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Drug-Involved Mexican-Origin Girls' HIV Prevention Needs: A Pilot Study

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Abstract

The purpose of this pilot study was to collect data to inform the development of an HIV prevention program for drug-involved Mexican-Origin (MO) adolescent girls. Eighteen in-depth semi-structured interviews were conducted with drug-involved MO girls in addition to focus group discussions with 19 other drug-involved MO girls and 8 clinical service providers (CSPs) in 2009–2010. Emergent themes indicated that HIV prevention programs for drug-involved MO girls should be girl-centered, focused on relationship development, and include trained peer facilitators who share the same cultural and “street” background as the girls. The program should omit scare tactics associated with risky sexual behaviors and emphasize individual empowerment skills useful to negotiate sexual decisions successfully. In addition, a girl-centered intervention for MO girls should address important concerns for this group, including resistance skills and strategies regarding relationships with older men, teenage motherhood, sexual infidelity, sexual coercion, and dating violence. Participants noted that intervention activities should be interactive with an emphasis on guiding girls as they learn to assess critically personal risk while at the same time learning skills and resources to address these issues in real life.

Latinas between the ages of 18 and 24 years make up 18% of all young women diagnosed with HIV in the United States (CDC, 2014). HIV/AIDS represents a significant public health problem for Latinas. The incidence of HIV among Latina women is almost four times that of white women (CDC, 2012a). While Latinas represent less than 16% of U.S. female adolescents, they account for approximately 20% of recently diagnosed HIV and 16% of AIDS cases (Henry J. Kaiser Family Foundation, 2005). CDC (2014) data indicated that the majority of young women with HIV/AIDS, irrespective of race/ethnicity, contracted the disease from heterosexual contact with high-risk partners.

Latina adolescents are more likely than other girls to engage in multiple sexual risk taking behaviors, placing them at risk for HIV. According to the National Youth Risk Behavior Survey (NYRBS), only 53% of sexually active Latinas reported that their partners used condoms at last intercourse (CDC, 2012b). A large-scale study also revealed that detained Latina adolescents were more likely than detained African American girls to have ever had

unprotected sex with a high-risk partner (Teplin, Mericle, McClelland, & Abram, 2003). These sexual risk-taking behaviors place Latina adolescents at heightened risk for HIV.

Drug Involvement, HIV Risk, and Latinas

The epidemics of drug use and HIV are intertwined. Drug use increases the likelihood that girls will engage in risky sexual behaviors (Tapert, Arons, Sedlar, & Brown, 2001) which in turn, elevates their risk of HIV. Latina girls, in particular, are at increased risk due to their earlier drug use onset (Grunbaum et al., 2002), higher lifetime use for almost all types of drugs (CDC, 2012b), and higher rates of injection drug use (CDC, 2012b) relative to white and black female adolescents. Research on detained girls indicated that Latinas were more likely than other girls to engage in unprotected sex while under the influence of drugs (Teplin et al., 2005). Nearly one in five (17.4%) Latina girls used drugs and/or alcohol at last intercourse (CDC, 2012b), increasing the likelihood that they would be detained. These findings are alarming given that drug use decreases the ability to negotiate safe sexual practices, impairs judgment and decision-making (Leigh & Stall, 1993), and has been linked with sexual risk taking among high-risk adolescent girls (Teplin et al., 2005).

HIV and Substance Use Prevention for Latinas

Although numerous adolescent HIV prevention programs exist (see Kirby, Laris, & Roller, 2007), few have included, much less specifically targeted, Latina adolescents. Of the few programs that include Latina adolescents, only a handful have examined ethnicity or gender as possible moderators of program effects (Herbst et al., 2007; Robin et al., 2004). Furthermore, while several well-respected girl-only interventions for ethnic minorities do exist, only a few include Latinas. Unfortunately, none of these programs have been culturally tailored to address the needs of specific ethnic subgroups of Latinas. An exception is the SHERO (a female gendered version of the word *hero*) program, which was designed to address the cultural and gender-specific needs of Mexican American girls (Harper, Bangi, Sanchez, Doll, & Pedraza, 2009). While this intervention is promising, it does not focus on the needs of drug-involved girls.

Ethnicity, Gender, Culture, and Prevention

Contextualized HIV interventions that take into account ethnicity, gender, and culture are needed to address the concerns of specific Latina groups, such as sexually active, drug-involved Mexican-Origin (MO) girls. Given that different risk and protective factors are associated with high risk behaviors (e.g., drug use, unprotected sexual activity) for different ethnic groups, culturally tailoring interventions to meet the needs of specific ethnic groups, such as drug-involved MO girls, might result in higher levels of engagement, retention, and success (Kumpfer, Alvarado, Smith, & Bellamy, 2002; Prado, Pantin, Schwartz, Lupei, & Szapocznik, 2006). We, therefore, examined the processes used to engage this underrepresented and difficult to access group as well as undertook data collection and thematic analyses that illuminated critical elements to be included in either the development of a prevention program or the adaptation of an existing curriculum to address HIV risk and prevention for drug-involved MO girls.

Methods

The purpose of this pilot study was to collect data to inform the development of a culturally relevant, gender-specific HIV prevention program for drug-involved MO adolescent girls. Important to the effort was the inclusion of both girls who were directly involved in behaviors that were targeted for prevention and community providers who had an array of experiences providing direct services to this specific population. The research team began its investigation by engaging representatives of both groups in semi-structured interviews and focus groups. The inclusion of the dual formats of one-on-one interviews and focus groups allowed the full range of responses to queries posed by the research team. The inclusion of members of the target population as well as Clinical Service Providers (CSPs) added depth and richness to data interpretation by fostering multiple perspectives and allowing data analysts the advantage of a full spectrum of contextualization. To recognize their commitment of time and effort to the project, all participants received \$25 Target gift cards. The Arizona State University Institutional Review Board (IRB) approved the study protocol.

Interviewer Training/Supervision

The interview team consisted of four people. Two of the interviewers were white, and two were Latinas, including the Principal Investigator (PI), a Mexican American. Interviewers received 10 hours of training and conducted practice interviews that were observed and critiqued by the PI. In addition, interviewers attended weekly supervision meetings to discuss interviewing issues and review content. The PI and two research assistants also led the focus groups.

Pilot Participants: Girls

Recruitment: Gaining Access to Members of Target Population: The PI had extensive experience working in the community as both a clinician in the state's female juvenile correctional facility and as a member of the Arizona Girls' Roundtable (AGR) steering committee. The AGR was formed to bring together girl-serving organizations and agencies for collaboration and networking and to develop a collective vision for girls in Arizona. The PI's affiliation with the AGR strengthened recruitment efforts because community members knew and trusted her. Consequently, the staff at a large nonprofit agency agreed to be a community partner. The partner agency provides mental health and educational services for "at-risk" girls dealing with abuse, neglect, substance abuse, and teen parenting. Its campus includes a residential treatment center (RTC) for girls and a coed alternative school for at-risk youth. Youth from the community with histories of emotional and behavioral problems in traditional school settings attended the alternative school along with girls living at the RTC. Approximately 40–45 percent of the 150 youth who attended the school were Latinos. (The focus groups were held six months after we completed interviews; none of the girls who participated in the focus groups had been previously interviewed by the research team.)

Inclusion/Exclusion Criteria: Girls: English-speaking MO girls who used drugs (other than nicotine or alcohol) at least twice in the past 30 days and who were sexually active (had vaginal sexual intercourse at least once in the past 6-months) were eligible to participate.

Recruitment: Girls

Interview recruitment: Five clinical intake staff members at the RTC were responsible for screening girls for eligibility, presenting the study to parents and daughters, and obtaining signed parental permission and teen assent forms. All five staff members completed human subjects training in accordance with the University's IRB guidelines. During the six-month recruitment period, twenty Latina girls entered the RTC. Staff used a standard recruitment script to introduce the study to Latina girls' parents during the initial intake meeting. Nineteen parents consented to their daughters' participation. Staff then discussed the project, determined eligibility, and obtained teen assents in separate, individual meetings with girls. All 19 girls met the inclusion criteria (as indicated by self-report), and 18 (95 percent of the 19 known eligible girls) assented to participate in the study.

Focus group recruitment: Recruitment for the focus groups took place in the cafeteria of the school for at-risk youth. Members of the research team coordinated with the on-site school social worker to meet with and present the study to Latina girls between the ages of 14 and 18 years. During a group meeting, the team described the study to 31 Latina girls via a standard recruitment script, discussed the inclusion criteria, and distributed parent permission and teen assent forms. As a confidentiality safeguard, all 31 girls were asked to walk behind a half-wall partition in the cafeteria--one at a time--to turn in an assent form irrespective of whether they agreed to participate. While turning in their assent forms, they could also pick up a either the Spanish or English parental consent form. Due to the half-wall barrier, the other girls were unable to see if someone picked up a parental consent form.

Interested and eligible girls were asked to sign and leave their assent forms with the research staff. Twenty-four of the 31 girls (77.4%) turned in a signed assent form and picked up a parental consent form. Over half of the girls who turned in *signed* assent forms opted to take home a Spanish-language parental consent form. Bilingual members of the research team called parents to discuss the project and answer questions. Ultimately, 19 of the 24 girls participated in one of two focus groups, which were held one week later. The eligibility status of the girls who did not participate is unknown. Given this unknown, we can only conclude that the response rate ranged from 61 percent (assuming all 31 girls who attended the session were eligible) to 79 percent (assuming only the 24 girls who assented and picked up parental consent forms were eligible).

Semi-Structured Interviews: Girls: Each interview lasted between 1½ and 2 hours. All interviews took place in a private conference room located in the administrative wing of the nonprofit agency. The primary intent of the interview was to obtain more nuanced and contextual information about drug-involved MO girls' lives that was not possible to gather within the focus groups due to participant confidentiality concerns.

The interview protocol included both quantitative and qualitative questions on a number of issues related to girls' sexual risk taking, relationships, and substance use. Two qualitative questions related to what each participant would like to see in an HIV prevention program for MO girls were also included. Pre-scripted prompts were used to follow up on the

qualitative questions when necessary. This paper focused only on the qualitative questions and their responses.

Working with drug-involved MO girls required that a number of ethical concerns be addressed. In the interviews, girls were asked to provide sensitive information about their sexual and drug use backgrounds, information that potentially could incriminate them if such information was subpoenaed. Recognizing this risk, we used a number of procedures (e.g., random numerical identifiers, no master list) to be able to protect girls' confidentiality in the interviews. As a research team, we were able to maintain confidentiality of the interview data because we were not collecting longitudinal data that required baseline results to be linked with post-assessment data.

Focus Groups: Girls: To accommodate the adolescent participants, we held the 90-minute focus groups immediately after school in a large conference room on the campus of the nonprofit agency. Focus group questions addressed issues related to participation and implementation barriers (e.g., Do you think your parents would be willing to let you participate in an HIV prevention program? Why or why not?), acceptability of program to members of the target population (e.g., How can we make an HIV prevention program more interesting for Mexican American girls?), adaptability (e.g., Do you have suggestions on how we can make an HIV prevention program more relevant for Mexican American girls? What types of topics should we include?), and culture, gender, drugs, and relationships (Why do you think some Mexican American girls might have sex when they don't feel like it? How does drug use influence Mexican American girls' decisions to have sex?).

For the focus groups, we developed a set of procedures to minimize the possibility that sensitive information would be shared outside the group. In accordance with IRB suggestions, we encouraged adolescent participants to avoid sharing personal information of a sensitive nature (e.g., drug/alcohol use, sexual history) because we were unable to guarantee confidentiality. Focus group facilitators, while reminding participants that focus group sharing cannot be considered confidential, emphasized the importance of keeping the conversation "in the room" and encouraged all participants to maintain the confidentiality of what was discussed.

Pilot Participants: Clinical Service Providers (CSPs): The Clinical Director of the nonprofit agency distributed flyers to the clinical staff. Eight members of the 12-member all-female clinical staff (67%) signed up to participate in a 90-minute focus group. The CSPs included one school social worker, three intake staff, and four masters level therapists. All staff members had worked at the agency for at least six months. Six were white, and two were Latina. To be eligible for participation, staff members had to be CSPs working directly with members of the target population. All CSPs provided signed informed consent before participating in the study. The focus group with CSPs was held in a conference room located on the campus of the nonprofit agency.

Focus Groups: CSPs: CSP focus group questions addressed issues related to participation and implementation barriers (e.g., What problems might we encounter if we were to implement an HIV prevention program for MO girls? Do you think MO parents would be

willing to participate in such efforts? If such a program were offered at your agency, what barriers do you anticipate?), acceptability of program to members of the target population (e.g., What ideas do you have for engaging drug-involved MO girls in an HIV prevention program?), adaptability (e.g., How might we further refine an HIV prevention program to target the unique needs of girls with drug use histories?), and culture, gender, drugs, and relationships (e.g., Do you think MO are more likely than other girls to engage in unprotected sex with boys? What role do drugs play in MO girls decisions to have sex?)

Analysis—All interviews and focus groups were conducted in English. The qualitative portions of the interviews and focus groups were audiotaped and transcribed verbatim. Each member of the research team then read through the first three interviews and all of the focus group transcripts. Then, the team developed a list of codes and an operational definition for each code. The coding process targeted suggestions for making a future intervention program more specific to girls' needs. Once the initial coding list was developed, it was circulated and used to code the additional 15 interview transcripts. The research team was divided into two pairs for coding. Each member of Coding Pair A and the PI independently coded interviews 1–8. In addition, each member of Coding Pair B and the PI independently coded interviews 9–15. Thus, each interview was independently coded by at least three raters. The PI met with all raters on a weekly basis to discuss coding and to resolve any coding conflicts. Final coding decisions were based on group consensus.

Results

Themes Related to Parental Concerns

One of the goals of this pilot study was to gauge informally whether MO parents would be receptive to allowing their daughters to participate in a future program designed to help MO girls make healthy sexual and relationship decisions. The research team also asked both girls and CSPs about potential parental concerns as part of the pilot study.

All girls reported that their parents would agree to them participating in an HIV prevention program. They said their parents would “probably appreciate” someone else talking to them about sex because their parents, especially fathers, found such conversations “awkward.” Most of the CSPs also believed that parents would be willing to allow their daughters to participate in HIV prevention programs because, as one CSP noted, “Deep down they know it needs to happen...It’s something they might be willing to do just because of the fact that it’s not them; the pressure is not on them to talk to their daughters about sex.”

Although all of the girls and most of the CSP staff agreed that parents would be willing to allow their daughters to participate in an HIV program, some CSPs had concerns regarding parental willingness. They were concerned that parents would: (1) “believe that teaching girls about sex might encourage them to have sex”; (2) “be in denial” about their daughters’ sexual and drug behaviors; or (3) be fearful of sharing “family secrets” that might “incriminate themselves or their daughters.” The latter, according to three of the CSPs, would be especially true of immigrant parents.

Our experience talking to parents as part of the recruitment for the adolescent focus groups indicated that, with two exceptions, parents were receptive to their daughters participating in a prevention program designed to help girls make healthy sexual and relationship decisions. Two parents were worried that their daughters might be labeled as promiscuous or drug users if they participated in such a program. Parents did not disclose concerns related to documentation or immigrant generation.

Themes Related to Relationships and Sexual Risk

Views on Teenage Pregnancy and Motherhood—The *elevation of motherhood* as a desired status among MO girls emerged as a prominent theme. Most of the girls and CSP participants indicated that motherhood was something that was valued among MO families. One CSP indicated, "...Motherhood is so embraced within the Hispanic community. Girls actually become a very valuable member of the family as a mother." Another CSP noted that "immigrant families" valued and supported teen motherhood more than "Americanized families." She then elaborated: "On my caseload, girls from immigrant families who have children are more psychologically ready to be mothers than other girls. It's a bigger part of their culture." Although several girls agreed with the assessment that "being a mother is something that MO girls are good at", most girls resented other people "always thinking" that MO girls are "teen moms." One girl noted, "Yeah, like my mom had my baby sister, and I was holding her, and this white lady is all like, 'Oh, your kid is so cute,' and I'm like, 'That's my sister!'"

These data indicated that HIV prevention efforts targeting drug involved, sexually active MO girls should address the perceived importance of motherhood. The data indicated that drug-involved MO girls maintained conflicting views about teen motherhood and motherhood in general. Perspectives offered indicated that the participants knew of no options to protect themselves from HIV if teen girls (or their partners) desire to have a child.

Dating Older Boys and Men—A preference for dating older men was another theme that emerged from data gathered from girl participants and was validated during the CSP focus group. Participants indicated that dating older boys and men was a frequent phenomenon among drug-involved MO girls. Most girls said they preferred "older boys" because they were "more mature" and that boys their age "don't know how to act" and "act like little kids." Many of the girls clarified that their definition of "older" meant 4–5 years older than them. In contrast, most of the CSPs believed that many drug-involved MO girls were involved with much older (i.e., more than 4–5 years older) men: "It seems to be profoundly different, Mexican girls are 15-years-old, and they're with men that are in their 40s...late 30s and 40s. Where you might see older men with Caucasian girls or African American girls, they might be older, but they are 15-year-old girls with 25-year-old men." CSP data attributed this dating pattern phenomenon to being part of "their culture." As one participant described it:

From what I find, it's with the consent of the parents. Because the parent feels he's an established man, he's going to care for my daughter, and they don't see anything wrong with it. And, it is a big difference. In the Hispanic communities, 15 and 16-

year-old girls are dating men who are in their 30s and 40s...like a big age difference. It's definitely a cultural thing.

Although most of the CSPs believed that dating older men was a problem for all MO girls, several acknowledged that girls' immigrant generation might play a role in dating motives. They believed that girls from immigrant families were romantically involved with older men primarily for economic reasons (e.g., "older man can provide for them financially") that involved the ultimate goal of marriage, whereas more Americanized girls relied on older men for "free drugs along with respect and protection on the streets." Irrespective of girls' motives, dating older boys and men has been associated with increased sexual risk taking for girls (Marin, Coyle, Gomez, Carvajal, & Kirby, 2000).

Sexual Infidelity—Most of the interview participants reported that either their current or past boyfriend had cheated on them. Not infrequently girls would stay with cheating boyfriends or break up with cheating boyfriends only to resume the relationship later. For example, one 16-year-old found her boyfriend "in bed watching TV with another girl." Although this participant broke up with her boyfriend, they reconciled a few days later. She said her boyfriend's attitude had shifted away from his commitment to her: "Oh, I can have her. I can cheat on her, and she will forgive me." She believed her boyfriend would cheat on her again and that he was the one "now in control" of the relationship.

Several of the CSPs provided insights into why MO or Hispanic girls might 'choose' to stay in relationships marked by sexual infidelity. One of the CSP focus group participants noted that, "It's just real accepted. Where it is, to me, with the Caucasian girls it's like 'Oh, no he's not.' It's like a whole different vibe." Girls who participated in the focus group acknowledged that "cheating is a big problem" and that "you just never know when someone is gonna cheat on you". Interestingly, they seemed to blame other girls for boyfriends' infidelity. As one of them stated, "A lot of females will just do it cause they're taken. Because they're like, 'Oh, I could get caught by his girlfriend, but I don't care'. It's like an adrenaline rush to them." In describing those circumstances, some of the girls referred to these "other girls" as "hos," "nasty," "stupid" and "as wasting their time."

As the data above revealed, sexual infidelity was a major concern for most girls in this study, a finding consistent with other research on MO girls (Lopez, 2014). Given that sexual infidelity has been associated with increased risk for sexually transmitted infections (STIs) among youth (Kelley, Borawski, Flocke, & Keen, 2003), HIV prevention programs for MO girls should include a focus on sexual infidelity along with an emphasis on understanding the meaning girls make of cheating and what skills and strategies girls can learn to assert themselves in situations that place them at further sexual risk.

Sexual Coercion—All focus group participants, youth and adults alike, agreed that boys "guilt" girls into having sex with them. Several adolescent focus group participants, for example, said that boys sometimes coerced girls into having sex, with one girl stating, "There's always some that say, 'Well, if you don't do it with me it's cause you don't love me'", while a second participant emphatically confirmed that coercion by saying, "Yeah,

boys will try to make you feel guilty by saying how hard it is for them. I hate the blue balls term! I hate that!”

These data indicated that girls often realized when boys were attempting to “guilt them” into having sex. Intervention developers need to build upon this strength and integrate skill development designed to assist girls in their efforts to negotiate successfully their decisions about whether to engage in sexual activity.

Dating Violence—Girls offered varying opinions about whether boys or girls maintained more power and control in their own relationships versus adolescent dating relationships in general. During interviews, some girls discussed boys’ attempts to control them via physical violence. One girl said: “My boyfriend would get jealous. If I even looked at another guy, he would get jealous.... Sometimes he would push me. I pushed him back, but he pushed harder. I stayed with him because...I don’t know why. I just did. Maybe I was stupid.”

A few girls who participated in the focus groups acknowledged that they “knew of” girls who had engaged in sexual activities with boyfriends even when they did not want to or because they were afraid. Yet, most girls maintained that they themselves had more relationship power than their male partners. They denied that MO girls were more passive or subservient than girls from other racial/ethnic groups and described MO girls as “strong” and “independent.” In contrast, all of the CSPs believed that issues of power and control were “big problems” for drug-involved girls in general, but especially for MO girls, who they believed to be more “passive” and “subservient” than African American or white girls.

Themes Related to Drug Use and Sexual Risk

Remorseful Sexual Activity—All CSP and adolescent participants noted that drug use often led to risky sex. One adolescent focus group participant provided an example of a girl who had engaged in risky sex while under the influence of drugs:

She drank a little too much, and I saw her going into the room, but I didn’t know there was a guy in there. I thought she was gonna go lie down. So I was sitting outside just chilling, and then I hear in the room something, you know the bed, I’m like, “Oh no, what is going on in there?” But she’s like my best friend so I was scared for her, and she was a virgin so I went knocking on the room and it was locked. I banged on the door, and I was like, “Get out, get out, I want you to come out right now, you don’t know what you’re doing”, and she came out and she’s just buckling her pants, and I’m like, “Dude, what did you do? What’s wrong with you?” and she’s drunk, so she’s like, “Oh, leave me alone.” And I was like, “Oh, my God. We gotta go. I can’t stay here. We gotta go”, so we went to my house, and I let her sleep it off. The next morning I was talking to her like, “Do you know what you did? Do you remember anything you did?” And she did. She remembered. But she regrets it.

The adolescent focus group participants unanimously agreed that drugs/alcohol lead to sexual risk-taking. Most also agreed that, later, girls often regret the behavior they exhibited while under the influence. Most of the interview participants admitted they had engaged in sexual activity while under the influence of drugs and/or alcohol. When asked how often

girls used drugs (or alcohol) and then engaged in unprotected sex with acquaintances, most focus group adolescent participants reported “All the time” and “Probably at every house party...” According to these participants, house parties are full of “alcohol” and “free drugs” like “marijuana, ecstasy, crack, X, pills, coke, and just about everything.” Most CSPs believed that for many girls “sex serves as a trigger for drug use” and that drug use resulted in social or sexual enhancement: “They talk about the ecstasy pill which goes hand in hand with sex and the alcohol, and it all correlates”, and “They’ll say ‘Yeah, I drink tequila. It makes you more sexy.’”

Sexual Victimization In Party Settings—All CSPs believed that drug use increased the risk of sexual victimization. One CSP suggested that MO girls were more likely than African American or white girls to use drugs just because “trusted others ask them to”, and that such drug use can lead to victimization.

It’s shocking when they admit to some of the drugs they have used. I’m talking rufies, the date rape drug. Why would you take that? “Well, my ‘homie’ gave it to me, so I know I was safe.” And it’s comments like that. Or some very heavy hitting drugs, it’s not just wine, beer and weed, and maybe coke once or twice. Some of them are using heroin because their ‘homies’ said it was okay. Unidentified pills, they take pills, they don’t even know what these pills are. And the fishing, they put them [pills] in a bowl, and they take them.

Similarly, most adolescent focus group participants reported that drug use could increase the risk of being “taking advantage of” and “having sex against your will.” Once again, these data illustrated that HIV prevention programs for drug-involved MO girls should focus on drug use heightening the possibility of sexual risks within the context of social settings.

Non-Content Related Themes: Suggestions for Intervention Development

Participants had several recommendations on how to structure HIV prevention programs for MO girls. These recommendations are presented below.

Girls Only-Without Boys—Adolescent focus group and interview participants unanimously stated that they would rather attend an all-girls intervention. They believed that the addition of boys would be a distraction and were worried that boys might judge them and get “jealous.” They also feared that boyfriends might think of them as “sluts.” The girls were not comfortable discussing sexual topics with boys and wanted a “safe” place to discuss these issues without being judged for past sexual experiences. Most of the CSPs confirmed this perspective, noting that girls’ need “a space” to discuss their own experiences without the “distraction” of boys.

Girls Only-Without Parents—Our pilot data indicated that a family-centered approach would not work well with our target population. Most of the CSPs indicated that many of the girls’ parents had drug use or legal issues that might preclude their consistent involvement in a prevention program supporting their daughters. They suggested that parents might need a separate program to help them “with their own issues.” Other parental barriers included lack of transportation and time to participate in an extended prevention program.

Focus on Relationships and Inclusion of MO Peer Facilitators—Most of the adolescent focus group participants recommended using peer facilitators who not only were Mexican or Mexican-American, but also had “street” experience and could relate to the girls. Most of the CSPs agreed. The importance of using program facilitators who “genuinely” cared about the participants was also emphasized, or as one CSP stated, “I think it’s much better if they get people that they recognize, they see, ‘cause, especially in a Hispanic community, if you go get a White girl to go talk to Chicanas, they’re not gonna listen. “What the heck does she know? You don’t know my life.” You need to get girls from their age group, someone they can identify with, that they feel they’ve come where they’ve come from, and they know what they’re talking about, or else these girls are just not gonna listen.”

Avoid Scare Tactics—Most CSPs strongly argued that prevention programs “need to stay away from the sex is bad view”. One CSP, for example, stated, “Some prevention, you know as far as STDs and pregnancy go, some prevention messages need to be separate from the risky behavior view. Not put [sex] in the same category as using guns and all the other risky behavior, but rather focus on sex as something that happens and look at emotional maturity rather than physical maturity. But, when you do decide to do these things, this is how you do it.”

Emphasize Empowerment—Most CSPs believed that MO girls often engaged in sexual activity with boys/men because they did not feel confident or comfortable enough to say no, a finding that was consistent with existing literature on Latinas (Gomez & Marin, 1996). They all suggested that HIV prevention programs should emphasize empowerment, as illustrated by the following CSP statement, “Well, you got to approach teens on their level. It always seems to me that even the condom commercials and things that you do see on TV; they put the responsibility on the boy. I think I’ve seen one or two public service announcements where the girl reaches in her purse, and she’s got it, and it was a white girl. I say put the power in the young lady’s hands! Empower her! Once she is empowered, she’ll realize it’s her decision. She won’t even go for it. She’ll say: “Wait a minute, I’m worth more than this.”

Discussion

The purpose of the current study was to gather pilot data to inform the development of an HIV prevention program for drug-involved MO girls. To accomplish this aim, we collected interview and focus group data from drug-involved MO girls and the CSPs who worked with them. The interviews provided in-depth information about the types of issues that drug-involved MO girls faced, while the focus group data allowed us to glean more information on issues related to program feasibility, acceptance, and adaptability.

A number of themes related to heterosexual relationships and sexual risk emerged from the data. These themes included: “Views on Teenage Pregnancy and Motherhood,” “Dating Older Boys and Men,” “Sexual Infidelity,” “Sexual Coercion,” and “Dating Violence.” Relationship power and control seem to tie these themes together. Although the girls in this study said they did not want to be teen mothers and adamantly declared that they had the most power in their relationships with older boyfriends, previous research has indicated that

older male partners, because of the potential power differential created by differences in age and sexual experiences (Marin et al., 2000), can dissuade teen girls' from insisting on condom use (Schwartz, Brindis, Ralph, & Biggs, 2011), which in turn can increase girls' risk of contracting STIs (Ryan, Franzetta, Manlove, & Schelar, 2008), particularly when girls' partners have had unsafe sex with others outside the main relationship (Kelley et al., 2003). Violence or the threat of violence also contributes to Latinas' increased risk for HIV. Gomez and Marin (1996) found that fear of a partner's anger in response to requests to use condoms was a significant predictor of non-condom use among Latinas. Taken together, these studies have indicated that partners influence girls' decisions and behaviors irrespective of girls' own desires, and this is particularly true when girls are romantically involved with older partners. These findings, along with our own, underscore the importance of taking relationship and power dynamics into account when developing HIV programs for drug-involved MO girls.

Our second set of themes related to drug use and sexual risk and included the following themes: "Remorseful Sexual Activity" and "Sexual Victimization in Party Settings." Focus group participants said drug (and alcohol) use directly contributed to girls' spontaneous decisions to engage in casual sexual encounters and increased the likelihood of sexual victimization in parties and other high-risk social contexts. Previous research with high-risk Mexican American girls similarly found that drug and alcohol use contributed to girls' sexual risk in party situations (Cepeda & Valdez, 2003; Valdez, 2007). Although drug and alcohol use and social context can affect girls' sexual risk, it should be emphasized that gender-based inequities and views that privilege men's sexual desires over women's play a significant role in influencing adolescents' behavior within high-risk contexts and situations. HIV interventions targeting drug-involved MO girls should focus not only on the fact that drug (and alcohol) use increase the possibility of sexual risk-taking and victimization in party and other social settings, but also the methods girls can use to minimize these risks and protect themselves in such contexts.

Although we did not ask focus group participants to distinguish between girls of varying immigrant generations (or acculturation levels), some of the CSPs spontaneously made such distinctions. They believed that girls from immigrant families were more likely to maintain traditional gender role expectations, were more subservient, and more likely to date older boys and men for economic reasons than more "Americanized" girls. The CSPs' perspectives were consistent with previous research, which has suggested that less acculturated Latino youth have more traditional gender expectations and sexual values than more acculturated Latino youth (Deardorff, Tschann, & Flores, 2008). The CSP data also underscored the importance of acknowledging the role of immigrant generation (or acculturation) when designing or adapting interventions for MO individuals (Castro, Barrera, & Martinez, 2004). Taking into account immigrant generation (or acculturation) will result in more nuanced and targeted HIV prevention programs that avoid a one-size-fit all approach rooted primarily in cultural stereotypes, such as "Latinos place a high value on childbearing even for adolescents" and "Latino males won't use condoms because of machismo" (Villarruel & Rodriguez, 2002, p. 260).

Accessing sexually active, drug-involved MO girls is challenging because they represent a hard-to-reach and hidden population (Magnani, Sabin, Saidel, & Heckathorn, 2005). Given that we would like to adapt an HIV prevention program that can be implemented in youth facilities, we decided to partner with one agency for this pilot study. Ideally, we would have preferred to partner with multiple agencies, but time and funding constraints prohibited us from doing so during this phase of the research. These constraints contributed to the small sample size, which was smaller than that generally required to achieve saturation of themes in qualitative studies. Nevertheless, the pilot study, though small in scope, yielded information essential to the learning of the research team. The themes that emerged from the data provided the research team with important insights into areas in which the investigation needs to move to “dig deeper” to substantiate the critical elements of intervention development. The pilot study also indicated that modest response rates are possible if a strong relationship exists between the researchers and agency staff.

The pilot study also yielded critical information about possible parental concerns related to daughters’ participation in an HIV prevention program targeting drug-involved MO girls. Interactions with parents of the adolescent focus group participants indicated that the majority would allow their daughters to participate in an HIV prevention program for girls; however, two parents expressed concerns, as did CSP staff on behalf of parents. Parents were worried that their daughters would be labeled as promiscuous drug users, whereas several of the CSP staff believed that some parents might be concerned about their own immigration status. Suggestions for parental engagement included obtaining a Certificate of Confidentiality to alleviate parent fears further, eliminating all mention of personal or family immigrant generation, emphasizing what the program will accomplish rather than discussing any personal behaviors of the youth participants, and incorporating trained native Spanish-speaking peer facilitators from Mexico in addition to working directly with the CSPs to establish protocols to aid with recruitment.

Although the results of this pilot study provided important data that can be used to inform the development of an HIV prevention program for MO girls, several limitations merit mention. First, the data were obtained from a small convenience sample and thus may not adequately represent any population of sexually active, drug involved MO girls. Our methods of identifying and selecting participants and our modest participation rates may have resulted in selection and participation biases. Girls who declined to participate or spoke Spanish and those not formally referred to the nonprofit agency may have other opinions and experiences than the ones reported by our participants. These potential biases could have affected both the accuracy and generalizability of our findings. A second limitation was that we did not distinguish adolescent participants on the basis of acculturation, which has been associated with the sexual and reproductive health of Latino youth (Afaible-Munsuz & Brindis, 2006). Additionally, while we asked all girls the same qualitative questions during the interviews and focus groups, the participants differed with regard to how much they were willing to reveal. The focus group format, in particular, might have made some participants less likely to challenge the dominant narrative of the group in favor of providing socially acceptable responses. On the other hand, it is also possible that the focus group format capitalized on the group members’ already established relationships, which may have increased their comfort levels and willingness to share in a research setting (Kitzinger,

1994). Finally, although all transcripts were coded by at least three independent raters, the same raters did not code all of the transcripts. The PI limited the number of transcripts for which each coding pair was responsible because several of the raters were graduate research assistants who were still learning the research methods used in this study. To ensure the integrity of the coding process, the PI coded all transcripts and met with the other raters on a weekly basis to discuss the coding process in detail and address any potential coding conflicts. Although the PI is a seasoned investigator, some may see the use of unseasoned raters for coding as a limitation of the analysis protocol.

Conclusion

Pilot data from both girls and service providers suggested that intervention development and adaption for drug-involved MO girls should be girl-centered, focused on relationship development, and use peer facilitators who share the same cultural and “street” background as the girls. The program should minimize scare tactics associated with risky sexual behaviors and emphasize girls’ own power to successfully negotiate sexual decisions. In addition, the intervention should address important concerns for this group including relationships with older men, relationship power, teenage motherhood, sexual infidelity, sexual coercion, and dating violence. Intervention activities designed to highlight resolution of these issues should be interactive with an emphasis on helping girls critically assess personal risk while at the same time providing them with the support and skills to address these issues in their own lives.

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