!	Peers	Maybe young people should talk to young people but some grownups act like they ain't even been through some stuff, like they never did wrong. And young people would more likely listen to another young person who's been through it, or knows about it.
	Respected community adults	The people in the neighborhood that are really trying to do things. They're trying to do positive stuff with the bad kids.
	People living with HIV/AIDS	The people who already got it [HIV/AIDS]. They step [at you] like, "I got it. Y'all don't want it." And then they express what they go through. They'll make the next person think two or three times before they have unprotected sex.
	Collaborative approach	Adults won't be effective at speaking to youth; if you're like 17, 18 you don't want to hear somebody grown telling you [that] you can't do this and you can't do that. So, we think that in order to get the youth, we start with the youth but bring the adults in to educate us 'cause we don't know everything.
	Appropriate venues for recruitment activities and intervention delivery	Find us, and then you try to put your purpose in the middle of it. I think that'll be a good thing.
	Acceptable communication styles (dress, talk, act, intervention format)	No suit! Man I ain't gonna listen to him. You ain't gonna just walk up to nobody like that and go, "Listen to this, son." Could I talk to you for a second? May I have some of your time to talk to you? Boring programs won't catch people's attention.
	Incentive structures (money, food)	Money! I'll be honest. But y'all got to be paying something good. You know what I'm saying. Y'all got to be throwing out $11.15 an hour or something like that. Food is the thing that's gonna draw them out there.
Potential collaborators: It takes everyone in the village to reach the youth!	Respected members of a youths' social networks	Mr. [name of teacher/coach] he'll tell the class some of the stuff he done and the road he went down. So, he'll like, [encourage us to] not do the stuff we do 'cause he's been down that road. He was our age one time, and knows the consequences.
	Popular icons	Listen to somebody famous or something just to get the word through, 'cause everybody listen to them 'cause they're famous or whatever.
	Negative role models	Talk to people that most people would not listen to. Like a wino or something, they talk sense but won't nobody listen to them. But they got more wisdom than half these people in school. Just 'cause they ain't got book sense, they still got sense. To me, they done messed up. So, they're gonna learn from their mistakes.
	People living with HIV/AIDS	Let's talk to people that got HIV, you know what I mean, give a speech to somebody. They're going through it, so we would listen.
Barriers: You won't hear nobody talking about AIDS!	Lack of a local public transportation system	A lack of transportation, cause a lot of people ain't got no cars or nothing, [they] can't get around.

Theme	Subtheme	Illustrative Quotes
	Pervasive social stigma and discomfort discussing sex and HIV/AIDS	For young people, I think what stands in the way is that they're so, what's the word, they might be embarrassed and uncomfortable to talk about it.
	Perceived lack of involvement in HIV prevention	They [city government] don't care about us 'cause we live in the hood. This town ain't gonna do nothing for us. They [key community stakeholders] need to show us some love. Do something about this.
	Unwillingness of social institutions and other community organizations to collaboratively acknowledge and address sexual activity among adolescents	They don't talk about it enough around here. They don't talk about it hardly. The only person you will probably hear it from most likely is from your parents. Unless you're with your parents, you won't hear about nobody talking about AIDS or nothing like that. And if you hear it in the streets, they talking bad. They taking bad about it. So when they [Health Department personnel] clock out, they clock out. They ain't doing nothing else. They're going home, going to sleep. They ain't worried about telling nobody nothing [about HIV/AIDS]. They just clock out. They're done.

Table 3

Suggested Recruitment and Intervention Locations and Events

Educational institutions	**Community colleges**
Community-based organizations	Recreational centers
	Youth-serving organizations
Local businesses	Beauty shops
	Barbershops
	Nail salons
	Restaurants
	Corner stores
Local “hang-out spots” for young people	Wal-Mart
	Dance clubs
	Strip clubs
	Malls
	Parks
Neighborhood locations	Street corners
	Front porches
	Housing projects
Community events	Festivals
	Cook outs
	Fundraisers
	Block parties