

Sexual Initiation with Older Male Partners And Subsequent HIV Risk Behavior Among Female Adolescents

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Data from a 1993–1994 survey of 150 black and Hispanic teenagers were used to examine differences in HIV risk-related behavior between young women who have a first sexual partner three or more years older than themselves and those whose first partner is their age. Compared with teenagers whose first partner had been roughly their age, the 35% of adolescents with an older partner had been younger at first intercourse (13.8 years vs. 14.6) and less likely to use a condom at first intercourse (63% vs. 82%). They also were less likely to report having used a condom at last intercourse (29% vs. 44%) or having used condoms consistently over their lifetime (37% vs. 56%) or in the previous six months (44% vs. 66%). Some 38% of teenagers with an older first partner had ever been pregnant, compared with 12% of those with a peer-age first partner. The mean number of partners and history of sexually transmitted diseases did not differ between the two groups. (Family Planning Perspectives, 29:212–214, 1997)

Each year, approximately three million American teenagers acquire a sexually transmitted disease (STD). Adolescents and young adults are at great risk for acquiring STDs, including HIV, because they may be more likely than older people to engage in unprotected intercourse and to have partners who are infected with STDs.¹

The leading cause of HIV infection among women aged 13–24,² for example, is heterosexual transmission, the mode of transmission that has experienced the greatest proportional growth since 1989. Furthermore, women represent the overwhelming majority of those who are infected through heterosexual contact: Among 13–19-year-olds who had acquired HIV infection through heterosexual transmission by the end of 1996, 91% were women; among 20–24-year-olds, the proportion was 82%.³ This disparity is partially explained by the efficiency with which HIV is transmitted from men to women,⁴ the physiologic susceptibility of young women because their cervical cells are easily traumatized⁵ and the likelihood that young women will have sexual contact with older men.⁶

The ages of adolescent women's sex

partners are generally neither collected in AIDS and HIV surveillance efforts nor examined in relation to HIV risk behavior. However, research indicates that older male partners present a greater HIV transmission risk because they are more likely than adolescent men to have had multiple partners,⁷ to have had varied sexual and drug use experiences (e.g., anal intercourse or injection-drug use),⁸ and to be infected with HIV.⁹

Additionally, adolescent women with older male partners may have an elevated risk of acquiring HIV because of the potential power differentials created by differences in age and sexual experience. Teenage women may not be able to negotiate condom use with an older partner or may trust the older, more experienced partner to take responsibility for the health consequences of the sexual interaction.

Adolescent women may be at a particular disadvantage if their first sexual partner is an older man. First sexual experiences may contribute to sexual "scripts," or ideas about sexual interactions (e.g., that condoms are used only for contraception),¹⁰ that are played out in the future with the same or different partners. Consequently, examining the circumstances surrounding sexual initiation is important to understanding the factors associated with risky sexual practices among adolescent females.¹¹

Finally, recent research on the involvement of adult men in teenage pregnancy sheds some light on the extent to which sex with older partners puts young women at risk.¹² This information further

supports the need to document and address the HIV risk of female adolescents whose first sexual encounter is with an older male.

In this article, we compare HIV risk-related behavior of female adolescents who experienced their first voluntary sexual intercourse with an older partner with that of their counterparts who initiated sexual activity with a peer-age partner. We then discuss the implications of these findings for the design and implementation of programs aimed at reducing adolescent heterosexual risk for HIV.

Methods

Data Collection

Data for this analysis were gathered as part of the Family Adolescent Risk Behavior and Communication Study, which examined HIV risk behavior among male and female 14–17-year-olds.¹³ Study participants were recruited from public high schools with an overrepresentation of black and Puerto Rican students in New York City; San Juan, Puerto Rico; and Montgomery, Alabama. The study targeted black and Hispanic teenagers because these groups are disproportionately affected by the HIV epidemic. Recruitment and data collection took place between October 1993 and June 1994.

To be eligible to participate, the adolescents had to be 14–16 years of age at the time of recruitment, self-identified as black or Hispanic, and enrolled in one of the targeted schools. They must have lived with their biological or adoptive mother or their stepmother for at least the past 10 years. In addition, participants must have resided in the recruitment area for at least 10 consecutive years.

Participants were recruited through presentations in classes about the project, flyers and mailings. Interested persons were asked to return a form to the school or contact the research office directly. Those returning the forms were screened by phone to determine their eligibility. Of the 4,610 students who were contacted about participating, 1,733 provided screening information and 1,124 appeared to be eligible.

We initially interviewed 982 pairs of teenagers and mothers, for an overall re-

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cruitment rate of 87% (83% in San Juan, 88% in Montgomery and 92% in New York). Subsequent analysis showed that 907 of these pairs actually met the eligibility criteria; these comprise the study population. Among this group, 153 were females who reported that they had ever willingly had vaginal sex (defined as when “a boy or man inserted his penis in your vagina”). Our analyses are based on data from the 150 female adolescents who provided information on the age of their partner when they first had voluntary intercourse.

Face-to-face interviews were conducted with each adolescent and her mother at the teenager’s school or at an off-site research office, using a structured questionnaire developed by the study investigators on the basis of many previously validated measures and scales. The questionnaire, which was available in both English and Spanish, elicited information on participants’ demographic characteristics, drug and alcohol use, sexual behavior, family communication, and contraceptive and condom use.

All of the interviewers were women, and they were matched with participants by ethnicity; older women interviewed the mothers, and younger women interviewed the adolescents. Interviews were conducted in English or Spanish, according to each participant’s preference.

At the beginning of the interview session, the interviewer explained confidentiality and procedural issues to the participant. Additionally, the interviewer reviewed the consent form with the mother and adolescent separately and had each sign the form. To reduce adolescents’ concern about disclosure of information to their mother, the teenagers’ interviews were conducted second when possible (in 91% of cases). Each interview lasted approximately one hour. Mothers were paid \$45 and adolescents were paid \$25 for their participation.

Analyses

Our analyses concentrate on data about HIV risk behavior collected in the interviews with adolescents. A teenage woman’s partner at first vaginal intercourse was classified as peer-age if he was up to one year younger or less than three years older than she at her initial sexual encounter; he was classified as older if his age exceeded hers by three or more years.

The three-year distinction for defining an older partner, although a relatively

crude proxy for actual social and developmental differences, captures distinctions that may be important factors affecting adolescent females’ risk when they “learn” about sex from an older partner. This age gap makes it likely that partners are in different school settings (e.g., female in junior high vs. male in high school; female in high school vs. male beyond high school status)¹⁴ or have different status within the same school (freshman vs. senior). In addition, it distinguishes early from late adolescence¹⁵ and increases the likelihood that the male is sexually experienced.¹⁶

We examined the adolescent women’s age at first intercourse, condom and contraceptive use at first intercourse, and subsequent risk-related behavior in relation to partner type (older vs. peer-age). Subsequent risk-related types of behavior were condom use at last sex (coded yes or no), condom use during intercourse in the last six months and since the initiation of sexual activity (both coded always or less than always), number of lifetime partners, and lifetime experience of STD and pregnancy (both coded yes or no).

Results

Of the 150 adolescents in our sample, 34% were Hispanic* (17 teenagers from San Juan and 34 from New York) and 66% were black (63 young women from Montgomery and 36 from New York). Almost all (97%) lived with their biological mother, and the rest with their stepmother or adoptive mother. Their age ranged from 14 to 17 and averaged 15.6 years (standard deviation, 0.79).

In all, 35% of the respondents had first had intercourse with an older partner, and 65% had had a peer-age partner (Table 1). Hispanic adolescents were significantly more likely than blacks to have had an older partner (55% vs. 24%). No significant difference was observed in the teenagers’ current age or residence by partner type (not shown). Only one respondent had had a younger partner at first intercourse. For 58% of the teenagers who had had an older partner, the three-year age gap meant that the female adolescent had been a minor and her male partner an adult (i.e., aged 18 or older).

On average, respondents who had had an older first partner were significantly younger at first intercourse than were those who had had a peer-age partner (13.8 years vs. 14.6—Table 2), and they were significantly less likely to have used a condom at that time (63% vs. 82%). Their levels of consistent condom use, both within the past six months and since they had become sexu-

Table 1. Percentage distribution of female adolescents, by partner’s age relative to their own at first intercourse, according to race or ethnicity, New York, San Juan and Montgomery, 1993–1994

Partner’s relative age	Total (N=150)	Black (N=99)	Hispanic (N=51)
Peer	65.4	75.8	45.1
1 year younger	0.7	0.0	2.0
Same age	8.7	10.1	5.9
1 year older	23.3	28.3	13.7
2 years older	32.7	37.4	23.5
Older	34.6	24.2	54.9***
3 years older	15.3	15.2	15.7
4 years older	8.0	4.0	15.7
5 years older	5.3	2.0	11.8
6–9 years older	4.7	3.0	7.8
≥10 years older	1.3	0.0	3.9
Total	100.0	100.0	100.0

***Difference is significant, based on chi-square test, at p<.001.

ally active, also were significantly lower than those among teenagers whose first partner had been roughly their age.

Teenagers who had had an older partner at first intercourse had been sexually active longer than those with a peer-age first partner (1.8 years vs. 1.0), but the average number of lifetime partners did not differ between the two groups. Those with an older first partner were considerably more likely than those with a peer-age partner ever to have been pregnant (38% vs. 12%), but no more likely ever to have been told by a doctor or nurse that they had an STD.

Some 66 of the teenagers (46 whose first partner was about their age and 20 whose first partner was older—not shown) reported that they were still involved with

Table 2. Characteristics of female adolescents’ sexual behavior, by partner’s age relative to their own at first intercourse

Characteristic	Peer-age partner (N=98)	Older partner (n=52)
1st intercourse		
Mean age	14.6	13.8***
% used condoms	82	63**
% used birth control	44	43
Condom use		
% used at last intercourse	44	29*
% used in last six months†	66	44*
% ever used	56	37*
Risk indicator		
Mean yrs. of sexual activity	1.0	1.8***
Mean lifetime no. of partners‡	2.2	2.2
% ever pregnant	12	38***
% ever had STD‡	3	6

*Difference is significant, based on chi-square test, at p<.05. **Difference is significant, based on chi-square test, at p<.01. ***Difference is significant, based on chi-square or t-test, at p<.001. †Excludes 25 adolescents who had not had intercourse in the previous six months (16 in the peer-age partner group and nine in the older partner group). ‡Excludes three or fewer adolescents for whom data were missing.

*Of the Hispanic respondents, 92% were Puerto Rican and 8% Dominican.

their first partner and that this was the only sexual relationship they had ever engaged in. Although differences achieved only a marginal level of statistical significance, data for this group suggest that teenagers with a peer-age partner may have been more likely than those with an older partner to have used a condom at last intercourse (74% vs. 50%; $p < .06$) and to have used condoms consistently during the last six months (65% vs. 40%; $p < .09$).

Discussion

While previous research has documented the increased HIV transmission risk of older partners because of their more extensive sexual contacts and experiences,¹⁷ our study is one of the first to specifically address the behavioral risk of sexual initiation with an older partner. We have suggested that initiation experiences may be one important avenue by which older partners influence the development or reinforcement of subsequent risky sexual behavior among female adolescents.

Several limitations of the current investigation should be noted. Participants were in a school-based community sample representing stable families, in that each pair of mothers and adolescents had resided together in the same city for at least 10 years. Therefore, these findings may not be generalizable to other populations. However, it seems plausible that adolescents in less stable environments (e.g., homeless or incarcerated youth) may be more likely to have an older partner and thus would be at greater risk than the teenagers in our sample.

In addition, this sample included black and Hispanic adolescents from geographic areas with high HIV infection rates (New York City and San Juan), as well as an area less likely to be bombarded with messages aimed at reducing risk (Montgomery). However, these data may not be generalizable to other geographic areas or to other racial or ethnic groups (e.g., whites).

Current intervention and prevention strategies rarely emphasize to youths the increased risk an older sex partner may pose. Previous research has shown that adolescent females are not aware of the im-

portance of a partner's past behavior in determining their potential risk for HIV infection.¹⁸ Additionally, teenage women may not have the negotiation skills needed to promote self-protective behavior during sexual encounters, particularly with older, experienced partners. Targeted interventions need to teach communication and negotiation skills, and need to specifically address how older partners may present barriers to enacting these skills.

Further, interventions need to explore issues related to adolescents' implicit trust that an older partner is not infected or is taking the necessary precautions to avoid health consequences. Additionally, interventions should alert female adolescents that men who do not use condoms during sexual encounters with inexperienced females may not be concerned about their sexual risk protection.

This research has documented the risks posed to female adolescents as a result of sexual involvement with older male partners. Understanding the social context of sexual behaviors among adolescent women in their heterosexual relationships may provide important insights needed to strategically target efforts to prevent pregnancy and STDs among young women.

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