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Acknowledging Adult Bias: A Focus-Group Approach to Utilizing Beauty Salons as Health-Education Portals for Inner-City Adolescent Girls

Alexis Lieberman, MD
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To assess the feasibility of using beauticians as health literacy agents and beauty salons as health-education portals for adolescent, inner-city, African American girls, the authors conducted focus groups with 25 women: salon clients, salon owners, and medical students. Facilitators to program development included (a) beautician-client relationships, (b) teens' access to health information, and (c) beauticians as information resources. Barriers included (a) adult opinions of teen behaviors, (b) teen mistrust of adults, and (c) low health literacy of beauticians. In developing a health-education program for this population, beauticians and salons may be excellent health information agents and portals if barriers including beautician poor health literacy, adolescent mistrust in adults, and adults' anti-adolescent bias are improved. Program implementation must not solely focus on teens but should also include adult salon users, with the goal of reaching the teens first through these adults and, with time and trust, reaching the teens directly.

Keywords: *beauty salon; beautician; adolescent; bias; health education; inner city; urban; African American*

Inner-city, African American adolescent girls, faced with multiple health-risk factors stemming from their developmental stage, their race, and their socioeconomic status, require a source of reliable health information in a setting that is easily accessible and acceptable to them. This focus-group study examined the feasibility of developing local beauty salons into such a source of health information.

It is well documented that health disparities between minorities and the White population in the United States lead to important differences in life expectancy, infant mortality, and outcomes for a wide range of disease conditions (see *Healthy People 2010* by the U.S. Department of Health and Human Services [USDHHS], 2000). African American adolescent girls are more likely to be overweight, less likely to be physically active (USDHHS, 2000), have more severe mental health disorders (National Mental Health Association [NMHA], 1999), and experience lower-quality mental health care than White teens (U.S. Public Health Service, 2001). Although teen pregnancy rates have dropped significantly in the African American population, with a 45% decrease since 1991, more than in any other population, the rate of unintended pregnancies in this group is still higher than that for Whites, and the rate of sexually transmitted diseases (STDs) in this population is still rising (Abma, Martinez, Mosher, & Dawson, 2004). Adolescent African American girls have a higher rate of sexual risk behaviors, including a greater likelihood of having had sexual intercourse at a young age, a greater number of sexual partners, a lower likelihood of using birth control pills, more unintended pregnancies, and a higher rate of STDs, including HIV infection and AIDS, than their White counterparts (CDC, 2000).

Some successful strategies to decrease health disparities have focused on increasing the health literacy of

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individuals and communities (Averill, 2003; Pestronk & Franks, 2003; Rothman et al., 2004). *Health literacy* refers to "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (USDHHS, 2000). Patients with low health literacy often have poor knowledge of disease, deficient self-care management skills, and decreased medication adherence (Kalichman, Ramachandran, & Catz, 1999; Kim et al., 1999; Williams, Baker, Honig, Lee, & Nowlan, 1998a; Williams, Baker, Parker, & Nurss, 1998b).

In some cases, health literacy of individuals in a community or high-risk group may be increased through education programs delivered by non-community members acting as professional (Kim, Love, Quistberg, & Shea, 2004; Van Servellen et al., 2003) or volunteer health educators, such as medical students (Mak & Plant, 2001). However, such programs may have the inadvertent effect of insufficiently integrating into a community's norms, rendering them less than optimal for meeting community needs and for ensuring program success (Stetson & Davis, 1999). Programs designed to increase health literacy that acknowledge the cultural milieu within which they are delivered and that are delivered in a culturally competent and accessible manner may experience greater success in improved health literacy (Hardy, Wynn, Huckaby, Lisovicz, & White-Johnson, 2005).

A culturally competent program acknowledges and includes the strengths of a community's cultural heritage (Davis & Voegtle, 1994). When working with an African American population, ideal programs should be delivered in a manner that emphasizes the community's strengths and assets. Traditional African American culture relies heavily on word of mouth and informal networks, as well as elders within the community, to deliver information and establish norms. Social scientist Elijah Anderson (1990) referred to "old heads," respected community elders who influence behavior in a wide range of spheres. "The old head's acknowledged role was to teach, support, encourage, and in effect socialize young [people] to meet their responsibilities with regard to work ethic, family life, the law, and decency" (Anderson, 1990, pp. 197-222). A reliance on these natural community leaders builds on a Freirian educational strategy, in which a community identifies its own core agenda. Such an approach is integral to the creation and success of health-education programs within African American communities.

One type of "old head" might be a community or lay health educator. These educators have been shown to be effective in promoting healthy behaviors in a variety of settings. For example, *promotoras*, or Hispanic lay health educators, increased the rate of receipt of cervical and breast cancer screens in Hispanic women aged 23 to 62 (Hansen et al., 2005). In another study, urban African American women who received weight-loss education from lay health educators in a church-based program lost more weight than the control group whose members were simply placed on a waiting list for the program (McNabb, Quinn, Kerver, Cook, & Karrison, 1997).

Some would argue that improved health literacy, as defined by *Healthy People 2010*, is not necessarily linked to improved health outcomes, especially in an adolescent population in which there are many factors influencing health outcomes. For example, it has been shown that adolescents with increased knowledge about STD prevention take just as many risks in their sexual lives as their peers with less knowledge (Shrier, Goodman, & Emans, 1999). However, although knowledge alone may not be sufficient to improve health behaviors, it is accepted that increased knowledge is a necessary component in promoting healthier behaviors (Stanton, Kim, Galbraith, & Parrott, 1996). In some cases, lay health-education and peer-education programs have been shown to not only increase health literacy in African American adolescent girls but also to reduce their risk-taking behaviors. In one such study, 251 girls in a community-oriented, lay-provided, health-education-intervention group increased their consistent condom use from 46% to 73% of the population, whereas the control group increased only from 46% to 57% (DiClemente et al., 2004)

Today, beauty salon owners are potentially one type of "old head," or natural community leader, and a center of influence in the lives of many young African American women. Building on the above-mentioned concept of "empowerment education" by Paul Freire (1970; Wallerstein & Berstein, 1988), beauty salon owners functioning as lay health educators are an example of a community setting its own educational agenda and seeking its own positive health outcomes. In practice, the concept of involving beauty salon owners in

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promoting health is supported in the medical literature (Hart & Bowen, 2002). In one study, 82% of cosmetologists surveyed were interested in discussing health with their clients and were already discussing a wide range of health topics with their clients, including healthy eating, physical activity, and dieting (Linnan et al., 2001). The Barber and Beautician STD/HIV Peer Educator Program of the Durham County Health Department's Project Straight Talk has allowed local barbers and beauticians to successfully provide condoms, educational materials, and information about STDs and HIV to their clients (Lewis, Shain, Crouse Quinn, Turner, & Moore, 2002). In addition, visits to beauty salons have been shown to boost the mood of women who attend, and this may render young women more open to behavioral change. (Picot-Lemasson, Decocq, Aghassian, & Leveque, 2001).

Based on our literature review and experiences within the community, we posited that beauty salon owners might be in an advantageous position to promote awareness of health issues among teenage African American girls and to create new community norms that would lead to improved health behaviors in this population. "Health and Beauty, That's What's Up," a focus-group study funded by the Community Access to Child Health (CATCH) program of the American Academy of Pediatrics, was our first step in assessing the feasibility of a community-based screening and health promotion program for adolescent girls who frequent beauty salons in an inner-city section of Philadelphia, Pennsylvania. Barriers and facilitators to successful implementation of such a program are described and recommendations for future programs are discussed.

METHOD

Teen girls and women were recruited to participate in a series of separate focus-group discussions. The first group was solely comprised of adolescent African American girls recruited from the Teen Health Center at Albert Einstein Medical Center's (AEMC) Department of Pediatrics in Philadelphia. A second group consisted of female, first-year medical students, all of whom had experience offering health education in a community setting, recruited from an affiliated hospital during a mandatory student seminar. A third group included only female beauty salon owners who were recruited through a mass mailing to three local zip codes. The mailing provided information about the focus-group discussion and also noted that an informative educational session on "Health and Beauty for Beauticians" would be held. The final group consisted of adult, female, African American salon clients who were also staff affiliated with the AEMC Women's Center (referred to hereafter as "adult women salon clients").

All focus groups were conducted at AEMC between March and August 2004. Focus-group participants received a modest honorarium for their participation. All participants provided written consent for participation and consent to be videotaped. In the case of minors, their guardians provided written consent; teens also signed assent forms. The Institutional Review Board of AEMC approved this study.

Data Collection and Procedures

An experienced African American health care professional (DH) and the project director (PD) moderated all focus groups. Focus groups were based on a preset semi-structured interview guide with a series of probes to help stimulate conversation. Participants were asked about their attitudes concerning, and use of, beauty salons, use of health care services, and views on the benefits of and problems with providing health education in local beauty salons. Adult participants were asked about their understanding and perceptions of adolescent behaviors and practices. Demographic information was collected from all participants.

Data Analysis

All focus-group discussions were videotaped and transcribed for content analysis. Consistent with performing content analysis, the PD and the project coordinator (PC) independently reviewed the tapes and each of the focus-group transcripts, paying particular attention to body language, context, and content. The PD and PC held ongoing meetings to identify categories (themes, views, philosophies) based on the codes as they emerged. All the focus-group transcripts were subjected to this iterative process. The PD and the PC discussed any disagreements, achieved consensus in identifying modifications to codes, and refined content area of subsequent focus-group guides when appropriate. Meetings were also used to discuss alternative interpretations and to reach agreement on the representative quotations for each category. Based on the results of these meetings, collective participant responses were thematically categorized. Descriptive statistics were used to characterize the study sample.

RESULTS

Table 1 illustrates demographic information of our entire focus-group sample (N = 25). The themes that emerged are described below.

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TABLE 1
Demographic Characteristics of all Focus-Group Participants

Characteristic	*Group*	N	%
Age	Teen girls	Range: 16-18; Mean: 16	
	Medical students	Range: 22-26; Mean: 24	
	Adult women	Range: 32-55; Mean: 42	
	Salon owners[a]	Range: 37-58; Mean: 48	
Race/ethnicity	Teen girls	African American: 8	100%
	Medical students	Caucasian: 4	66%
		Asian-Indian: 1	17%
		African American: 1	17%
	Adult women	African American: 5	100%
	Salon owners	African American: 4	67%
		Latina: 1	17%
		Southeast Asian: 1	17%
Income	Medical students' parents	$50K-$75K: 1	17%
		$75K-$100K: 2	33%
		> $100K: 3	50%
	Adult women	$25K-$50K: 4	80%
		> $100K: 1	20%
Grade completed	Teen girls	Grades 9-10: 3	37%
		Grades 11-12: 4	50%
		Postsecondary: 1	13%
	Medical students	College: 6	100%
	Adult women	Grade 12: 3	60%
		Some college: 1	20%
		College: 1	20%
Have children	Teen girls	0	
	Medical students	0	
	Adult women	2	40%
	Salon owners	6	100%

a. Information provided by only 4 salon owners.

Description of the Need for a Teen Health-Education Program

Teens' access to health information. Teen focus-group participants expressed difficulties in accessing health information in general because of their reticence about being open with parents, lack of comfort with health care providers, and frequent changing of providers. Changes in providers occurred because of changes in health insurance, inconsistent availability of the same physician, and change in residence. Concerns about confidentiality of health information from parents impeded several of the teens from utilizing their health care provider, especially concerning sensitive topics such as sexuality. They noted their reluctance to ask their doctor information about sexuality if their mother was present with them in the exam room; several found it embarrassing to have their mothers at their appointments with them at all. None of the teen participants were willing to ask their mothers for intimate health information, with one stating, "What she doesn't know won't hurt her, that's the way we keep it," and another stating, "Some things moms just aren't ready to know." All the teens identified a wish to have access to more health information, especially relating to sexual health matters.

Facilitators to Implementing a Teen Health-Education Program in Local Beauty Salons

Beauty salon as health-education setting. The beauty salon is a comfortable setting for nearly all the teens. One summarized the feeling of several of the other participants, saying that the "hair salon is like a female sanctuary; if you're not comfortable at your hair salon,

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you don't need to be there." Furthermore, the beauty salon was revealed in the focus groups to be a setting where the teens would feel comfortable gaining health information, either informally through listening to others or, more formally, by asking questions. With regard to providing a health information program in beauty salons, one teen expressed, "Some teens need this [health education in beauty salons] . . . some teens just like to talk and be open to other people 'cause they're not getting [it] in their household . . . so this is for teens who don't get it in their household."

As described by focus-group participants, the beauty salons themselves were revealed to be a setting where information is often shared, usually in an informal manner. An adult woman salon client in our focus groups commented that, for example, in beauty salons frequented by African American women, conversations are often highly interactive and include all the clients in the salon at that moment.

The salon owners revealed themselves as being open to offering information to teens and acting as role models. Salon owners disclosed that they both receive and give information freely to their clients, including teen clients. One stated, "I've done generations and generations of hair . . . people entrust a lot of information with me for some reason." Another salon owner noted that teens tell her things that they won't tell their parents. Another participant affirmed that teens open up to her about very personal information, stating, "You should hear some of the things they talk to me about," and then listed primarily sexual topics (e.g., oral sex) as those that teens discuss with her.

The comfort felt by customers at a beauty salon makes them open to learning information, according to some of the salon owners. One noted,

> You know when you feel down, then you get your hair done—you feel good—at the same time you feel good, you're learning something—you feel good—it's like the right time to talk—the right time—they will listen because they feel good.

Beauticians as information resources and health educators. Many beauticians are seen as information resources by their clients and also see themselves in this light. One adult woman salon client summarized this expectation as follows:

> I think the salon, the stylists, are experts on everything. They're like the bartender, or whatever. They're a person that people come to and talk to and tell their problems to…and think they can help resolve whatever the issue is.

One of the beauticians said something similar: "We're like the yellow pages.…People come to you for information and referrals."

Extending this role of information provider to health information provider comes naturally to the beauticians. For example, one beautician stated that when she sees clients with hair loss, she advises them to go see their doctor, to see what can be done. One adult woman salon client commented that her beautician frequently encourages her to quit smoking cigarettes. Another salon owner commented that, for many of her clients' problems, she recommends that they see a doctor because it "may be problem of the inside."

Teen health is also important to a number of the beauticians. One salon owner explained that she used to keep a soda machine in her salon "because I can make money all day off of people buying sodas." However, after she asked a teen how often the girl drinks water and received the response, "Well, usually on the fourth of July," the beauty salon owner decided to replace the soda machine with a free water cooler to encourage more healthful dietary behavior. This salon owner also commented that, when teens watch sexually explicit videos on the television in her salon, she will sometimes make them stop and will discuss the video and the actions displayed therein with the teens. The reason she expressed for embracing her role not only as a beautician but also as a resource for teens was that "there are so many teenagers dying," that she wanted to do whatever she could to help within her community.

It is worth noting that, although the beauticians readily referred clients to doctors, when offered the choice of providing the health information themselves or having a medical student come to their salon to offer health information to their clients, the salon owners unanimously wanted control of what occurred in their salons. One explained that, if a medical student were used as an educator, "The student would have to approach me first . . . it would be like a domino effect." Another salon owner expressed concern that an educator other than a member of her staff, such as a medical student, would be considered an "outsider," appearing artificial and uncomfortable to the teen clients, stating, "If it looks like punishment or something forced on teens, they won't want it." She added that, if there was to be a medical student health educator, it was important to her that this student blend into her salon environment: "No lab coats," she said. Other salon owners felt that, during a busy day, someone coming from outside to educate would not be productive, stating, "If I'm busy and you come into the salon, you can talk all you want, but it doesn't mean you'll know what they're saying."

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Barriers to Implementation of Teen Health Education in Beauty Salons

Adult opinions of teen behavior. All of the adult focus-group participants (salon owners, medical school students, and adult women salon clients) expressed disapproval of teens' health choices. Adult participants also made negative comments about teen clothing, appearance, and quality of character and shared their beliefs about the suitability of information and access to care for teens.

For example, beauticians commented on teens' dietary behaviors including statements like: They "drink to entertain themselves . . . not . . . because they're thirsty," and "It's a pastime, they are bored or something." Another stated that she keeps chips and soda in her salon because "otherwise they can't sit still." When asked if any of their teen clients would tell them if they smoked cigarettes, one of the salon owners commented, "They don't have to tell you—they'll light up right in front of you if you let them." The other participants smiled and nodded in agreement.

Adolescent appearance and clothing generated many negative comments from the salon owners, including statements based on misinformed health beliefs such as the idea that tattoos enter the bloodstream or that teens wear "tight jeans and get yeast infections" because of lack of circulation. The salon owners often commented on teen trends and styles, making remarks such as, "Tongue rings, eyebrow rings . . . [they] see people on TV . . . teens are copycats."

Furthermore, the adult focus-group participants negatively commented on teen quality of character, with salon owners making comments such as, "Teens don't always do what you need them to do—you can never find them when you really need them to do something." The medical student focus-group participants, young adults themselves, used negative adjectives to describe teens in general, such as "loud," "trouble," and "attention seeking."

Some adult participants believed that certain types of information, as well as access to care, especially relating to sexual health matters, was not appropriate or suitable for teens and therefore should only be selectively discussed. For example, one adult participant commented about health education for teens: "They (the educators) were so geared to give out information concerning condoms…whereas, is anyone teaching the girls about abstinence?" Another participant went on to say that if teens were doing "that stuff (having sexual intercourse)," she didn't want to know or hear about it. One of the salon-owner participants commented that she had been given condoms for distribution in her salon. She said that she had accepted them but commented, "Girls shouldn't be using those things—they shouldn't be having sex," and shared that she gave the condoms to male but not female teen clients.

Mistrust of adults. Many of the teens voiced mistrust of adults and had concerns about confidentiality when seeking information or help from adults. The teens seem to yearn for adult input and help and yet simultaneously not trust its sincerity when they receive it. A comment from a teen illustrated the sentiments of the whole group. "Adults say they are listening, but they aren't really."

Concerns raised by teens about privacy were mirrored in one story told by a beauty salon owner, who revealed that one of her clients, a 12-year-old, told her that she had gotten a tattoo but had not told her mother and did not want her mother to know. The salon owner told the child's mother. Later, the teen client asked if the beauty salon owner had "squealed" on her. "She [the 12-year-old client] still comes to salon and says, 'I'm not gonna talk to you anymore,'" related the owner.

Several of the teens expressed that they do not discuss anything within their beauty salons, conveying the point that in some salons, "They tell all your business." A few of the teens added that they rarely ask questions but instead just listen to the general conversation because of their concerns for privacy. Some teen participants added that they learn a lot from the conversations.

DISCUSSION

Our results suggest that beauty salons may be possible sites for the health education of adolescent, inner-city African American girls. The results showed some factors that could facilitate health education in this setting, such as cultural appropriateness, comfort felt by beauty salon customers, and beauticians' natural role as information sources. Factors that could hinder health education in this setting were also revealed, such as the salon owners' low health-literacy levels, adolescent mistrust of adults and need for confidentiality, and adults' anti-adolescent bias. Beauticians may be able to act as health literacy agents, and their salons as portals to health information, if these barriers can be overcome.

We learned from our study that beauty salon owners may, indeed, be the "old heads" we posited they could be. As small business owners and professionals, these women consider themselves community leaders and

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information resources, and they take pride in sharing health information with their clients. Their clients, including their teen clients, share very personal information with them and seek them out for information on social issues, sexual health matters, and general health issues.

Our results also indicate that adolescent girls yearn for health information—in particular, for sexual health information—and wish that they had a reliable, acceptable source of information. Our teen focus-group participants avoid discussing sexual health matters with their mothers and often do not have access to, or comfort with, doctors with whom they can discuss these subjects. The teens all support the idea of having beauticians provide them with specific health information provided that the teens' sexual health issues remain confidential from their mothers. However, the results also showed that, although beauticians want to help teens, the beauticians generally despair about whether they can truly affect the teens' behavior. In turn, the teens, as much as they want and need help, guidance, and information, are concerned that information they share in a beauty salon environment may inadvertently reach their mothers and may not be entirely free of stigma and judgment.

Early in our planning stages, we considered that medical students might be able to enter beauty salons as "on-site" providers of health information, acting as a bridge between teen girls, beauticians, and program personnel. In theory, medical students could bring to the proposed project an appropriate level of health literacy, and this made them appealing during preliminary program planning. However, our focus-group discussions with the salon owners revealed that the students might not be acceptable to the salon owners, who preferred to provide the education themselves.

With medical students excluded from our current approach, the low health literacy of the salon owners may impact negatively on their ability to share accurate and needed health information with teen clients. Salon owners in the focus groups made statements that reflected erroneous health beliefs, such as the idea that tight jeans cutting off circulation leads to yeast infections throughout the body or that tattoos can enter the bloodstream. These clinical fallacies (see Carr, Felsenstein, & Friedman, 1998, about yeast infections; Mayers, Judelson, Moriarty, & Rundell, 2002, about tattoos), and other faulty health beliefs would need to be addressed through a culturally responsive health-education program targeting the participating beauticians. In conversation with the director of "Shop Talk," a certificate program in Alabama in which beauty salon owners are trained and paid to discuss health issues with their clients, the issue of beauticians presenting nonstandard health information to clients was discussed. It was noted that all beautician participants in that program agreed to provide only "approved" information while they were part of this program (T. Wynn, personal communication, May 5, 2004).

Perhaps the most complex aspect of utilizing salons as portals of health information for teen girls rests in the nearly uniform, negative attitude that all the adult focus-group participants had about teenagers. Indeed, on initial reading of the Results section, the theme related to "Adult Opinions of Teen Behaviors," may likely strike one as simple truth, reflecting commonly held beliefs and attitudes about teens. Most adults carry negative attitudes about adolescents (Public Agenda, 1999) and may not consider these an anti-adolescent bias. When asked to describe today's youths, 74% of adults surveyed used pejorative terms such as "wild," "lazy," and "disrespectful" (Public Agenda, 1999), whereas, in another study, the words most often thought of in terms when describing adolescent behavior were "wild behavior, sex, drugs, and violence" (Bostrom, 2000). The attitudes of the adults in our focus groups mirrored those seen in these studies. Such an anti-adolescent bias, juxtaposed with the teens' mistrust in adults, is a major obstacle that must be overcome to provide health education that is responsive to the needs of adolescents. Acknowledging and then ameliorating negative stereotypes of adolescents are the first steps in reaching this goal.

An interesting aspect of adult attitudes toward adolescents lies in some adults' belief that sexual health information is inappropriate for adolescent populations. African American teenaged girls have increased rates of sexual risk taking compared to Whites (USDHHS, 2000), and our teen focus-group participants repeatedly expressed that they need and want access to sexual health information. Yet some of the adult participants were adamant that sexual health information was not suitable for teen girls or that abstinence should be the cornerstone of sexual health education for teens. A health-education program based in beauty salons would have to address this dichotomy: the teens' wish for more sexual health information versus adults' discomfort with sharing such information with them at all.

The issue of confidentiality also remains a barrier in salon owners discussing sexual health information with teens directly. Many teens are reluctant to attend local clinics because their mothers might find out (Cowan & Mindel, 1993; Metcalfe, 2004). This concern was mirrored in the teens in our focus groups, some of whom preferred to overhear information they needed in the salon, rather than tell anyone in the salon their

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own issues because "they tell all your business." Staging general discussions of sexual health issues in the salon, to be heard by teens, rather than expecting the teens to have private discussions with the salon owners, is one way to address this issue.

We set out to conduct this needs assessment with a specific purpose in mind: to lay the foundation for providing health education in local beauty salons within an African American, inner-city, female, strictly adolescent population. Our journey through this series of focus groups led us to our most important finding: A culturally sensitive and feasible education program based in beauty salons must address the beauticians and adult women clients in those venues, indeed, before the teens themselves. Educating the adults first is likely to be the best way to overcome the barriers to reaching the teen girls, especially the issues of confidentiality and of anti-adolescent bias. As communication barriers between beauticians, program personnel, and the teens are broken down, program participation will be maximized. Through ongoing dialogue, community involvement, and active collaboration, the gap between the adult world and the adolescent world may be bridged.

Conclusions

The primary barriers to using salons as health-education settings that deserve further review include beauticians' low health literacy, adult anti-adolescent bias, adolescent mistrust of adults, and adolescent need for confidentiality. The study was limited by the small number of participants in each group, particularly the small number of beauty salon owners participating. Thus, our results should be interpreted with caution as they may not be generalizable to a larger population. Our study does suggest that professionals developing a health-education program should consider that a program delivered in local beauty salons may benefit inner-city teenaged girls. This benefit may be felt especially in the realm of sexual health information, an area in which these teens have the least access to reliable, acceptable information and the highest levels of risk-taking behavior. For the designers of such a program, we especially recommend that this health-education program be comprehensive, not focusing solely on adolescent females but, rather, engaging salon owners and workers, adult women who frequent those salons, and teenaged girls throughout all phases of the program. The ultimate goal will be to reach the teens initially through the adults in their lives and in the salons and, with time and trust, to reach the teens more directly.

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