

tendency in adolescent health research to homogenize partner-types into binary categories, very little attention has been given to the contextualized relationships of Black adolescent girls. In particular, Black adolescent girls who are also mothers may have different types of sexual partners than adolescent girls who are not mothers. The purpose of this study was to elicit and re-present Black adolescent mothers' descriptions of their male sexual partners, including sex partners who were also the fathers of their children.

Methods: This study was a qualitative description using data from six focus groups and two interviews. Participants were recruited from community and clinical sites using peer driven recruitment ($n = 31$). The mean age was 15.5 years (SD 1.4). All of the participants in the study were mothers who identified as Black (10% Hispanic; 90% non-Hispanic). Data were transcribed verbatim by research assistants. Data were organized using Atlas.ti software and analyzed using matrix assisted qualitative content analysis. Preliminary findings were presented to a critical reference group of adolescent mothers to increase confidence that the low-inference findings were generally reflective of the participants own experiences.

Results: Nine sexual partner-type categories were identified. These partner-types included hubby, baby daddy, boyfriend, boo, friend, friend with benefits, shorty/booty call, pop, and one night stand. The adolescent mothers classified and organized these partners using a taxonomy based largely on the relationship characteristics of trust, love, emotional connection, and perceived seriousness of the relationship. The partner-type taxonomy demarcated boundaries for the limits and possibilities of various aspects of the relationships including sex and sexual risk negotiation.

Conclusions: The sexual partner-types of Black adolescent mothers are more robust (in depth and breadth) than the "main" and "casual" partner categories typically referenced in adolescent health research. The partner-types of Black adolescent mothers may also include male partners who are also the fathers of their children. The "baby daddy" partner departs from traditional partner type categories that exist at the intersection of gender and sexuality. The "baby daddy" sex partner exists at the intersection of gender, sexuality, and maternity/paternity. Thus sexual risk reduction research that does not account for the role of maternal/paternal/child relatedness are unlikely to effectively sustain sexual risk reductions between adolescent mothers and their "baby daddy" partners.

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SESSION III: SEXUAL RISK AND REPRODUCTIVE HEALTH

1.

ARE CHILDBEARING MOTIVATIONS GETTING IN THE WAY OF STI PREVENTION IN YOUNG WOMEN?

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Purpose: Urban communities with high sexually transmitted infection (STI) prevalence often have disparities in unplanned pregnancies among young women. Research using single measures of pregnancy desire and/or intention has not yielded guidance on

dual prevention strategies. Exploring childbearing motivation (CBM), the first step in the psychological sequence to childbearing behavior, may enable us to better understand reproductive decisions. The objective of this study is to examine the relationship between CBM and use of hormonal contraception, condoms, and dual contraception.

Methods: A cross-sectional household study was conducted from 2004-2007. Data was collected from 297 sexually active females 15-25 years in age residing in high STI- prevalent neighborhoods in Baltimore, Maryland. Participants completed audio-computerized assisted self- interviews eliciting demographic, reproductive history and behaviors, and CBM. CBM was measured using a youth-specific adaptation of Miller's childbearing questionnaire. Positive (P)CBM subscales included measures of satisfaction from raising a child, feeling needed/connected, value of children/parenthood, and positive aspects of pregnancy, birth, and infancy ($\alpha = .94$). Negative (N) CBM subscales included discomforts of pregnancy and childbirth, fears/worries/stressors of parenthood, and negatives of caring for child ($\alpha = .85$). The highest and lowest quartiles from each subscale were combined to create overall positive (high PCBM/low NCBM) and negative (low PCBM/high NCBM). Data outside of these groups was characterized as intermediate (I). Data were evaluated using multivariable regression analyses.

Results: Participants were 90% African American with a mean age of 19.4 (SD 2.8). More than half (55%) had a history of pregnancy and 42% had children. 35% had a history of STIs. Using the quartile-based groups (21%; $n = 64$) were in the positive CBM group, 39.3 were in the negative group, and 39.7% ($n = 118$) were in the ICBM group. Those in the ICBM group were less likely to use condoms at last sex with main partner compared to the NCBM group (AOR: .54; 95% CI: .32-.93), controlling for STI history, pregnancy history, and age. Those in the PCBM group were 2.8 times more likely to use hormonal contraception (AOR: 2.75; 95% CI: 1.35, 5.62), and 3.3 times more likely to use dual contraception (consistent condom use with hormonal contraception) with their main partner (AOR: 3.31; 95% CI: 1.46, 7.50) compared with those in the NCBM group, controlling for STI history, pregnancy history, and age.

Conclusions: Young women with overall positive attitudes about parenting are more likely to engage in simultaneous family planning and STI/HIV prevention behaviors than those with NCBM. Those in the intermediate group who appear to be ambivalent or indifferent about parenting are at highest risk for STIs due to inconsistent condom use compared with those in NCBM group. Given the health disparities associated with early childbearing and STIs, additional research exploring how CBM evolves over adolescence and the potential role of CBM in the prevention of STIs and unplanned pregnancy is warranted.

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2.

TEEN USE OF EMERGENCY CONTRACEPTION: METHODS OF ACCESS AND PERCEIVED BARRIERS

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Purpose: To examine the effect of policies regarding access to emergency contraception (EC) on promptness of use of EC and satisfaction with experience of using EC among adolescents.

Methods: A 15-minute online survey was completed by females, ages 14 to 19, who engaged in unprotected intercourse (UPI) at a time when they were aware of EC. Outcomes included

promptness of use after UPI, satisfaction with experience of using EC, and perceived barriers to accessing EC. We compared outcomes for those who obtained EC by prescription to those who obtained it without a prescription. In addition, we compared experiences in states that allow pharmacist-access to EC to those that do not. Generalized linear mixed models were used to account for repeated episodes of EC use. Age, race, maternal education, and history of pregnancy were considered as confounders but only included in the models if $p < .10$.

Results: Surveys were completed by 531 teens from 50 US states; 58% were white, 14% were African American, and 28% were other races/ethnicities. Although all reported a history of UPI and awareness of EC, only 48% had ever used EC. Twenty-seven percent used EC when they were younger than 18; 78% of minors obtained EC without a prescription. Participants who obtained EC without a prescription were more likely to use it within 24 hours than those who obtained it with a prescription (OR = .42; 95% CI: .18, .99). Minors showed a trend toward being more satisfied with the experience of using EC in pharmacist-access states than in non-access states ($p = .06$). Among teens who had UPI but had never used EC, barriers among those living in pharmacist-access states included “didn’t think I would really get pregnant” (40%) and concern that parents would find out (17%), while among those in non-pharmacist access states, barriers included “didn’t think I would really get pregnant” (38%) and high cost of EC (30%).

Conclusions: Over half of teen respondents who had engaged in UPI had never used EC, though all were aware of EC at the time they had UPI. Policy changes which allow minors to access EC without a prescription can increase timely use of EC.

Sources of Support: Doris Duke Clinical Research Fellowship Program; University of Pittsburgh School of Medicine Clinical Scientist Training Program.

3.

ASSOCIATIONS BETWEEN SOCIAL EMOTIONAL INTELLIGENCE AND ADOLESCENT GIRLS’ SEXUAL RISK BEHAVIORS

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Purpose: Social emotional intelligence has been linked to both health and risk behaviors during adolescence. Distinct from general mood, social emotional intelligence incorporates intrapersonal, interpersonal and stress management skills. While relationships between adolescents’ social emotional intelligence and sexual behaviors are conceptually plausible, few studies to date have examined associations between adolescents’ social and emotional skills and their sexual behaviors. The purpose of this study is to examine associations between indicators of social emotional intelligence and sexual risk behaviors among sexually active adolescent girls at high risk for pregnancy and sexually transmitted infections (STI).

Methods: Prime Time is a clinic-based youth development intervention study that aims to reduce multiple risk behaviors among teen girls at high risk for early pregnancy. This study utilized baseline survey data from 253 urban, sexually active 13-17 year old girls participating in the Prime Time study. Focal independent variables were intrapersonal (6 items; $\alpha = .79$), interpersonal (6 items; $\alpha = .80$) and stress management (6 items; $\alpha = .85$) scales from the Bar-On Emotional Quotient Inventory: Youth Version (EQi:YV, Short Form). Outcome variables included communication with most recent partner about sexual risk; number of male sex partners;

consistency of condom use and consistency of hormonal method use in the past 6 months. Initial bivariate analyses examined relationships between each independent and outcome variable. Preliminary multivariate regression models controlling for age and race/ethnicity examined relationships between social emotional intelligence variables and sexual behaviors.

Results: Greater intrapersonal, interpersonal and stress management skills were all associated with earlier communication with most recent partner about sexual risk at the bivariate level. In a multivariate model including all three EQi:YV variables, both stress management and interpersonal skills retained significant relationships with partner communication. Greater intrapersonal and interpersonal skills were associated with fewer male sex partners in the past 6 months at the bivariate level. In a multivariate model, both were negatively related to the number of sex partners, with interpersonal skills demonstrating a larger impact than intrapersonal skills. Of the three EQi:YV variables, only stress management skills predicted condom use consistency. Greater stress management skills were associated with more consistent condom use in the past 6 months. None of the social emotional intelligence variables predicted hormonal method consistency in this sample.

Conclusions: This study indicates that high levels of social emotional intelligence may be an important protective buffer against selected sexual risk behaviors among adolescent girls. Building adolescent girls’ social and emotional skills may be an effective strategy for reducing their risk for early pregnancy and STI.

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4.

ASSOCIATION BETWEEN YOUNG WOMENS PERCEPTIONS OF SEXUAL PARTNERS AND SUBSEQUENT PREGNANCY OR STI DIAGNOSIS

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Purpose: Adolescent women’s use of contraception or condoms with some but not all partners is common. Thus, some partners may be perceived to be less or more desirable as potential fathers, and some as less or more risky as potential STI transmitters. These perceptions are likely based in observable differences in partner attributes. We examined differences in women’s perceptions of sexual partners associated with a pregnancy compared to sexual partners associated with an STI.

Methods: Adolescent women ($n = 387$; ages 14-17 years at enrollment) were tested quarterly for STI and pregnancy status; and completed partner-specific questionnaires on relationship content. Total study duration was up to 8 years, but current analyses were limited to quarters in which only one partner was reported at a time. To examine differences in partner attributes, we classified each relationship into a 4-category outcome variable: Neither STI or pregnancy, STI only, pregnancy only, STI and pregnancy. Predictor variables included: physical attributes (5 items, $\alpha = .82$, e.g., “A cute face” and “A nice body”), emotional attributes (11 items, $\alpha = .91$, e.g., “Is always nice to me”, “Is easy to talk to” and “Cares for others”), personality attributes (4 items, $\alpha = .73$, e.g., “Likes to have fun” and “Willing to take chances”), social capital attributes (3 items, $\alpha = .70$, e.g., “Has a nice car” and “Has money”), and proximity (single item, “Lives in my neighborhood”). We also controlled for subject and perceived partner pregnancy intention (each single, 3-point Likert items), as well as relationship quality (5 items, $\alpha = .92$), relationship satisfaction (5 items, $\alpha = .93$), sexual