HHS Public Access

Author manuscript

Vulnerable Child Youth Stud. Author manuscript; available in PMC 2015 December 11.

Published in final edited form as:

Vulnerable Child Youth Stud. 2014 ; 9(2): 139–150. doi:10.1080/17450128.2013.832828.

The influence of social determinants on sexual risk among out-of-school African American female adolescents

Felicia A. Browne[a,b], **Wendee M. Wechsberg**[b,c], **Vanessa M. White**[d], **Rachel Middlesteadt Ellerson**[b], **Jerris L. Raiford**[e], **Monique G. Carry**[e], and **Jeffrey H. Herbst**[e]

[a]Department of Social and Behavioral Sciences, Harvard School of Public Health, Boston, MA, USA

[b]Substance Abuse Treatment Evaluations and Interventions Research Program, RTI International, Research Triangle Park, NC, USA

[c]Gillings School of Global Public Health, University of North Carolina, Chapel Hill, NC, USA

[d]School of Dentistry, University of North Carolina, Chapel Hill, NC, USA

[e]Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC), Atlanta, GA, USA

Abstract

Formative research was conducted to understand the social determinants of HIV risk among African American female adolescents as part of a systematic adaptation of an evidence-based behavioral HIV prevention intervention, the Women's CoOp. Semi-structured in-depth interviews were conducted between November 2008 and April 2009 with 20 African American female adolescents aged 16–18 who reported engaging in sex, using alcohol or other drugs, and dropping out of school. All interviews were audio recorded, transcribed, and coded for key themes and emergent content patterns. The findings indicate that while female adolescents are knowledgeable about HIV and other sexually transmitted infections (STIs), myriad social factors relate to their level of risk. Interpersonal relationships, primarily with older boyfriends and friends, played a pivotal role in their decision-making regarding sex risk behavior, substance use, and educational attainment. A lack of viable employment opportunities, exacerbated by the lack of a high school education, resulted in some young women trading sex to make money. In addition, violence, victimization, and gang involvement are pervasive in their communities. Out-of-school African American female adolescents face a plethora of issues that are directly and indirectly related to their sex risk behaviors and consequently their HIV/STI risk. To reach a vulnerable population disproportionately affected by HIV and other STIs, these factors must be addressed in prevention interventions, when feasible. The findings were incorporated into the intervention adaptation that is currently being tested in a randomized controlled trial.

*Corresponding author. wmw@rti.org.

RTI International is a trade name of Research Triangle Institute

Keywords

adolescents; HIV; African American; adaptation; social determinants of health

In the United States, African American female adolescents are disproportionately affected by HIV and other sexually transmitted infections (STIs) compared with white and Hispanic female adolescents (Centers for Disease Control and Prevention [CDC], 2010a, 2011). An estimated 16% of African American females diagnosed with HIV during 2005 and 2008 were between the ages 13 and 24 (CDC, 2011); and, in 2007, HIV was among the leading causes of death for African American female adolescents (CDC/National Center for Injury Prevention and Control, 2011). Approximately one in four female adolescents aged 14–19 in the United States has at least one of the most common STIs, and nearly half (44%) of the African American female adolescents have at least one (Forhan et al., 2009). Findings from the same nationally representative survey indicated that when accounting for time one has been sexually active and number of lifetime partners, African American female adolescents had more than three times the odds of having any STI than white female adolescents.

The landscape of HIV/STI risk for African American female adolescents is multifaceted, highlighting the importance of addressing the social determinants of health. The CDC has defined social determinants of health as “the complex, integrated, and overlapping social structures and economic systems” that influence health at the individual, community, and jurisdictional levels (CDC, 2010b). Further, the disproportionate burden of HIV and other STIs among African American female adolescents is not merely determined by gender and race but also by the inequitable social and economic environments in which they navigate (Sharpe et al., 2012). Farley (2006) presented a model to explain higher rates of STIs among African Americans related to several social and environmental factors, such as chronic joblessness, drug and alcohol marketing, social disorganization, and male incarceration.

Many African American female adolescents face social structures that increase their exposure to and experience with multiple risk factors (Annang, Walsemann, Maitra, & Kerr, 2010; Voisin & Neilands, 2010a), and these factors can independently and synergistically increase the risk of HIV/STI acquisition (Adimora et al., 2006; CDC, 2005; Lang et al., 2011; Salazar, Crosby, & DiClemente, 2009). Studies have shown that adolescents with sexually or physically violent partners engage in high-risk sex behavior (Wingood & DiClemente, 1997; Wingood, DiClemente, McCree, Harrington, & Davies, 2001), and previous experience of violence or fear of violence can limit a woman’s ability to negotiate or use condoms (Pettifor, Measham, Rees, & Padian, 2004; Wingood & DiClemente, 1997), even when knowledgeable about STIs (Salazar et al., 2009). Furthermore, African American female adolescents who reported being forced to have sex have higher frequencies of sex while they or their partners are under the influence of alcohol or other drugs (Lang et al., 2011). Studies have also shown that negative influences of peers can serve as a pathway to greater risky sex and drug use (Voisin & Neilands, 2010a, 2010b; Wright & Fitzpatrick, 2004), and involvement with gangs has been associated with STI acquisition among African American female adolescents (Wingood et al., 2002), in addition to substance use and violence (Harper & Robinson, 1999).

Economic systems can also increase HIV/STI risk. Approximately 25% of African Americans live in poverty-stricken areas (United States Census Bureau, 2008), and the concentration of poverty in certain geographical areas can elevate the risk of HIV/STI infection of African Americans for whom choices where to reside are limited to ones known for HIV/STI clusters (Hixson, Omer, del Rio, & Frew, 2011). A recent study of low-income women in Baltimore reported an association between HIV risk behavior and unstable housing, incarceration, residential mobility, and income levels (German & Latkin, 2012).

With the myriad of issues that affect young African American women in North Carolina and their HIV/STI risk, evidence-based interventions (EBIs) are needed that address these issues. EBIs exist for African American women (Crepaz et al., 2009), including the Women's CoOp that originated in North Carolina that not only resulted in significant reductions in alcohol and other drug use and unprotected sex, but also homelessness and unemployment (Wechsberg, Lam, Zule, & Bobashev, 2004).

The present study comprised in-depth interviews with African American female adolescents to elicit potential drivers of the HIV/STI epidemic to identify social determinants of health that can be modified. This approach is consistent with the literature for both policymakers and healthcare providers to improve service provision and increase healthier outcomes (Sharpe et al., 2012). Findings from the interviews with African American female adolescents were used to adapt the Women's CoOp EBI for this population.

Method

This study activity was funded by the CDC as part of the Adopting and Demonstrating the Adaptation of Prevention Techniques (ADAPT-2) project to systematically adapt and pilot test an EBI for populations at-risk for HIV (CDC, 2007). In-depth interviews were conducted with 20 African American female adolescents in Raleigh and Durham, North Carolina between November 2008 and April 2009. The Institutional Review Boards of RTI International and the CDC approved the study protocol.

Recruitment and eligibility

Participants were recruited and screened primarily through targeted street outreach, which has been a successful strategy with hard-to-reach populations in the same geographical area (Wechsberg et al., 2004). Study staff identified and regularly visited areas where young African American women were known to frequent, such as bus stops, to inform potential participants about the study. To supplement this method, staff posted recruitment cards and fliers in community-based organizations. Interested adolescents could visit or call one of the two project sites to be screened for eligibility.

To be eligible, individuals had to (1) be female, (2) identify as black/African American, (3) be aged 16–18, (4) have dropped out of school, (5) have had sex, (6) ever drank alcohol or used one of the following – marijuana, cocaine/crack, heroin, ecstasy, methamphetamine, or other illicit substance, and (7) live in Durham or Raleigh. Substance use was an eligibility criterion because the original EBI was for substance users, and information about substance use is a core element of the intervention (Wechsberg, Browne, Ellerson, & Zule, 2010).

Additionally, there is a significant relationship between substance use and HIV risk behaviors among adolescents (Broman, 2007; Seth, Wingood, DiClemente, & Robinson, 2011).

A total of 48 young women were screened for the formative phase, which included in-depth interviews and focus groups. Of those screened, 27% did not meet eligibility criteria. Adolescents who were eligible, attended their scheduled appointment and provided consent or assent to participate were interviewed at one of the two sites.

Interview procedures

Interviews lasted approximately 2 hours and were audiotaped. Participants were asked about teens' experiences regarding education and employment, sex risk behaviors, pregnancy, substance use, violence, social support, housing, sex trading, and the justice system. Example questions include: "What are the reasons why female teens drop out of school?" and "Do drugs and alcohol change the ways young people have sex?" Because of the sensitive topics and reporting requirements, participants were instructed to discuss the experiences of teens in their community rather than personal experiences. All interviews were conducted by a master's-level African American female. Participants received a $15 gift card and a kit with toiletries valued at $10 for participation.

Data collection and analysis

Audiotapes were transcribed into Microsoft Word. After confirming their accuracy, these documents were imported into ATLAS.ti version 5.6 (Scientific Software Development GmBH, Berlin, Germany). A hierarchically ordered codebook was created to allow for primary codes and subcodes, which was reviewed and revised through an iterative process. Coding was conducted using grounded-theory approach, specifically open coding (Corbin & Strauss, 1990). To ensure intercoder reliability, the interviewer and note taker coded the first two interviews (10%) independently. Once coding was complete, they discussed and resolved discrepancies and refined the codebook for clarity. Coders then recoded the interviews using the revised codebook. Once the coding and codebook were agreed upon, the coders coded the remaining 18 interviews independently. After coding, the two sets of transcripts were merged to determine co-occurrence, and discrepancies were resolved through discussion. Next, data were analyzed to identify emergent themes based on the frequency of codes and their relationship with other codes.

Results

Study sample

The majority of the 20 participants were 18 years old (60%); with the remaining 17 years old (30%) and 16 years old (10%). More participants lived in Raleigh (60%) than Durham (40%). Alcohol was the most common substance of lifetime use (95%), followed by marijuana (70%), ecstasy (15%), and cocaine/crack (5%). No other drugs were reported.

Results of qualitative analysis

Results of the analysis revealed five themes related to substance use and sex risk behaviors: the influence of boyfriends and other male sex partners, inconsistent condom use despite HIV/STI knowledge, trading sex, exposure to violence and rape, and involvement in gangs. Each theme and illustrative quotes are displayed in tables. Themes that were significant to increased HIV/STI risk are described.

Influence of boyfriends and other male sex partners

Many decisions female adolescents make regarding substance use and sex risk behavior are greatly influenced by boyfriends and other male partners (shown in Table 1). Participants reported that important men in their lives, including (mostly older) boyfriends, introduce them to alcohol and other drugs, in addition to family members and friends. Many participants added that a strong desire to be with men is associated with appearing cool to fit within their social group. While hanging out with these men, they are repeatedly exposed to alcohol and other drugs.

Several participants reported that female adolescents drop out of school to spend time with their boyfriends, and most (80%) indicated that once they drop out, they spend time with their boyfriends. Often, older boyfriends have dropped out of school and stay out all night and sleep during the day. As these young women desire to be with these men, they too consider dropping out of school. The majority of participants (70%) also indicated that many female adolescents learn about sex from their sex partners and friends. In addition, some defer to their male partners to make decisions regarding sex, including whether or not they use condoms.

Inconsistent condom use despite HIV/STI knowledge

Participants reported female adolescents have knowledge of HIV and other STIs, yet condoms are not used consistently (shown in Table 2). While there was variation in how much knowledge they believed their peers to have, all reported that female adolescents are aware of HIV and other STIs. They primarily learn about them from the health department and medical providers. The most commonly reported STIs in their community are chlamydia, gonorrhea, trichomoniasis, and herpes; only a few participants mentioned HIV. One participant stated: “Even HIV/AIDS, but it’s rare for young girls, unless they are out there like that. If they are not out there tricking and having sex with all these different people it would be hard for them to get it.” Despite having this knowledge of HIV and other STIs, participants reported condoms are not used consistently because many young women and their partners do not like the way they feel.

Often, female adolescents learn about the benefits of using condoms when it is too late. For instance, 30% said that female adolescents learn about STIs by contracting one. Others do not think about condoms until they become pregnant. When asked whether female adolescents get pregnant on purpose or by accident, 75% responded “both,” and 20% indicated on purpose. According to participants, teenage pregnancy is pervasive and many female adolescents have children to “trap” a man (i.e., to make him stay with them).

Trading sex

Most participants (90%) reported that sex trading was a common way female adolescents make money and acquire other goods, such as food, clothing, and drugs. Young women may turn to sex trading because of limited employment opportunities, especially without a high school education (shown in Table 3). While fast-food and retail jobs are ways to earn money, these jobs can be difficult to secure and many want to earn “fast money.” The desire for fast money leads female adolescents to trade sex with a variety of men. Moreover, many of the men with whom female adolescents trade sex are significantly older.

Exposure to violence, including rape

All participants reported that violence is pervasive in their communities, with the most common type of violence being gang-related (shown in Table 4). They also reported that many male and female adolescents have experience with the criminal justice system for acts of larceny, drug possession and distribution, and other illegal acts. Moreover, substance use by female adolescents is often related to victimization and, in some cases, rape.

The majority of participants (75%) indicated that substance use changes the way young women have sex; while under the influence of alcohol and other drugs, female adolescents are more likely to engage in high-risk sex, including unprotected sex with multiple and/or unknown male partners. Participants also reported that men sometimes rape young women after they have gotten them drunk or high. Rape is rarely reported to the authorities, and alcohol and other drug use are ways these young women cope with life stressors. When asked about the circumstances that place a young woman at-risk for rape, more than half of the participants believed female adolescents who are raped may be at-risk because of their style of dress; participants also reported that how one acted or talked put them at-risk.

Involvement in gangs

Participants reported that female adolescents are attracted to gangs because of male members, and sometimes are “sexed-in” (i.e., having sex with multiple males consecutively) as their initiation (shown in Table 5). Female adolescents are attracted to gangs for various reasons, such as gang colors (i.e., colors as insignia worn by gang members to identify each other), a sense of belonging (“family”), and for protection. However, the primary attraction is through dating a gang member.

Common ways female adolescents get initiated into a gang is by fighting, going on a mission, being “sexed-in” or being “blessed-in” (i.e., allowed to affiliate with the gang because of who they are or if they have relatives in the gang). While a few participants said that being “sexed-in” was a myth, others shared detailed stories about this type of initiation.

Discussion

Findings indicate that African American female adolescents who use alcohol or other drugs, drop out of school, and are sexually active face a plethora of issues related to HIV/STI risk. Interpersonal relationships, particularly with boyfriends who often exert a gender power differential, are integral to decision-making about using alcohol and other drugs, dropping

out of school, sexual risk behavior, and affiliating with gangs. Participants discussed the lack of condom use among their peers, despite being knowledgeable about HIV and other STIs. A finding of great concern was the pervasiveness of intentional pregnancy to secure a man. Finally, participants noted that men often offer attractions, which can place young women at even greater risk for HIV/STIs because sex is often expected in exchange. Structural issues, such as limited employment opportunities and barriers to returning to school, appear to be related to behavioral risk. However, good role models, a social support system, and personal motivation can be factors that help female adolescents to change their risk behaviors and address the barriers before them (Crosby et al., 2008; Seth et al., 2011; Turner, Latkin, Sonenstein, & Tandon, 2011).

These findings are consistent with other studies in the literature. For example, a study found that African American female adolescents who perceived their male sex partners having sex with other women experienced less power in their relationship, diminished commitment to the relationship, greater interpersonal stress, and greater STI diagnoses (Brown, Sales, DiClemente, Latham Davis, & Rose, 2012). Additionally, a recent study with African American female adolescents found that the relative importance adolescents place on having a partner was significantly associated with a variety of HIV/STI risk behaviors, including unprotected sex at last sex with their main partner, and sex while their partner was high (Raiford, Seth, & DiClemente, 2013). In another study, African American female adolescents who experienced violence from boyfriends were more likely to have an STI, have non-monogamous male partners, use condoms inconsistently, and feared negotiating condom use and talking about pregnancy prevention with male partners compared to those not experiencing violence (Wingood et al., 2001). Finally, a study of sexually active African American female adolescents who desired to become pregnant had boyfriends at least 5 years older, lower self-esteem, greater perceived barriers to using condoms, and lower perceived levels of family support (Davies et al., 2004).

A view toward social determinants of health can help address these issues through the development of comprehensive prevention interventions, as well as social policies and interventions that target the social and environmental drivers (Farley, 2006). Given the complexity of the drivers of HIV risk among this group, a multi-pronged approach is needed (Strathdee, Wechsberg, Kerrigan, & Patterson, 2013). At the individual level, interventions should focus on increasing adolescents' self-efficacy with communication and negotiation skills with partners about sex and related issues that may otherwise compromise their personal power. Such efforts should be coupled with interpersonal level strategies, including programs that engage adolescents' main partners to challenge norms and expectations in relationships and address the decisions and risk behaviors that are shaped by male partners, such as alcohol and other drug use, dropping out of school and gang involvement. Additionally, these programs should encourage female adolescents to support each other from negative social determinants that will impact their future. At the policy level, given the paucity of employment opportunities, it is important to have innovative and engaging skills development programs that lead to viable employment opportunities, so that female adolescents can be motivated and encouraged to return to school to obtain their diploma, or gain technical skills.

One limitation of this study is that participants were asked to not share their own behaviors and experiences, but rather those of other female adolescents. This was done to protect participants' confidentiality and privacy. A concern with this approach is that participants may be reporting the behaviors of the same individuals. To limit this possibility, participants were recruited from different neighborhoods throughout the study area. Similarly, another concern is that adolescents may incorrectly assess others' behavior, leading to incorrect estimates regarding how pervasive certain issues are. However, previous research indicates positive associations between adolescents' perceptions of peers' sexual behavior and their own behavior (Boyer et al., 2000; Prinstein, Meade, & Cohen, 2003; Romer et al., 1994), providing support for such assessments as appropriate proxy measures for actual behaviors. One advantage of this method is that it allowed participants to discuss sensitive topics that may not otherwise be discussed (Johnson, 2001).

Another potential limitation is generalizability of findings. Although participants were recruited from different areas, it is possible they comprise a non-representative sample. More than half were 18 years old, which may bias the findings; 18 year olds may be more knowledgeable about the topics than younger participants. However, the narrow age range for eligibility (16–18) was used to ensure that participants were at similar developmental stages. Five clear themes were identified in the data, reaching saturation among the sample. A sample size of 20 was sufficient for qualitative analysis and reaching saturation in coding. The purpose of this activity was to learn more about the contextual issues that at-risk African American female adolescents in Raleigh–Durham encounter for adaptation of an EBI; therefore, the issue of generalizability is less of a concern.

To reach adolescents at-risk, researchers must listen to them and develop prevention interventions that are informed by their social and structural determinants of health risk (Smedley & Syme, 2000). It is imperative that applied researchers and practitioners challenge the social and structural determinants of HIV when developing and adapting HIV prevention interventions for African American female adolescents, so that new behaviors and skills can be embraced and sustained within their own ecology.

Acknowledgments

This study was supported by cooperative agreement URPS000665 awarded to RTI International by the Centers for Disease Control and Prevention. The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention. The authors gratefully acknowledge Paul Mihas at the Odum Institute for support in the initial codebook construction, Jennifer Galbraith at the CDC for support during the formative phase of this research project, and Jeffrey Novey for editorial assistance.

References

Adimora AA, Schoenbach VJ, Martinson FE, Coyne-Beasley T, Doherty I, Stancil TR, Fullilove RE. Heterosexually transmitted HIV infection among African Americans in North Carolina. JAIDS: Journal of Acquired Immune Deficiency Syndromes. 2006; 41(5):616–623. [PubMed: 16652036]

Annang L, Walsemann KM, Maitra D, Kerr JC. Does education matter? Examining racial differences in the association between education and STI diagnosis among black and white young adult females in the US. Public Health Reports. 2010; 125(suppl. 4):110–120. [PubMed: 20629254]

Boyer CB, Shafer M-A, Wibbelsman CJ, Seeberg D, Teitle E, Lovell N. Associations of sociodemographic, psychosocial, and behavioral factors with sexual risk and sexually transmitted

diseases in teen clinic patients. Journal of Adolescent Health. 2000; 27(2):102–111. [PubMed: 10899470]

Broman CL. Sexual risk behavior among black adolescents. Journal of African American Studies. 2007; 11(3–4):180–188.

Brown J, Sales J, DiClemente RJ, Latham Davis T, Rose E. Characteristics of African American adolescent females who perceive their current boyfriends have concurrent sexual partners. Journal of Adolescent Health. 2012; 50:377–382. [PubMed: 22443842]

Centers for Disease Control and Prevention. HIV transmission among black women–North Carolina, 2004. Morbidity and Mortality Weekly Report. 2005; 54(4):89–94. [PubMed: 15689856]

Centers for Disease Control and Prevention. Adopting and demonstrating the adaptation of prevention techniques for persons at highest risk of acquiring or transmitting Human Immunodeficiency Virus (ADAPT 2)-(UR6). 2007. Retrieved from http://grants.nih.gov/grants/guide/rfa-files/RFA-PS-07-004.html

Centers for Disease Control and Prevention. HIV surveillance report, 2008. Atlanta, GA: Centers for Disease Control and Prevention; 2010a.

Centers for Disease Control and Prevention. Establishing a holistic framework to reduce inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States. Atlanta, GA: U.S. Department of Health and Human Services, Author; 2010b.

Centers for Disease Control and Prevention. Disparities in diagnoses of HIV infection between blacks/African Americans and other racial/ethnic populations–37 states, 2005–2008. Morbidity and Mortality Weekly Report. 2011; 60(4):93–98. [PubMed: 21293323]

CDC/National Center for Injury Prevention and Control. Web-based injury statistics query and reporting system (WISQARS) [online]. 2011. Retrieved from http://www.cdc.gov/ncipc/wisqars/

Corbin JM, Strauss A. Grounded theory research: Procedures, canons, and evaluative criteria. Qualitative Sociology. 1990; 13(1):3–21.

Crepaz N, Marshall KJ, Aupont LW, Jacobs ED, Mizuno Y, Kay LS, O'Leary A. The efficacy of HIV/STI behavioral interventions for African American females in the United States: A meta-analysis. American Journal of Public Health. 2009; 99(11):2069–2078. [PubMed: 19762676]

Crosby RA, DiClemente RJ, Wingood GM, Salazar LF, Lang D, Rose E, McDermott-Sales J. Co-occurrence of intoxication during sex and sexually transmissible infections among young African American women: Does partner intoxication matter? Sexual Health. 2008; 5(3):285–289. [PubMed: 18771645]

Davies S, DiClemente RJ, Wingood G, Person S, Crosby RA, Harrington K, Dix E. Relationship characteristics and sexual practices of African American adolescents girls who desire pregnancy. Health Education & Behavior. 2004; 31(4):85–96.

Farley TA. Sexually transmitted diseases in the Southeastern United States: Location, race, and social context. Sexually Transmitted Infections. 2006; 33(suppl. 7):S58–S64.

Forhan SE, Gottlieb SL, Sternberg MR, Xu F, Datta SD, McQuillan GM, Markowitz LE. Prevalence of sexually transmitted infections among female adolescents aged 14 to 19 in the United States. Pediatrics. 2009; 124(6):1505–1512. [PubMed: 19933728]

German D, Latkin CA. Social stability and HIV risk behavior: Evaluating the role of accumulated vulnerability. AIDS and Behavior. 2012; 16(1):168–178. [PubMed: 21259043]

Harper GW, Robinson WL. Pathways to risk among inner-city African-American adolescent females: The influence of gang membership. American Journal of Community Psychology. 1999; 27(3): 383–404. [PubMed: 10492881]

Hixson BA, Omer SB, del Rio C, Frew PM. Spatial clustering of HIV prevalence in Atlanta, Georgia and population characteristics associated with case concentrations. Journal of Urban Health. 2011; 88(1):129–141. [PubMed: 21249526]

Johnson, JM. In-depth interviewing. In: Gubrium, JF.; Holstein, JA., editors. Handbook of interview research. Thousand Oaks, CA: Sage; 2001. p. 103-116.

Lang DL, Sales JM, Salazar LF, Hardin JW, DiClemente RJ, Wingood GM, Rose E. Rape victimization and high risk sexual behaviors: Longitudinal study of African-American adolescent females. Western Journal of Emergency Medicine. 2011; 12(3):333–342. [PubMed: 21731791]

Pettifor AE, Measham DM, Rees HV, Padian NS. Sexual power and HIV risk, South Africa. Emerging Infectious Diseases. 2004; 10(11):1996–2004. [PubMed: 15550214]

Prinstein MJ, Meade CS, Cohen GL. Adolescent oral sex, peer popularity, and perceptions of best friends' sexual behavior. Journal of Pediatric Psychology. 2003; 28(4):243–249. [PubMed: 12730281]

Raiford JL, Seth P, DiClemente RJ. What girls won't do for love: Human immunodeficiency virus/sexually transmitted infections risk among young African-American Women driven by a relationship imperative. Journal of Adolescent Health. 2013; 52(5):566–571. [PubMed: 23298990]

Romer D, Black M, Ricardo I, Feigelman S, Kaljee L, Galbraith J, Stanton B. Social influences on the sexual behavior of youth at risk for HIV exposure. American Journal of Public Health. 1994; 84(6):977–985. [PubMed: 8203696]

Salazar LF, Crosby RA, DiClemente RJ. Exploring the mediating mechanism between gender-based violence and biologically confirmed Chlamydia among detained adolescent girls. Violence Against Women. 2009; 15(3):258–275. [PubMed: 19139491]

Seth P, Wingood GM, DiClemente RJ, Robinson LS. Alcohol use as a marker for risky sexual behaviors and biologically confirmed sexually transmitted infections among young adult African-American women. Women's Health Issues. 2011; 21(2):130–135. [PubMed: 21276736]

Sharpe TT, Voûte C, Rose MA, Cleveland J, Dean HD, Fenton K. Social determinants of HIV/AIDS and sexually transmitted diseases among black women: Implications for health equity. Journal of Women's Health. 2012; 21(3):249–254.

Smedley, BD.; Syme, SL. Promoting health: Intervention strategies from social and behavioral research. Washington, DC: National Academies Press; 2000.

Strathdee S, Wechsberg W, Kerrigan D, Patterson T. HIV prevention among women in low-and middle-income countries: Intervening upon contexts of heightened HIV risk. Annual Review of Public Health. 2013; 34:301–316.

Turner AK, Latkin C, Sonenstein F, Tandon SD. Psychiatric disorder symptoms, substance use, and sexual risk behavior among African-American out of school youth. Drug and Alcohol Dependence. 2011; 115(1–2):67–73. [PubMed: 21145182]

United States Census Bureau. 2007 Economic Census. 2008. Retrieved from http://www.census.gov/econ/census07/

Voisin DR, Neilands TB. Low school engagement and sexual behaviors among African American Youth: Examining the influences of gender, peer norms, and gang involvement. Children and Youth Services Review. 2010a; 32(1):51–57. [PubMed: 20161422]

Voisin DR, Neilands TB. Psychosocial challenges facing black high school students in Chicago: Does gender matter? The Journal of Adolescent Health. 2010b; 46(6):600–602. [PubMed: 20472218]

Wechsberg WM, Browne FA, Ellerson RM, Zule WA. Adapting the evidence-based women's CoOp intervention to prevent human immunodeficiency virus infection in North Carolina and international settings. North Carolina Medical Journal. 2010; 71(5):477–481. [PubMed: 21473554]

Wechsberg WM, Lam WK, Zule WA, Bobashev G. Efficacy of a woman-focused intervention to reduce HIV risk and increase self-sufficiency among African American crack abusers. American Journal of Public Health. 2004; 94(7):1165–1173. [PubMed: 15226138]

Wingood GM, DiClemente RJ. The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. American Journal of Public Health. 1997; 87(6):1016–1018. [PubMed: 9224187]

Wingood GM, DiClemente RJ, Crosby R, Harrington K, Davies SL, Hook EW III. Gang involvement and the health of African American female adolescents. Pediatrics. 2002; 110(5):e57. [PubMed: 12415063]

Wingood GM, DiClemente RJ, McCree DH, Harrington K, Davies SL. Dating violence and the sexual health of black adolescent females. Pediatrics. 2001; 107(5):e72. [PubMed: 11331722]

Wright DR, Fitzpatrick KM. Psychosocial correlates of substance use behaviors among African American youth. Adolescence. 2004; 39(156):653–667. [PubMed: 15727405]

Table 1

Theme 1: influence of boyfriends and other male sex partners.

Subtheme	Illustrative quotes
Influence on substance use	• "I think most girls start smoking [marijuana] from their boyfriends or guy friends and stuff. You know just to be cool or to have an excuse to hang out with that person.…" [#17]
	• "I think the main reason [for substance use] goes back to the peer pressure and wanting to fit in. You hear people saying 'Oh, this weekend I got so high, I felt so good'…. Like 'I forgot about all my problems,' so it's used to fit in again…. Curiosity and wanting to fit in is a big part of that." [#16]
Dropping out of school	• "They drop out [of school] because they get pregnant; they drop out because they want to be with a man or a boy…. That's because of these older men, or these young boys, and they want to be like them…. They have one baby, then they have two babies, and they have nobody to help them." [#20]
	• "Most teens go with a boyfriend that is older than them, that sells drugs. They already dropped out of school, so you want to be out with them all night, and then they don't go to school so they sleep the next day. You might want to be with them and your mind is not focused on school anymore." [#2]
Male partners make decisions about sex	• "… most teens use condoms, but then sometimes it might be the boy who's like 'Oh let's not use a condom' and then the teen is like 'Oh I love him, I don't need to use a condom'…. But some teens that care about their bodies will say 'No I'm going to use a condom.'" [#11]
	• "By the dude being like 'Do you want to have sex.' they might act kind of shy and be like 'No.' But the dudes got that talking game, they can make you do almost anything. That talking game is amazing, they can get you to do everything in the book. All they have to say is do one thing, then they will do everything else after that." [#19]

Table 2

Theme 2: inconsistent condom use despite HIV/STI knowledge.

Dislike feel of condoms	• "A lot of females don't like it [condoms] and a lot of males don't like. I guess they don't get the feeling or whatever.… I think the females don't like it because number one, it doesn't feel right, number two, because it chafes your skin a little bit. A lot of people don't like using them, but they should though, they should." [#14]
	"[…] a lot of teens these days feel that they don't want to use condoms because it's the 'thang,' all young girls have babies." [#2]
Learn to use condoms when it is too late	• "They don't think about [condoms] until they get pregnant, or until they contract an STD. That should make them want to use condoms from then on." [#13]
Desire to get pregnant	• "… I was sitting at school here the other day thinking that there are four girls out of my whole school that don't have kids. All of them have babies; everybody that I know has babies." [#18]
	• "… some just want to have a baby by that boy, just to have a baby by them so I guess he won't go nowhere." [#3]

Table 3

Theme 3: trading sex.

Limited employment opportunities	• "There are a lot of females out here who don't have jobs, so they get it how they can. You can go out here and take out somebody's trash, you can mow somebody's lawn, and you know you can keep an old lady company, read a book to her and they'll pay you a little money. But they want fast money. Fast money is hopping in and out of cars, and that's how they get it." [#20]
	"For a normal female that doesn't have any problems, parents love them and care about them and all that, where they don't have to want for nothing … it's [sex trade] not common in them. It's common in the ones that dropped out of school, don't have nowhere to go, don't have an income, don't know how to go out and get a job, and can't get a job and is on drugs. It's common for females like that." [#15]
Influence of older men	• "All these old dudes know that there are a lot of young girls they can take advantage of for like $10…. It's older men out here looking for tricks." [#10]
	• "It's an older man that wants to have sex with a young [girl], like older men like young, pretty, it might be African American, it might be any other race, they just see pretty teenagers and they be like, you can make some money come with me, or something like that. So the teens are like, yeah that's my sugar daddy he's going to give me money, any time I need money I can call him because he is older he got money and stuff like that." [#1]

Table 4

Theme 4: exposure to violence, including rape.

Lost control due to drugs	• "Yeah, it you are very high and drunk, you don't know what you are doing … but you don't think about like 'Am I going to get pregnant' or 'Am I going to get a disease.' You don't think about none of that stuff, you are just in that moment." [#14]
	• "… they'll feel like you belong to them. If they let you smoke their product [marijuana] and you don't have to pay for it, or they give you weed on credit and you owe them whatever. They feel that you are theirs, and if they want a couple of friends to join in, then they feel that they have the right…." [#16]
Circumstances that increase risk of rape	• "It's their fault that they got raped. If you show some level of respect for yourself, and actually show that you have standards, I don't think that a lot of it would happen. If someone sees you talking to a lot of different people, they might think that you wouldn't mind talking to them, or doing something with them too. Show you have respect for yourself, I think more people would respect you." [#16]
	• "How they treat themselves, how they carry themselves. The way she talks, if she doesn't respect herself, if she is not talking lady like. Basically she is not presenting herself well, it could be the clothes, the way she talks, the things that come out of her mouth when she is around these dudes. They are like dang, 'this female is a slut, she's a ho, she's a jump-off.'" [#20]

Table 5

Theme 5: involvement in gangs.

Relationships with gang members	• "Yeah, 'cause like with [a certain gang], if you are officially a [gang member], then the girl he is dating is automatically … affiliated with the gang. Just because of who her boyfriend is … even if she breaks up with him, she is still affiliated because she has all those friends, she won't be official, but she is definitely affiliated." [#6]
	• "… that could be a spur of the moment thing, someone can say that to get in, as long as you give me and him some, you can get in. But it's like, however they want it, whenever they want it, you don't have any say so about it and stuff." [#16]
Being "sexed-in"	• "And it's not just one dude having sex with them, it's like half of the gang has to come in and have sex with them…. I know that's for [a certain gang], it has to be at least 15." [#15]