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Mitigating Disparities in Community HIV Testing among Youth and Young Adults

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ABSTRACT

Prevention strategies are a key lever for reducing HIV incidence, which differentially affects jurisdictions. HIV incidence coexists with social determinants of health, health-related disparities, poverty, and other risk factors. One zip code in Jacksonville, Florida's urban core fit the description of a disadvantaged jurisdiction; hence, the local HIV prevention consortia implemented a theory-based, social outreach HIV prevention event, which attracted 189 residents and 64 tested for HIV. Survey data from 120 respondents indicated that event attendees viewed the event's prevention activities and the supporting entertainment music favorably. Respondents liked the emphases on healthy behaviors, health education, and community capacity to address HIV; but they disliked the outdoor heat and the small turnout; therefore, they recommended hosting future events indoors and doing more advertising. Some respondents even volunteered to assist in planning future events. Logistic regression examined odds ratios for five dichotomous outcome variables cross-tabbed by race, comparing null and saturated models. None of the odds ratios were significant, indicating respondent's consensus on event feedback. Going forward, event planners aim to implement feedback received from participants; attract a large fan base, and increase the sample size from 120 to 263, so the margin of error is 6.0% rather than 8.92%.

Mims, J., Odell, K., Watts Sr., G.F., & Arts S. (2018). Mitigating disparities in community HIV testing among youth and young adults. *Florida Public Health Review*, 15, 49-60.

BACKGROUND

At the turn of the century, researchers described a challenge that typifies health promotion framed in the context of existing, current medical culture. A medical paradigm “emphasizes pharmacosurgical interventions that produce immediate results and whose dosage can be easily defined and controlled. [Notwithstanding internal validity] ...interventions that prove efficacious in randomized trials are much less effective in the general population” (Glasgow, Vogt, and Boles, 1999, p. 1322). With that background information, we describe here the opportunity to disseminate HIV prevention messages in one at-risk, inner-city jurisdiction in Jacksonville, Florida, zip code 32206, located in Health Zone one, (HZ1). No prior assumptions about outreach dosage and corresponding effects emerged because no brief, point-in-time event has efficacy to produce an immediate and sustainable change in the health culture of a freestanding community. The assumption here is this brief, point-in-time outreach will

reinforce the coordinated public health and health services work in Metropolitan Jacksonville, Florida.

There is an urgency for disseminating HIV prevention messages in 32206. Why? A brief examination of two data sources underscores the urgency! Based on Florida Department of Health—Duval data, the HIV epidemiology in HZ1 presents this picture. Among adults, there were 490 HIV diagnoses from 2012 to 2016. Males represented 63%, (n=311), females represented 37%, (n=179), 13-to-29-year-olds represented 33%, (n=163), and African-Americans/Blacks represented 82%, (n=404). Gender stratification showed differences within race groupings. Among males, African-Americans/Blacks represented 80%, (248 of 311), and among females, African-Americans/Blacks represented 87%, (156 of 179). Gender stratification also showed differences within age groups. Among males, 13-to-29-year-olds represented 41%, (126 of 311), of the cases, and for females, 13-to-29-year-olds represented 21%, (37 of 179), of the cases. The primary mode of HIV infection, among females, was

heterosexual contact with percentages upwards of 90% over the five-year period. Among males, the dominant modes of HIV infection were primarily men who have sex with men, (MSM 59% to 72%) and secondarily heterosexual contact (35% to 43%). The *2011-2015 American Community Survey 5-Year Estimate* data source provides context for understanding the community. Zip code 32206 population, (N=17,141), comprised 76.95%, (n=13,190), Blacks/African-Americans and 19.1%, (n=3,327), White. Whereas 77.0% completed at least high school, almost one-fourth (22.9%) had less than high school completion. About 42.1% of the population, lived below poverty—income below the minimum that an individual or family needs for necessities

(https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml). In Duval County, "...11.90% of the population and 9.20% of families are below the poverty line" (<http://duvalcounty.org/>). Targeted HIV prevention in 32206 appears warranted since "HIV prevalence rates in urban poverty areas [among the poor are] inversely related to annual household income—lower income [co-occurs with] greater HIV prevalence..." (https://www.law.berkeley.edu/files/bccj/Denning_and_DiNenno_XXXX-1.pdf).

HIV prevention messaging has a behavioral dimension. Behaviors include seeking information, getting tested, returning for test results to know one's HIV status, negotiating condom use, carrying condoms, using condoms appropriately, taking pre-exposure medications, and so on. Hence, "...preventing the transmission and the acquisition of HIV must focus on behavior and behavior change. ...There has been a growing recognition that behavioral science theory and research can play an important role in protecting and maintaining the public health" (Fishbein, 2000, p. 273). The public health literature is replete with theory-based HIV prevention programs. Albarracín, Gillette, Earl, Glasman, and Durantini, (2005), has an excellent meta-analysis that is useful for informing HIV prevention outreach work. Consequently, guidance exists for addressing the needs of youth and young adults in HZ1 and attempting to do so in a way that holds promise to reduce exposure to HIV in the population over the long-term. The first iteration in a planned series of annual HIV prevention outreach programs seeks to raise community awareness about susceptibility to sexually transmitted infections, (STIs), including HIV and widespread availability of STIs prophylaxis and testing services in the local community. The programmatic assumption rests on these tenets:

- Youth and young adults unaware of free, community-based, HIV testing and

prophylaxis services are less likely to get tested,

- Youth and young adults who are less likely to test for the HIV antibody are correspondingly less likely to know their HIV status.
- Youth and young adults who are less likely to be aware of their HIV status are also less likely to engage in using prophylaxis and sharing HIV prevention information with sexually active peers.

In some of the published, behavioral science literature, there is a tendency for HIV prevention activities to focus on small groups of the type typically seen in workshops. Within this format, emphases embrace a mix of strategies. Providing information aims to raise awareness about actual or perceived risks. Engagement in role play exercises promotes cognitive problem solving and behavioral decision-making to support healthy behaviors. Skills training offer tools for mitigating risks of HIV infection in real-world situations. Finally, use of positive reinforcement and or affirmations serve as cues to action to trigger behavioral change among participants. The typical classroom approach has roots in person-centered behavior change theories such as Social Cognitive Theory, and it has succeeded in diverse population groups such as adolescents and others with sexually transmitted infections (Kelley, Somlai, DiFranceisco, & Otto-Salaj, 2000).

However, influencing behavior change in larger groups than might be held in classrooms, among participants with different stages of readiness for attitude or behavior change, or more fundamentally, awareness of the need to change requires different theoretical approaches.

HIV Prevention Intervention Theories

The organizing frameworks for the design of the community-wide, HIV prevention outreach event was the Diffusion of Innovation model, (DIM) and Vroom's Value Theory of Achievement Motivation. DIM informed the HIV outreach planning process by providing insights on community mobilization and participation.

In the DIM model, Diffusion encompasses all of the processes by which an idea transmits from source to receiver, in specific channels. Innovation, on the other hand, identifies an object, such as a message, which is either new or pre-existing but presented in a new way. Based on these fundamental tenets, the DIM postulates key features of successful message transmission to would be adopters and implementers. By definition, adopters are participants who evaluate an object and make a decision regarding its usefulness. In contrast, implementers are adopters who change their thoughts, attitudes, and behaviors toward an object, solely because of either the

innovation or the combination of the innovation and preexisting factors. The constructs of the DIM that guided the development of the HIV prevention outreach event were — *Simplicity*, *Relative Advantage*, and *Compatibility* — SRC. *Simplicity* refers to the emotional appeal and ease of identifying with and recalling the intervention messages. It suggests that if participants can quickly get a cognitive grasp of the intervention messages that they are more likely to perceive them as memorable, and perhaps meaningful. *Relative advantage* refers to the attractiveness of the intervention to the target population. It suggests that if participants like the intervention they are more likely to pay attention to intervention activities. Finally, *compatibility* refers to the capacity of participants to become engaged in thinking about the import of the HIV prevention messages during delivery on account of the delivery format and message attractiveness. Considering that the audience is 13 to 24 year-olds, both delivery format and content, if appropriate, can encourage identification with the intervention messages (Dearing, 2009; Murray, 2009), which are the first step toward future dissemination of the messages in interpersonal contacts.

The second theory that informed development of this community-wide HIV prevention event was Vroom's Value Theory of Achievement Motivation, (VVTAM), described elsewhere (Wigfield & Eccles, 2000 & Van Eerder & Thierry, 1996). It provided insights on the determinants of HIV prevention awareness and readiness to take action to avoid HIV infection or limit the spread of HIV. The constructs of the VVTAM that guided the development of the HIV prevention outreach event were—*Expectancy* and *Ability Beliefs*, (EAb). *Expectancy*, (a.k.a., efficacy expectation in an Albert Bandura paradigm), describes the subjective assessment of the likelihood of acting such as taking an HIV test, negotiating condom use, carrying condoms, using condoms, or choosing to postpone intercourse. In contrast, *Ability Beliefs* refers to one's perception of competence in carrying out an action, which is a valence or weighted estimator of the likelihood of taking action that results in success. Ability beliefs suggest a sense of control, commitment, and power in one's life (Mirowsky & Ross, 1986). By organizing both theories in a 3 x 2 matrix, six themes emerged as criteria for framing HIV prevention messages: (1) Easy to grasp and perceived as doable—the intersection of *Simplicity* and *Expectancy*; (2) Likeable and perceived as doable—the intersection of *Relative Advantage* and *Expectancy*; (3) Memorable and perceived as doable—the intersection of *Compatibility* and *Expectancy*; (4) Easy to grasp and carry out with predetermined results—the intersection of *Simplicity* and *Ability Beliefs*; (5) Likeable and can be carried out with predetermined

results—the intersection of *Relative Advantage* and *Ability Beliefs*; and (6) Memorable and can be carried out with predetermined results—the intersection of *Compatibility* and *Ability Beliefs*.

The purpose of this study is to describe the community-wide HIV prevention Outreach intervention in such details that permit replication in other free-standing communities. Eleven questions provide a framework for the evaluation of this HIV prevention event!

1. Who attended the event?
2. How did attendees perceive the event?
3. What did attendees recall from the event?
4. What did attendees like about the event?
5. What did attendees dislike about the event?
6. Would attendees volunteer for planning future events?
7. Was race associated with interest in planning future events?
8. Was race associated with being in the targeted age group?
9. Was race associated with sharing contact information?
10. Was race associated with attendees' perceptions of the event?
11. Was race associated with attendees' perceptions of the entertainment at the event?

These *a priori* questions had two benefits. First, they provide a window for assessment of the event planning process and the assumptions that guided planning. Second, participant's responses will provide a barometer of how well the event matched the cultural needs of the participants.

METHODS

Directive

Northeast Florida has an Integrated HIV Prevention and Patient Care Plan, (IHPPCP). Multiple work groups, including the Prevention Outreach group, staff the IHPPCP. The focus of the Prevention Outreach group is to develop and implement strategies for identifying and promoting routine HIV testing in the jurisdiction. One strategy for promoting routine HIV testing centered on hosting a block party to attract youth and young adults through music, food, and giveaways. Work group members collaborated with others to plan the block party. It coincided with the August school reopening because Duval County High School students 2015 Youth Risk Behavior Survey indicated that "...1 in 4 high school students reported... sexual activity, [among whom], 40% did not use a condom the last time that they had sex" (http://duval.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/_documents/sexual-behaviors-hs-2015.pdf).

Settings

A. Phillip Randolph Heritage Park (APR) hosted the event. It lies on the east side of Jacksonville (<http://apps2.coj.net/parksinternet/parkdetails.asp?parkid=213>), in zip code 32206, in the urban core, called Health Zone 1, (HZ1). HZ1 has a "...population density of 2,516.4 people per square mile.... [Of] six Health Zones in Duval County, [HZ1 has] the highest poverty rates, (29.6%). [It also has] the largest percentage of minority population, (81%)..., almost twice the percentage of [minorities than] any other Health Zone. [HZ1 has] the lowest percentage of the population with more than a high school education" (http://duval.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/_documents/chip.pdf) and "...the most students that did not use any method to prevent pregnancy during last sexual intercourse" (http://duval.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/_documents/sexual-behaviors-hs-2015.pdf). This zip code has social determinants of health (<http://www.who.int/hia/evidence/doh/en/>). It is part of Jacksonville, which "...ranks among the top 10 U.S. cities with the highest rates of new HIV diagnoses" (<https://images.gettested.com/Press/gettested-hivmap-2016.jpg>). Jacksonville, FL is a region that also acknowledges sexually transmitted diseases as one of its top five health concerns (http://duval.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/community-health-status/_documents/2016-duval-county-themes-and-strengths-assessment-fact-sheet.pdf). Therefore, HZ1 is fertile ground for the inauguration of planned, annual HIV prevention outreach events.

Event Planning

Planning the community-wide outreach event followed the consensus-building model described elsewhere (Margerum, 2002). This 3-step model sequenced through the stages of problem setting, direction setting, and implementation setting with the help of 12 volunteers from seven agencies. In the problem setting stage Northeast Florida, Integrated HIV Prevention and Patient Care Prevention Outreach subgroup coordinator coalesced stakeholders to assist with audience identification, segmentation, analysis, and understanding for focusing the HIV prevention outreach event. This preparatory work relied on data from three focus groups—consisting of 58 high school students, of which 32 received \$5.00 McDonald's gift cards. Members of First Coast Community AIDS Prevention Partnership, the local HIV prevention planning body, also guided the development of the event. In the direction setting stage, stakeholders

translated their understanding of the audience needs into an actionable proposal with a budget, timeline, and a Gantt chart, which garnered the vote of a simple majority, (51+%), of stakeholders' present. Under the consensus vote, the IHPPCP task force reviewed the plan and endorsed it, which cleared the way for implementation. Lastly, the committed stakeholders embarked on single and shared actions leading up to kickoff. The elapsed time from the decision to host the HIV prevention outreach event to kickoff was 20 weeks.

Event Implementation

Forty-seven volunteers implemented the HIV prevention event, hosted on August 4, 2017, from 2:00 pm to 6:00 pm, EST. Volunteers came from agencies such as UF Health, Northeast Florida AIDS Network, Gateway, AIDS Healthcare Foundation, River Region Human Services, JASMYN, Florida Department of Health—Duval, and City of Jacksonville Social Services Division. Some of the more intense roles performed by volunteers included setting up water stations, handing out water, setting up booths and mobile HIV testing vans, transporting materials, making security rounds in the park, holding up event signs, giving out event flyers in the community, and managing clean-up. On the lighter side, volunteers greeted attendees, distributed meal passes, handed out 194 backpacks with school supplies, staffed games, and first-aid stations, talked to event attendees, communicated with the media, and maintained phone contact with the event organizers. The presence of two-uniformed Jacksonville Sheriff police officers added to the security of the outdoor event, which was incident free.

Event Survey

Data collection used *The Jacksonville Florida Youth Leaders for Health Promotion Survey*. Three measures and associated statistics describe the readability of the survey—Words per sentence, Characters per word, and Flesch-Kincaid Grade level. There were nine words per sentence, 4.3 characters per word, for a Flesch-Kincaid Grade Level of 3.7. On average, it takes about 12 minutes to complete the 11 items survey. Four items are closed-ended, and seven items are open-ended. The open-ended items ask: "What did you learn from this event? What did you like about this event? What did you dislike about this event? How would you make this event better? Where can we hold events like this one? Would you be interested in planning events like this one? How can you be reached to help plan events like this one?" In contrast, the closed-ended questions ask: "How would describe this event? How is the prevention entertainment—music and songs?" Both questions used a five-point ordinal scale labeled as follows,

“Sucks, (awful), Okay, Good, Very Good, and Great.” The last two closed-ended questions asked about race and age. One item asked: “Would you say you are: White, Black/African-American, Asian, Native American or Alaska Native, Native Hawaiian or Other Pacific Islander, and other or mixed.” The other item asked: “What is your age-group”? Responses included “Under 13, 13 to 15, 16 to 20, 21 to 24, and over 24.”

Data Analysis

Analyses used a mixed design. Content analysis identified themes embedded in participant’s open-ended responses. Frequency distributions summarized the counts of identified themes and participant’s responses to the close-ended questions. Next, logistic regression odds ratios summarized effect sizes in multiple bivariate relationships. STATA, version 15, modeled two-by-two bivariate associations to generate odds ratios, using logit modeling for grouped data. Exploring null and saturated models with the Akaike Information Criterion, AIC—a goodness of fit statistic, defined as $-2L_m + 2m$, where L_m is the maximized log-likelihood and m is the number of parameters in the model” (<http://www.modelselection.org/aic/>). Smaller AIC values indicate a better fitting model, (Bozdogan, 1987), and lends credence to information in the 95% confidence intervals for the odds ratio.

RESULTS

The HIV prevention outreach event in-kind, share of cost was \$2,685.98, and actual expenditures totaled \$9,244.87. Hence, the budget—revenue and expenditures—for the event, which attracted 189 active participants—non-stragglers, was \$11,930.85. The estimated average per person cost, excluding in-kind contributions, was \$48.91, ($\$9,244.87/189$). Of the people in attendance, 120 completed the brief, event survey, and 64 took the OraQuick Advance Rapid HIV-1/2 Antibody Test. None of the completed tests yielded a reactive result. Twenty-nine vendors staffed the Outreach event, setting up food trucks along the eastern perimeter of APR Park. Public service volunteers gave 194 backpacks, stuffed with classroom supplies, to high school and college aged youth. Health booth staff spent 68 hours in safer sex and health education dialogs and gave away 1,600 condoms. Entertainers asked eight HIV-related trivia questions and hosted five-affle drawings. Altogether, 13 winners, (8 for the trivia questions and 5 for the raffles), each received a \$25.00 Walmart gift card. The social context of the HIV prevention event became a fun filled affair with gifts that included 30 t-shirts, 495 meals, and 320 Italian Ice 16 oz cups.

Table 1 presents the results of survey participants’ demographics and event perceptions and interests.

Most attendees were Black/African-American, (75%). One in four, (26%), were between ages 16-20. Slightly more than 1 in 10 were either 13 to 15 years old, (15%), or 21 to 24 years old (13%). Persons over 24 years old, (41%), comprised the largest age group. Of this mix of event participants, slightly more than half, (53%), were in the targeted age group, (13 to 24-year-olds). Most, (91%), perceived the event favorably—that is, rated it as good, very good or great. In contrast, 82% also expressed a favorable perception of the entertainment music. Two-thirds, (66%), of respondents, expressed interests in planning future HIV prevention outreach events, and almost six of ten, (58%), voluntarily shared contact information.

Table 2 presents participants’ thematic appraisal of the HIV prevention event. Open-ended questions provided unrestricted opportunities for a broad range of uncensored feedback. One question asked: “What did you learn, (take away), from this event?” Most, (76%), of the identified responses mapped to themes such as health education, (27%), healthy behaviors, (21%), community capacity, (16%), and health protection, (12%). Another question asked: “What did you like about this event?” Almost six of ten, (58%), respondents had specific likes. The educational emphasis, (24%), the entertainment music, (18%), and the ambiance, (16%), comprised things well liked. However, participants may also have dislikes; therefore, another question asked: “What did you dislike about this event?” Three in ten, (30%), reported, the heat; and 5% reported low turnout. Nonspecific dislikes reached 50%, which included nothing, (27%), and no response, (23%). Two questions focused on creativity. The first question asked: “How would you make this event better?” Improvement suggestions included doing more advertising, (12%), lifting the age restriction, (12%), and hosting the event indoors, (11%). The second question asked: “Where can we hold events like this one?” Suggested locations included the A. Phillip Randolph Park (9%), other neighborhood parks (8%), and in a building (6%); but one in five (19%), skipped the question.

Table 3 presents outputs of Logistic Regression analyses reported as odds ratios. Five logistic regression equations compared null and saturated models, which examined whether the probability of an outcome of interest in one group is significantly better than the probability of the same outcome of interest in another group. Making use of model comparisons ensured that the full, saturated model was substantively different from the nested model that omitted the predictor. The outcome variables were interests in event planning, target age-group attendance, contact information, event description, and music description. Outcomes one to three used a dichotomy, operationalized as “Yes,” and “No.” In

contrast, outcomes four and five used a dichotomy operationalized as “Good at Best” and “Very Good or Great.” The single predictor variable was race, dichotomized as “Black/African-American” and “non-Black/African-American.” Explanation of the five Logistic Regression analyses follow. The saturated model included race, the predictor variable, and the null model excluded it.

The odds ratio for the association between race and targeted age group was 1.63, 95% confidence interval 0.69 to 3.89. This saturated model had an AIC value of 164.2 compared to the null model AIC value of 163.5. Although the odds of being in the targeted age group was higher for Black/African-American respondents compared to other respondents, the difference was not significant at the alpha level of $p < .05$, because the range of values in the 95% confidence interval for the odds ratio includes one. The odds ratio for the association between the race of the respondent and interest in planning future events was 1.79, 95% confidence interval 0.74 to 4.33. This saturated model had an AIC value of 157.3 compared to the null model AIC value of 157.1. Although the odds of interest in planning future events was higher for Black/African-American respondents compared to other respondents, the difference was not significant at the alpha level of $p < .05$, because the range of values in the 95% confidence interval for the odds ratio includes one. The odds ratio for the association between the race of the respondent and contact information was 1.25, 95% confidence interval 0.52 to 3.00. This saturated model had an AIC value of 161.3 compared to the null model AIC value of 159.6. Although the odds of providing contact information was higher for Black/African-American respondents compared to other respondents, the difference was not significant at the alpha level of $p < .05$, because the range of values in the 95% confidence interval for the odds ratio includes one. The odds ratio for association between the race of the respondents the event description was 1.03, 95% confidence interval 0.40 to 2.66. This saturated model had an AIC value of 145.0 compared to the null model AIC value of 143.0. The closeness of the odds ratio to one in the saturated model means that differences in the odds of event description by race is not significant at the alpha level of $p < .05$, which is consistent with the value of one in the range of values in the 95% confidence interval for the odds ratio. The odds ratio for the association between the race of respondents and music description was 2.68, 95% confidence interval 0.99 to 7.26. This saturated model had an AIC value of 155.8 compared to the null model AIC value of 157.9. Although the odds of appraising the HIV prevention music was higher for Black/African-American respondents compared to other respondents, the difference was not significant at the alpha level of $p < .05$, because the range of

values in the 95% confidence interval for the odds ratio includes one.

DISCUSSION

On average, 16 participants completed HIV test each hour of the prevention event. Although none of the tests had a reactive result, testing staff held one-on-one health dialogs and answered questions during the testing encounters. This finding suggests that when HIV prevention staff provide opportunities for HIV testing in a friendly, non-judgmental context, people in at-risk groups will get tested and seek to clarify their knowledge about HIV transmission. Half of the event participants reported ages within the targeted age group, and among all event participants, most had favorable impressions of the music and the organization of the event as a whole. Some event participants expressed interest in collaborating with HIV prevention staff in planning future HIV prevention events and voluntarily shared personal contact information. Respondents attached value to the outreach event. Information recall identified health education, health protection, and community capacity to address HIV. Whereas attendees liked the event’s ambiance, music, and educational emphasis, the outdoor heat and the limited number of people ranked highest among their dislikes. To address the identified dislikes, they suggested more advertising, targeting people in other age groups, and hosting the event indoors. The event reviews and improvement suggestion did not appear to be race dependent, which suggests that the event had a broad consumer appeal.

Community-wide HIV prevention outreach events should mobilize large groups of people. What does that mean? The population of zip code 32206, based on the 2011-2015 American Community Survey 5-Year Estimate, was 17,141. In repeated sampling from a population, a desirable outcome would be to find a consistent measure of the population proportion for each survey item 95% of the time—*a.k.a.*, the 95% confidence level. Assume the expected response to each question—*a.k.a.*, the response distribution—was 50%, the value assumed when the real response distribution is unknown. Then the margin of error, (MOE)—the difference between the true population proportion and the sample estimate—of the measured sample proportion would be $\pm 8.92\%$ within the population parameter 95% of the time. However, even planners administered the survey just once. Therefore, to achieve a MOE of 6.0% will require a sample size of 263 respondents. Projections are that 800 people should attend the next HIV prevention event to ensure that at least one in every three participants voluntarily complete the event survey (<http://www.raosoft.com/samplesize.html>). Using the average per person cost of \$48.91, the cost to attract

Table 1. Survey participants' demographics and event perceptions and interests

Categorizations	Numbers	Percentages
Race		
White	17	14%
Black/African-American	90	75%
Mixed	10	8%
Age-Groups		
Under 13	5	4%
13-15	18	15%
16-20	31	26%
21-24	15	13%
Over 24	49	41%
Participants		
Of Targeted Age	64	53%
Not In Targeted Age	56	47%
Event Description		
Sucks, (Awful)	0	0%
Okay	7	6%
Good	24	20%
Very Good	40	33%
Great	45	38%
Music Description		
Sucks, (Awful)	3	3%
Okay	11	9%
Good	24	20%
Very Good	32	27%
Great	42	35%
Interested In Event Planning		
Yes	57	66%
No	30	34%
Provided Contact Information		
Yes	70	58%
No	50	42%

Note.

Percentages do not sum to 100% due to missing data

Table 2. Participants' thematic appraisal of the HIV prevention event

Category	Numbers	Percentages
Learn from Event (Take A Ways)		
Health Education	32	27%
Healthy Behaviors	25	21%
Community Capacity	19	16%
Health Protection	14	12%
HIV Transmission Modes	4	3%
Cues to Action	2	2%
Liked about the Event		
Educational Foci	27	24%
Music	20	18%
Ambiance	18	16%
Everything	8	7%
No Response	6	5%
Disliked about the Event		
Heat	35	30%
Nothing	31	27%
No Response	27	23%
Low Turnout	6	5%
Make Event Better		
No Response	22	19%
More Advertising	14	12%
Lift Age Restriction	14	12%
Host Indoors	13	11%
Non-Sequitur	8	7%
Future Event Locations		
No Response	20	19%
A Phillip Randolph Park	10	9%
Other Parks	8	8%
A Building	6	6%
Riverside	5	5%

Note.

Percentages do not sum to 100% due to missing data

Table 3. Logistic regression outputs reported as odds ratios and model testing statistics

Bivariate Associations: Cross-tabulations	Null Models			Saturated Models		
	GOF - AIC	ÓR (N)	95% C.I.	GOF - AIC	ÓR (N)	95% C.I.
1. Race Dichotomy, (African-American vs. non-African-American) by Interested in Event Planning, (Yes vs. No)	157.1221	1 (112)	0.7414 to 1.5560	157.3789	1.7990 (112)	0.7471 to 4.3317
2. Race Dichotomy, (African-American vs. non-African-American) by Targeted Age-Group (Yes vs. No)	163.5034	1.1667 (117)	0.8111 to 1.6780	164.2576	1.6346 (117)	0.6875 to 3.8862
3. Race Dichotomy, (African-American vs. non-African-American) by Provided Contact Information (Yes vs. No)	159.6455	1.4893 (117)	1.0291 to 2.1553	161.3807	1.2571 (117)	0.5270 to 2.9988
4. Race Dichotomy, (African-American vs. non-African-American) by Event Description (Good at Best vs. Very Good or Great)	143.0286	2.4411 (117)	1.6379 to 3.6385	145.0231	1.0364 (117)	0.4035 to 2.6625
5. Race Dichotomy, (African-American vs. non-African-American) by Music Description (Good at Best vs. Very Good or Great)	157.9092	0.6250 (117)	0.4307 to 0.9071	155.7659	2.6765 (117)	0.9861 to 7.2645

Note.

A value of 1 in the 95% confidence interval for the odds ratio, ($\hat{O}R = e^b$), implies no relationship

800 participants and provide entertainment for the next HIV prevention event would be \$79,128.00. An estimated \$39,128.00, (800 x \$48.91), will account for all activities to mobilize and engage the community and \$40,000.00 will go toward recruitment of an emerging, popular music artist that youth and young adults view as iconic.

Conclusion

This descriptive study presents the design, implementation, and process evaluation of an innovative, theory-based, social, HIV prevention event. The setting for the event was urban. However, urbanization should not evoke prejudicial sentiments because international research shows that urban dwelling alone is not the cause of HIV infection. Financially robust individuals who live in urban areas affected by HIV do not experience infection at the same levels as the poor. Having a better education and knowledge of HIV prevention strategies, including appropriate condom use, mitigates the risk of HIV infection compared to poorer individuals. Thus, there appears to exist a protective effect of general education and income for less risky behaviors. Therefore, developing HIV prevention programs that emphasize school continuation, and linkage to employment services, particularly among youth from impoverished communities, along with targeted HIV prevention messages is thought promising, particularly when prevention targets key determinants and drivers of HIV transmission within affected groups (Gillespie, Kadiyala, & Greener, 2007). Hence, the outreach event had two strengths. It exposed community youth and young adults, in the 16 to 24 years age group, to Eckerd services—a professional development and employment finder agency, which has resources to help with socio-economic advancement. It also linked school giveaways, at the start of the fall term, with HIV prevention activities, which propagated five key messages to youth and young adults in the zip code. These messages emphasized the following: stay in school and complete all educational requirements, get science-based facts about HIV transmission, protect yourself from HIV, know your HIV status if sexually active; and the community has a plethora of free HIV prevention and treatment resources available to help. HIV prevention messages given to the community in a socially friendly environment can help youth and young adults to feel appreciated and less isolated, to recognize that they are not alone in pursuit of living, and others care about their well-being.

The emphasis on packaging HIV prevention as a social endeavor is an attempt to augment other prevention work within Duval County. This approach

matters because research on the HIV epidemiology in the southern United States (U.S.) painted a grim picture. In 2011, the southern U.S. had almost half, (49%), of HIV diagnoses, representing just 37% of the U.S. population. The researchers felt that factors such as ubiquitous poverty, HIV-related stigma, and sexually transmitted infections, among others, contributed to the higher HIV rates. These findings suggest the need to improve both HIV prevention and care to help mitigate the swath of HIV prevalence as a regional crisis (Reif et al., 2014; <https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-in-the-south-issue-brief.pdf>).

Practice Implications

Where do we go from here? To begin, event planners recognize at least some of the limitations of the first innovative HIV prevention outreach event. Low budget, free advertising, restricted giveaways, non-iconic entertainers to draw people, the outdoor heat, and unpaid volunteers impose constraints; nevertheless, the local HIV prevention consortia has identified programmatic implications in six next steps: (1) Identify an appropriate sampling frame, sample size, and supportive budget to overcome the limitation of the first community-wide HIV prevention outreach event in HZ1; (2) Contact prospective community people who volunteered for planning future events to harness their ideas about extending the reach of community-wide HIV prevention; (3) Engage at least three volunteers in ongoing HIV prevention planning, implementation, and evaluation in Northeast Florida; (4) Develop sustainable, small-scale engagement events for youth and young adults throughout the year between each annual HIV prevention outreach event; (5) Engage committed volunteers in the recruitment of other community youth and young adults to help guide dissemination of community-wide health promotion messages, including HIV prevention. 6) Implement a planning cycle for event review, identification of improvement opportunities and redesign, and fund-raising to resource the next annual event.

Future Directions

The momentum of Northeast Florida's HIV prevention work draws upon *The National HIV/AIDS Strategy for the United States, updated to 2020, Indicator Supplement*. This policy document has 10-indicator specifications to guide local prevention work (<https://www.hiv.gov/sites/default/files/nhas-2020-indicators.pdf>). A journey of a thousand miles begins with the first step. Much work remains for building the capacity of HZ1 residents to reduce their risk of HIV infection. Community planners are aware

that “having information about a disease and how it spreads is unlikely to lead to behavior change...” (Fishbein & Guinan, 1996, p. 5), which is sustainable during the experimental years of youth. Therefore, helping youth and young adults to voluntarily adopt a success attribution outlook for knowing personal HIV status and embracing being HIV negative aware, as a desired and valued personal health outcome are worthy, macro-level, long-terms goals. The major stakeholders in Jacksonville, Florida HIV prevention outreach team include First Coast Community AIDS Prevention Partnership, the Florida Department of Health—Duval, and the Ryan White Part-A Integrated HIV Prevention and Patient Care planning and implementation workgroup. Two of these three entities have staff from local, non-profit and for-profit health and social services agencies. Together, the closely-knit consortia have aligned their resources and planning activities to “...strengthen HIV education and awareness, particularly among young people in communities most affected by HIV” in Duval County (<https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-in-the-south-issue-brief.pdf>). The aim is to promote HIV testing and knowing one’s HIV status, help youth and young adults develop disease prevention attitudes, social norms, and ability beliefs for self-and-community protection, foster participation in pre-exposure prophylaxis among high-risk negative individuals, and early access to treatment among the newly identified.

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