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race, or school status. Half as many teens receiving prenatal care in a SBHC compared to non-school-based settings made an ED visit (11% vs. 21%; $p = .02$). In multivariate models, adjusting for baseline differences and medical and pregnancy risk, the odds of an ED visit during pregnancy were 2.4 times greater for teens receiving non-school-based care (95% CI 1.2–4.7; $p = .01$) and 1.7 times greater if their pregnancy was high risk (95% CI 1.3–2.2; $p < .001$).

**Conclusions:** While problem acuity was not measured in this study, among this cohort of pregnant teenagers with a usual source of care, a significant number used the ED for care. ED use appears to be inversely associated with SES and most common among those with higher pregnancy risk and those who receive non-school-based prenatal care.

## DATING RELATIONSHIPS AND SEXUAL BEHAVIORS

### CORRELATES OF CONDOM USE IN ADOLESCENT MOTHERS

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**Purpose:** This study examined how condom use among poor, pregnant and parenting adolescents is influenced by theoretical variables and selected psychosocial, behavioral and demographic factors. We hoped to improve behavioral prediction of safer sex practices and explain a greater proportion of the variance in condom use than has been achieved in previous studies with use of theoretical variables alone.

**Methods: Study Design:** This correlational study employed baseline data from questionnaires completed by adolescent mothers in a clinical trial evaluating the effects of an HIV prevention program. Variables examined were *theoretical* (from Social-Cognitive Theory [SCT], the Theory of Reasoned Action [TRA], and the Theory of Planned Behavior [TPB] (self-efficacy, behavioral intentions, prevention beliefs, subjective norms, perceived behavioral control, AIDS knowledge); *psychosocial* (relationship status, history of sexual/physical abuse, partner's high-risk behaviors, perceptions of depressive symptoms and self worth); *behavioral* (substance use, sexual history, contraceptive practices); and *demographic* (age, age of partner, ethnicity, religion/religiosity. **Setting**: Participants were recruited from pregnant minor and parenting programs in Los Angeles County. **Participants:** The convenience sample (N = 572), predominantly Latinas and African Americans, ranged in age from 14–20 years (M = 16.5). At baseline 67% were pregnant, 33% had already given birth; 72% had a steady partner. **Outcome Measure:** The dependent variable (DV) of unprotected sex was based on the adolescent's report of number of times she had unprotected sex in the past 3 months. The DV was log transformed for analysis because of its marked skewed distribution. **Analysis:** A hierarchical regression analysis was conducted, first regressing the log transformation of unprotected sex onto the variables for the three theories (SCT, TRA, TPB) in three separate steps. Because of the absence of a theoretical ordering in the literature, the order of entry was rotated in successive regression analyses.

**Results:** The average $R^2$ for each construct was low: SCT = 1.8%, TRA = 7.1% and TB*P* = 0.4%. TRA variables (behavioral intentions and subjective norms) were the only theoretical ones that accounted for a significant amount of variance in unprotected sex. Other variables from SCT and TPB were dropped and the data reanalyzed in two hierarchical blocks, TRA followed by the remaining variables (psychosocial, behavioral and demographic) in a single step. Results showed 13% of the variance for factors associated with unprotected sex were accounted for by TRA constructs; other variables contributed an additional 17%. Unprotected sex was associated with behavioral intentions to use condoms, pregnancy, a steady partner, more frequent church attendance, and ever having anal sex.

**Conclusions:** These results indicate that constructs from SCT and TPB have limited usefulness in predicting unprotected sex of pregnant/parenting adolescents, and additional factors need to be considered. The data support the urgent need for broad-based educational efforts for adolescent mothers that build upon theoretical concepts but also address the realities of their lives (e.g., relationship issues) as an approach to reduce risky sexual behaviors.

### PRIME TIME: A YOUTH DEVELOPMENT APPROACH TO PREVENTING NEGATIVE SEXUAL HEALTH OUTCOMES

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**Purpose:** To develop, implement and evaluate a youth development intervention, *Prime Time* (*PT*), to improve contraceptive use, reduce number of sexual partners and decrease unwanted sexual activity among adolescent girls seeking clinic services who are at high risk for pregnancy and other negative sexual health outcomes.

**Design:** Experimental design with ½ study subjects recruited into intervention condition, ½ recruited into usual clinic services/ control condition. All *PT* subjects complete self-report surveys at study baseline and at six-month intervals for a 24-month period. **Participants:** Sexually active 13a–17 year old girls who meet specified risk criteria. **Intervention:** *PT* integrates principles of youth development, psychosocial theories of health behavior, and evidence from resiliency research. Spanning an 18-month period, the *PT* intervention includes three core components: one-on-one case management, training and employment as peer health educators, and participation in service learning teams. Program components address core risk and protective factors for sexual risk behaviors: Connectedness to supportive peers and adults; positive school and community involvement; emotional health; norms supporting contraceptive use; positive expectations for self and for relationships; contraceptive use self-efficacy; sexual communication skills; and intentions to delay pregnancy. **Outcome Measures:** Consistent contraceptive use; consistent condom use; number of sexual partners; refusal of unwanted sex; pregnancy.

**Results:** To date, 150 girls have been recruited into *PT* from 3 community clinic sites. Sample is 37% white, 35% black, and 28% of other ethnic backgrounds. Mean age at baseline is 15.7 years; 77% live with one or neither parent, 60% report ≥1 household moves in the past year. Baseline indicators suggest relatively high levels of sexual risk: Mean age of first consensual sexual intercourse is 13.7 years. Subjects report a mean of 2.6 male sex partners in the past month; 26.6% report ≥3 male partners in the past month. Subjects note using hormonal contraception during 23.6% of the months they are sexually active, and using condoms "every time" in 17.6% of these months. Rates of intervention participation varied widely between clinics (32%, 72% and 75% in