Are You Prepared to Address Adolescent Sexual Health?

Creating a safe, non-judgmental, and supportive environment can help teens feel more comfortable sharing personal information. There are many things that can be done to ensure that your practice is youth friendly. Here are some questions to consider as your read through Sexual Health Module of the Adolescent Provider Toolkit.

Does your office/clinic have…

- ❑ Information on where and how to access condoms? While all clinic settings may not be appropriate for displays, having a small sign near the intake area is recommended.
- ❑ Teen-friendly sexual health education materials with age-appropriate language in your waiting room? Do these materials contain positive imagery of teen relationships which do not portray sex only in terms of the risks and negative consequences? Are your educational materials inclusive of a diverse audience including LGBT youth and youth with disabilities?
- ❑ Confidentiality policies posted in areas that can be viewed by both patients and their families?
- ❑ Gender inclusive language on intake/history forms and questionnaires?
- ❑ A procedure for dealing with emergency and crisis situations including rape, sexual assault, and intimate partner violence?
- ❑ A policy regarding teens scheduling their own appointments? Not all health services require consent from the parent/caregiver.
- ❑ Policies regarding talking to a teen alone without his/her parent/caregiver?
- ❑ Financing options for teens accessing confidential services under minor consent?
- ❑ Clinic/practice hours that are convenient for teens?
- ❑ A network of referrals for adolescent-friendly providers in the area?

Is your staff…

- ❑ Friendly and welcoming toward teen patients?
- ❑ Knowledgeable about the laws of minor consent and confidentiality and consistent in upholding those laws?
- ❑ Aware of privacy concerns when adolescents check in?
- ❑ Careful to avoid making assumptions about gender or sexual orientation?
- ❑ Ready to maintain sensitivity for the age, race, ethnicity, gender, sexual orientation, disability, family structure, and lifestyle choices of your patients and their loved ones?

Are you…

- ❑ Aware of your own biases toward sexual health and how your own experiences have shaped your opinions toward sexually active adolescents?
- ❑ Confident, comfortable, and non-judgmental when addressing adolescent sexuality?
- ❑ Prepared to take a strengths-based approach when working with youth?
- ❑ Aware of the characteristics/features of positive adolescent sexual development and relationships?
- ❑ Ready to provide medically accurate information about sexual and reproductive health while also emphasizing the importance of healthy relationships?
- ❑ Familiar with the legal and confidentiality issues dealing with teen sexual activity and reproductive health services including access to birth control options, STI testing, abortion, sexual assault services; parent/caregiver involvement; and releasing medical records?

Provider's role in providing adequate care for adolescents:

- ☑ Make every interaction an opportunity
- ☑ Support healthy relationships
- ☑ Provide a framework for positive adolescent sexual development
- ☑ Promote health and reduce risk

Sources:

1) California Adolescent Sexual Health Work Group (ASHWG). Core Competencies for Providers of Adolescent Sexual and Reproductive Health Programs/Services. Februry, 2007.
2) Shalwitz J, Sang T, Combs N, Davis K, Bushman D, Payne B. *Behavioral Health: An Adolescent Provider Toolkit.* Adolescent Health Working Group. 2007: D-5. http://ahwg.net/resources/toolkit.htm.
3) Christner J, Davis P, Rosen D. Office-Based Interventions to Promote Healthy Sexual Behavior. *Adol Med: State of the Art Reviews.* 2007; 15(544-557).

Adolescent Sexual Development

STAGE	FACTS	TIPS
EARLY ADOLESCENCE Females: 9-13 years Males: 11-15 years	▸ Puberty/Concern with body changes and privacy. ▸ Development of first crush as a milestone to sexual orientation. ▸ Concrete thinking, but beginning to explore new ability to think abstractly. ▸ Sexual fantasies are common. ▸ Masturbation is common. ▸ Movement towards defining sexual identity. ▸ Sexual intercourse is not common. 4.9% of high school females and 13.5% of high school males had first intercourse before the age of 13.[1]	▸ Begin discussing healthy relationships using examples from friendships or concepts such as, "what are you looking for in a friend?" ▸ Focus on current issues facing the teen instead of future possibilities. Relate decision-making techniques to everyday situations instead of having him/her visualize what may happen in the future. Avoid asking questions framed with "why." ▸ Use health education materials with lots of pictures and simple explanations. Typically, males are not receiving as much information about puberty and body development as girls at this age. ▸ Focus on issues that most concern this age group (weight gain, acne, physical changes).
MIDDLE ADOLESCENCE Females: 13-16 years Males: 15-17 years	▸ Increasing concern with appearance. ▸ Peer influences are very strong in decision making. ▸ Experimentation with relationships and sexual behaviors is common. ▸ Concerned about relationships. ▸ Sexual intercourse is increasingly common. 44% of high school tenth graders and 56% of high school eleventh graders have had sexual intercourse.[2] ▸ Increased abstract thinking ability. ▸ Full physical maturation is attained. ▸ Dating is common. ▸ Sexual behaviors do not always match sexual orientation. ▸ Often aware of theoretical risk but do not see self as susceptible.	▸ Listen more and talk less. ▸ Help teens identify the characteristics of a healthy relationship and assess their own relationship quality. ▸ Peer counseling can be effective with this age group. ▸ Focusing on health promotion, prevention and harm reduction is key. ▸ Avoid making assumptions about sexual orientation and behaviors. ▸ Help provide gay and lesbian youth with positive role models and support systems. Assess family response to youth's sexual orientation. ▸ Be aware youth with disabilities, like their non-disabled peers, may be engaging in sexual behaviors and have questions around their sexual orientation ▸ Reinforce parent-child communication about sexual decision making and forming healthy relationships.
LATE ADOLESCENCE Females: 16-21 years Males: 17-21 years	▸ Firmer and more cohesive sense of identity. ▸ Attainment of abstract thinking. ▸ Ability to establish mutually respectful/trusting relationships. ▸ Firmer sense of sexual identity. ▸ Concern for the future. ▸ Feelings of love and passion. ▸ Increased capacity for tender and sensual love.	▸ More abstract reasoning allows for more traditional counseling approaches. ▸ Acknowledge and support healthy relationships or the choice to not be in a relationship.

[1]Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance-US 2007. *Morbidity and Mortality Weekly Report.* 2008; 55(SS-4).
[2]Ibid.

Adolescent Sexual Development *cont.*

The stages of adolescent development can be used as a guide to approaching counseling techniques in an age-appropriate/developmentally appropriate manner. Keep in mind that these age delineations are generalized and that actual development is affected by culture, abuse, and socialization.[1]

When considering the stages of development, be sure to….

⇨ Appreciate that the transition from childhood to adulthood may be a difficult and overwhelming. Healthcare providers can make these transitions easier by providing guidance and information to teen patients and their parents. For example, research has shown that menarche is less stressful when the teen knows what to expect.

⇨ Assess social, biological, and cognitive stages of development. Keep in mind that physical development does not always match cognitive and social development. Asking a question like, "when do you think a person is ready to have sex," can help identify where the teen is developmentally. When working with youth with disabilities be age appropriate unless cognitive delays are evident. Even if a person needs extra time to process information or has difficulty with language and expression, this does not mean he/she doesn't understand at an age appropriate level.

⇨ Educate both adolescent girls and boys about the stages of development. Boys generally receive less information than girls about developmental changes and puberty can be a confusing, uncomfortable time for everyone.

⇨ Support your teen patients in developing healthy sexual relationships and healthy attitudes toward sex. Ensuring that teens have a supportive adult in their life who can guide the teen while he/she builds relationships is extremely important for their overall development into adulthood. The provider can help the teen identify adults they can turn to.

⇨ Pay attention to how a teen feels about his/her development. Teens that develop earlier or later than average are vulnerable to health and social problems. If you feel that a teen is developing faster/slower than average, provide anticipatory guidance.

⇨ Realize that social pressures surrounding development are a reality for many teens. Girls who mature earlier are at greater risk of becoming sexually active at a younger age than their female peers. Teen boys who develop later can be bullied and are at higher risk for substance and/or tobacco abuse problems than their peers who develop earlier.

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[1]Short M B, Rosenthal SL. Psychosocial Development and Puberty. *Ann. N.Y. Acad. Sci.* 2008; 1135:36-49.

Sources:
1) Neinstein, L. Adolescent Health Care: A Practical Guide, Philadelphia: Lippincott Williams and Wilkins, 2002.
2) Getting Organized: A Guide to Preventing Teen Pregnancy
3) Short MB, Rosenthal SL. Psychosocial Development and Puberty. *Ann. N.Y. Acad. Sci.* 2008; 1135:36-49.
4) Biro EM. Adolescent Sexuality: Puberty. *Adol Med: State of the Art Reviews.* 2007; 18:3.
5) Marcell AV, Monasterio EB. Providing Anticipatory Guidance and Counseling to the Adolescent Male. *Adol Med: State of the Art Reviews.* 2003; 14:3.
6) Facts for Families: Normal Adolescent Development. American Academy of Child and Adolescent Psychiatry. June 2001; 58.

Provider-Youth Communication

Providers play a critical role in encouraging healthy behaviors in adolescents. Encouraging teens to practice making healthy decisions requires clear, nonjudgmental, confidential guidance or communication.

TIPS FOR TALKING TO TEENS

- ☑ **Remove distractions.** Spend part of every visit with adolescent patients alone. By asking teens in private if they want their parent and/or partner involved in their care, they will be more likely to give a comfortable answer. Also request that cell phones and pagers are turned off - both yours and the teen's.
- ☑ **Begin by discussing confidentiality and its limits.** This helps build trust and explains the basis for mandated reporting. These requirements differ by state; if you are unclear on the limits to confidentiality, contact your county's child protective services for more information.
- ☑ **Negotiate the agenda.** Make an effort to address the issue(s) that brought your patient through the door, and explain what you need to cover during the visit. You can address their concerns and yours while building trust along the way. Don't neglect to include a sexual history for a youth with a disability.
- ☑ **Avoid jargon or complex medical terminology.** Teens are often hesitant to ask for clarification. Simple, straightforward language ensures effective communication of important information. Check for mutual understanding by asking open-ended questions, and clarifying your patients' slang in a nonjudgmental manner (e.g., "Tell me what you know about how a person can get HIV?"; "I've never heard that term before, do you mind explaining what ___ means?" Unless it is natural for you, try to avoid using slang to relate.
- ☑ **Use inclusive language.** Language that includes LGBTQ or gender variant youth builds trust and indicates acceptance. Instead of 'do you have a boyfriend/girlfriend?' try saying 'are you seeing anyone?" or 'are you in a relationship?' The language we use when speaking of disabilities is important. For example, the term "disability" is preferred over "handicap" and "wheelchair user" over "wheelchair bound". Listen to the language your patients use and, when in doubt, ask what is preferred.
- ☑ **Listen.** This not only builds trust, but may give insight that affects the healthcare and advice you provide.
- ☑ **Respect an adolescent's experience and autonomy.** Many young people feel that adults and people in positions of authority discount their ideas, opinions and experiences. Health care providers, together with parents, can help patients make wise, healthy decisions.

RISK vs BLAME

Healthcare providers generally assess risk and protective factors when treating and providing guidance to teen patients. There are many factors that put an individual at risk of negative health outcomes including living in poverty, a violent neighborhood, a single parent home, etc. Many of these risks, however, are not by the choice of the individual. When assessing risk and counseling on behavior change, avoid communicating blame to the patient.

Provider-Youth Communication *cont.*

FRAMEWORKS FOR WORKING WITH YOUTH

Reinforcing Health Promoting Behavior (Harm Reduction)

While healthcare providers cannot control the decisions made by their patients, they do play an important role in encouraging and reinforcing healthy decision-making. For example, when teens are engaging in risky sexual behaviors, teach them to use a condom or other birth control methods correctly and consistently rather than solely focusing on trying to talk them out of a sexual behavior that is deemed as risky. When teens are having oral sex, encourage them to use protection and abstain from such an activity when they have a cold sore in their mouth, genital lesions or bleeding gums.

Motivational Interviewing

While many teens make healthy decisions, sometimes it's clear that teens would benefit from changing their behavior. Motivational Interviewing offers brief and effective methods for intervention and uses behavior change as a foundation for working with youth. Motivational interviewing techniques have been effective for alcohol or substance use counseling. There is increasing evidence of its usefulness for counseling around sexual health issues. For more information, see Behavioral Health Module of the Adolescent Provider Toolkit.

The basic framework for Motivational Interviewing is as follows:

1. **ASK PERMISSION** to engage in the topic of discussion.

2. **ASSESS READINESS** for change and the youth's belief in his/her ability to make a change.

1	2	3	4	5	6	7	8	9	10

- On a scale of 0 to 10, how ready are you to get some help and/or work on this situation/ problem?
- Straight question: Why did you say a 5?
- Backward question: Why a 5 and not a 3?
- Forward question: What would it take to move you from a 5 to a 7?

3. **RESPOND TO PATIENT'S READINESS**

READY FOR CHANGE (0-3): Educate, Advise and Encourage
UNSURE (4-6): Explore Ambivalence
READY FOR CHANGE (7-10): Strengthen Commitment and Facilitate Action

4. **KEEP "FRAMES" IN MIND** when counseling for behavior change

F: Provide **FEEDBACK** on risk/impairment (e.g. it sounds like your fear of getting pregnant is causing you a lot of anxiety)

R: Emphasize personal **RESPONSIBILITY** for change (e.g. I'd like to help you, but it's also very important that you take responsibility for changing things. What steps can you take to help yourself?)

A: Offer clear **ADVICE** to change (e.g. I believe the best thing for you would be to…)

M: Give a **MENU** of options for behavior change and treatment (You could try…)

E: Counsel with **EMPATHY** (I know that these things can be very difficult...)

S: Express your faith in the adolescent's **SELF-EFFICACY** (I believe in you, and I know that you can do this, when you decide the time is right)

Resource

⇨ Motivational Interviewing – Resources for clinicians, researchers and trainers: *http://www.motivationalinterview.org*

The Role of Providers in Parent-Child Communication

Providers play an important role in educating entire families on sexual health, sexual orientation and gender identity and facilitating communication between adolescent patients and their parents. Healthy communication about sex between parents and children is extremely important in ensuring that young people have the support and information they need to make healthy decisions about sex and sexuality. Although it may seem difficult to encourage communication while still respecting the teen's privacy, it is possible to maintain confidentiality and at the same time promote parent-child communication.

The Benefits of Parent-Child Communication

- Young people who feel connected to home and to their parent(s)/caregiver(s) delay initiation of sexual activity.[1]
- Young people who have conversations with their parents about sex are also more likely to have conversations with their partners about sex.[2]
- Young people who regularly use contraception are more likely to report having had discussions about sex with their parents than sexually active young people who are not using contraception.[3]
- Young people whose parents talked to them about condoms are more likely to use a condom at first intercourse and more consistently thereafter.[4]
- Young people whose families and caregivers openly talk about their sexual orientation are at lower risk for health problems and risky sexual behavior.[5]

TIPS FOR ENCOURAGING PARENT-CHILD COMMUNICATION

With Youth:

- ⇨ Reiterate the importance of parent-child communication each time you talk with the teen.
- ⇨ Ask why they do not want to involve a parent and try and get a sense of what they are afraid of. You can't force a teenager to talk to their parents, but you can probe further when a young person says they don't want to or can't talk to their parent about sensitive issues.
- ⇨ Let LGBT teens know that families that reject their LGBT identity may be motivated by care and concern for their teen and can become more supportive when they learn how to provide support to their teen.[5]
- ⇨ Ask if they need help talking to their parent about a particular issue and offer to meet with the youth and their parent together.
- ⇨ If they feel uncomfortable talking to their parent, identify other caring adults in their immediate or extended family that they can talk to.
- ⇨ Offer examples of ways that talking to parents/caregivers can help to ensure that they get support. E.g., help getting to appointments or someone to talk to when confusing things happen with their peers.
- ⇨ Share examples of young people who were afraid to talk to their parent about a sensitive issue and how it went better than they expected.

With Parents:

- ⇨ Reiterate the importance of parent-child communication each time you talk with parents.
- ⇨ For parents of LGBT teens, tell them that family support decreases risk for HIV, STIs, suicide and promotes well-being while family rejection increases these risks.[5]
- ⇨ Teach them medically accurate information, so that they can reinforce this at home.
- ⇨ Ask if they need help talking to their children or if there are particular issues they find hard to discuss at home.
- ⇨ Remind parents that teens are often afraid of disappointing their parents.
- ⇨ Encourage taking advantage of teachable moments, such as when a young person asks a question or something is witnessed while watching TV together, for example, where a bigger discussion and line of communication can be opened up.
- ⇨ Help parents find ways to be involved while respecting a young person's privacy and confidentiality.
- ⇨ Encourage parents to initiate and sustain open dialogues about health and sexuality with their children. Help parents put themselves in the shoes of a young person, to understand how difficult it is for their child to open up about sexuality and health.
- ⇨ Offer educational materials and resources about parent-child communication. See pg. 66 and pg. 68.

Resources

- Advocates for Youth - *http://www.advocatesforyouth.org/*
- Guttmacher Institute - *http://www.guttmacher.org/*

[1]Resnick, MD et al. Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health. *JAMA*. 1997; 278:823-32.
[2]Whitaker, DJ et al. Teenage Partners' Communication About Sexual Risk and Condom Use: The Importance of Parent-Teenager Discussions. *Family Planning Perspectives*. 1999; 31(3): 117-21.
[3]Hacker, KA et al. Listening to Youth: Teen Perspectives on Pregnancy Prevention. *J of Adol Health.* 2000; 26:279-88.
[4]Miller, KS et al. Patterns of Condom Use Among Adolescents: The Impact of Mother-Adolescent Communication. *Amer J of Public Health.* 1998; 88: 1542-44.
[5]Ryan C. Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Marian Wright Edelman Institute, San Francisco State University, 2009.

FACT SHEET

Adolescent Sexual and Reproductive Health in the United States

GUTTMACHER INSTITUTE

Sexual activity

- Sexual activity is a part of human development for many young people in the United States. As they develop, adolescents and young adults need access to comprehensive and non-stigmatizing information about sexual and reproductive health, support networks to have the pregnancies they want, and high-quality, affordable and confidential contraceptive services and abortion services to avoid the pregnancies they do not want.

- On average, young people in the United States have sex for the first time at about age 17, but do not marry until their mid-20s. During the interim period of nearly a decade or longer, they may be at heightened risk for unintended pregnancy and sexually transmitted infections (STIs).

- In 2011–2013, among unmarried 15–19-year-olds, 44% of females and 49% of males had had sexual intercourse. These levels have remained steady since 2002.

- The proportion of young people having sexual intercourse before age 15 has declined in recent years. In 2011–2013, about 13% of never-married females aged 15–19 and 18% of never-married males in that age-group had had sex before age 15, compared with 19% and 21%, respectively, in 1995.

- In 2006–2010, the most common reason that sexually inexperienced adolescents aged 15–19 gave for not having had sex was that it was "against religion or morals" (41% of females and 31% of males). The second and third most common reasons were not having found the right person and wanting to avoid pregnancy.

- Among sexually experienced adolescents aged 15–19, 73% of females and 58% of males reported in 2006–2010 that their first sexual experience was with a steady partner, cohabitor, fiancé or spouse. Sixteen percent of females and 28% of males reported having first had sex with someone they had just met or who was just a friend.

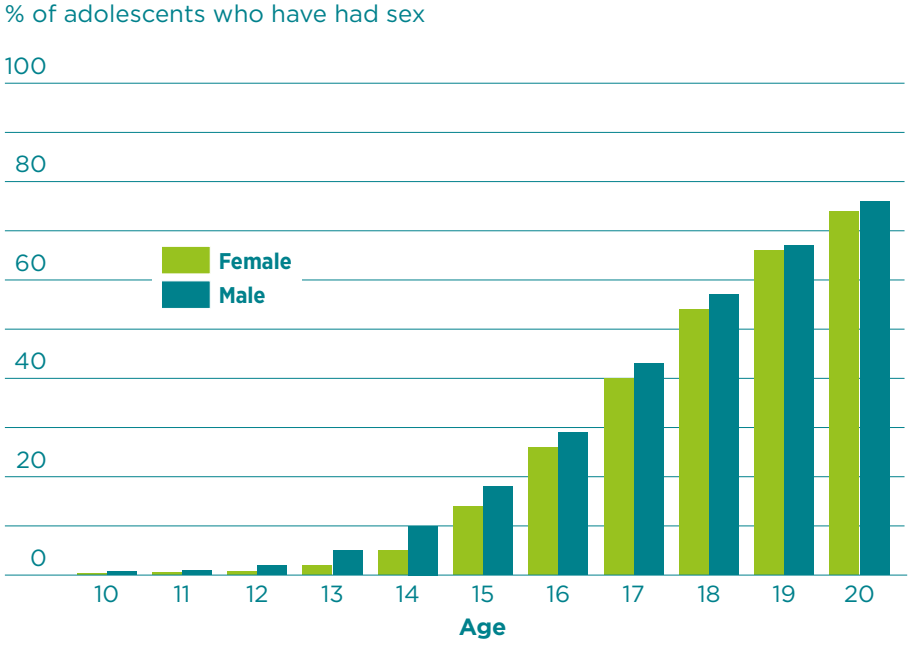
- Adolescent sexual intercourse is increasingly likely to be described as wanted. First sex was described as wanted by 34% of women aged 18–24 in 2002 who had had sex before age 20 and by 41% in 2006–2010. Among men in the same age-group, the share reporting first sex before age 20 as wanted increased from 43% to 62%.

- Three percent of males and 8% of females aged 18–19 in 2006–2008 reported their sexual orientation as lesbian, gay or bisexual. During the same period, 12% of females and 4% of males aged 18–19 reported same-sex sexual behaviors.

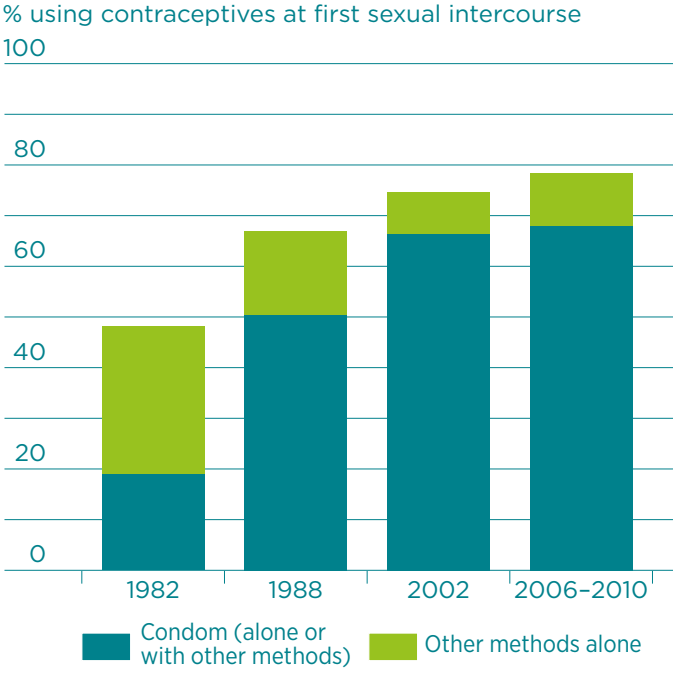
- Adolescent sexual activity may include behaviors other than vaginal intercourse. In 2007–2010, about half of adolescents aged 15–19 reported ever having oral sex with an opposite-sex partner and about one in 10 reported ever having anal sex with an opposite-sex partner.

SEXUAL INTERCOURSE AMONG YOUNG PEOPLE IN THE U.S.

The proportion of young people who have had sexual intercourse increases rapidly with age.



Contraceptive use at first sexual intercourse among 15–19-year-olds has risen steadily.



Contraceptive use

- The proportion of U.S. females aged 15–19 who used contraceptives the first time they had sex has increased, from 48% in 1982 to 79% in 2011–2013.
- Adolescents who report having had sex at age 14 or younger are less likely than those who initiated sex later to have used a contraceptive method at first sex.
- The condom is the contraceptive method most commonly used at first intercourse. In 2006–2010, 68% of females and 80% of males aged 15–19 reported having used a condom the first time they had sex.
- In 2006–2010, 86% of females and 93% of males aged 15–19 reported having used contraceptives the last time they had sex. These proportions represent a marked increase since 1995, when 71% of females and 82% of males in that age-group reported use of a contraceptive method at last sex. However, the proportions were generally unchanged between 2002 and 2006–2010.
- In 2012, 4% of female contraceptive users aged 15–19 used a long-acting reversible contraceptive method (IUD or implant) in the last month.
- Dual method use (i.e., use of a condom in combination with a short- or long-term reversible contraceptive method) can offer protection against both pregnancy and STIs. In 2006–2010, one in five sexually active females aged 15–19 and one-third of sexually active males in this age-group said that they used both a condom and a hormonal method the last time they had sex.
- In 2006–2010, 14% of sexually experienced females aged 15–19 had ever used emergency contraception.
- Adolescents in the United States and Europe have similar levels of sexual activity. However, European adolescents are more likely than U.S. adolescents to use contraceptives and to use the most effective methods; they also have substantially lower pregnancy rates.

Access to and use of contraceptive services

- Current federal law requires health insurance plans to cover the full range of female contraceptive methods, including counseling and related services, without out-of-pocket costs. However, some minors may not use insurance to access contraceptive services because they are not aware that these services are covered or because of confidentiality concerns.
- No state explicitly requires parental consent or notification for minors to obtain contraceptive services. However, two states (Texas and Utah) require parental consent for contraceptive services paid for with state funds.
- Twenty-one states and the District of Columbia explicitly allow minors to obtain contraceptive services without a parent's involvement. Another 25 states have affirmed that right for certain classes of minors, while four states do not have a statute or policy on the subject. The U.S. Supreme Court has ruled that minors' privacy rights include the right to obtain contraceptive services.
- Even when parental consent is not required for contraceptive services, concerns about confidentiality may limit adolescents' access to or use of contraceptive or other reproductive health services. In 2013–2015, 18% of 15–17-year-olds and 7% of 18–19-year-olds reported that they would not seek sexual or reproductive health care because of concerns that their parents might find out.
- In 2006–2010, 66% of sexually active females aged 15–19 reported having received contraceptive services in the last year; about one-third had received this care from publicly funded clinics and the rest from private health care providers.
- In 2014, an estimated 4.7 million women younger than 20 were in need of publicly funded contraceptive care because they were sexually active and neither pregnant nor trying to become pregnant.
- Nearly one million 15–19-year-old women in need of publicly funded contraceptive services received them from publicly supported family planning centers in 2014. These services helped adolescents to avert 232,000 unintended pregnancies, 118,000 unplanned births and 76,000 abortions.
- While school-based health centers are an important source of sexual and reproductive health services for students across the United States, only 37% of these centers dispensed

contraceptives in 2010–2011. Many are prohibited from doing so by state or local policies.

HIV and other STIs and related services

- Adolescents and young adults aged 15–24 accounted for nearly half (9.7 million) of the 19.7 million new cases of STIs in the United States in 2008. This disproportionate share likely reflects larger age-based disparities in access to preventive services and care.

- Human papillomavirus (HPV) infections account for more than two-thirds of STIs diagnosed among 15–24-year-olds each year. HPV is extremely common, often asymptomatic and generally harmless. However, certain types, if left undetected and untreated, can lead to cervical cancer.

- Three HPV vaccines—Gardasil, Gardasil 9 and Cervarix—are currently available, and all of them prevent the types of infections most likely to lead to cervical cancer. The Centers for Disease Control and Prevention now recommends HPV vaccinations for male and female adolescents, starting at age 11. Numerous research studies have confirmed that increases in HPV vaccinations have resulted in significant declines in HPV infections and related negative health outcomes.

- In 2015, 63% of females and 50% of males aged 13–17 had received one or more doses of the vaccine against HPV, and 42% of females and 28% of males had completed the recommended regimen of three doses.

- Chlamydia is the next most common STI diagnosed among 15–24-year-olds, accounting for nearly 20% of diagnoses each year. Genital herpes, gonorrhea and trichomoniasis together account for about 11% of diagnoses. HIV, syphilis and hepatitis B are estimated to account for less than 1% of diagnoses.

- Paralleling broader health disparities, rates of diagnosed STIs among 15–19-year-olds differ widely by race: Among non-Hispanic black adolescents, rates of diagnosed chlamydia are more than five times those among non-Hispanic white adolescents, and rates of gonorrhea are more than fourteen times those among non-Hispanic white adolescents.

- Young people aged 13–24 accounted for about 22% of all new HIV diagnoses in the United States in 2015. Most of these diagnoses occurred among gay or bisexual men (81%), with young black/African American and Hispanic/Latino gay and bisexual men disproportionately affected.

- All 50 states and the District of Columbia explicitly allow minors to consent to STI services without parental involvement, although 11 states require that a minor be of a certain age (generally 12 or 14) to do so. Thirty-two states explicitly allow minors to consent to HIV testing and treatment.

- In 2006–2010, 43% of sexually active females aged 15–19 reported having received counseling or testing for STIs or HIV in the last year.

Pregnancy

- In 2013, the adolescent pregnancy rate reached a record low of 43 pregnancies per 1,000 women aged 15–19, indicating that less than 5% of females in this age-group became pregnant. This rate represented a decline to just over one-third of the peak rate of 118 per 1,000, which occurred in 1990.

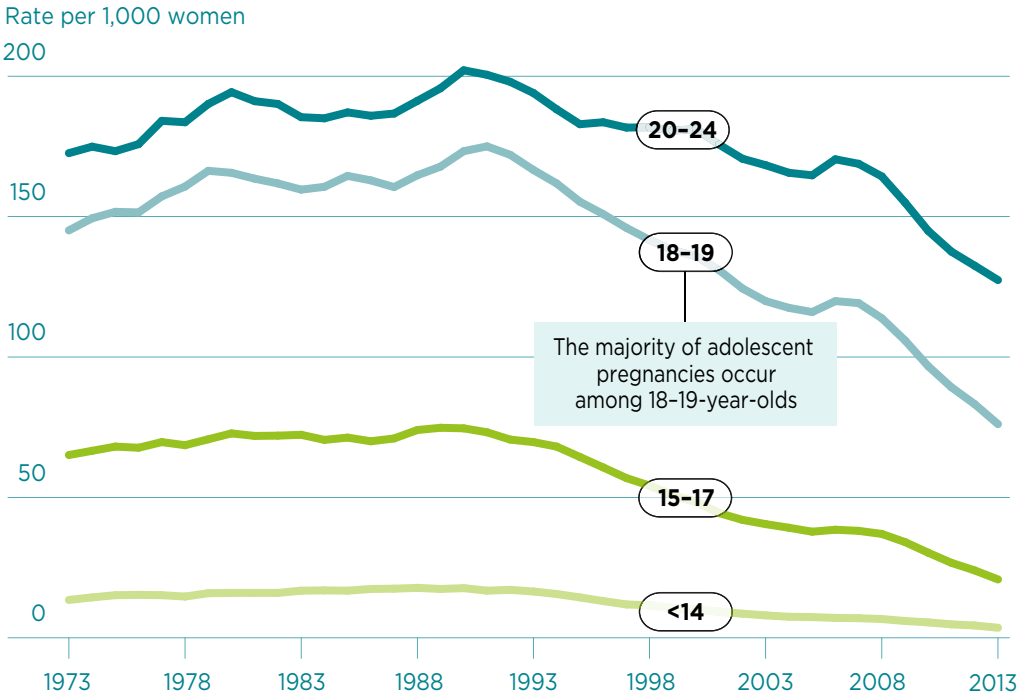
- In 2013, about 448,000 U.S. women aged 15–19 became pregnant. Seventy-two percent of adolescent pregnancies occurred among the oldest age-group (18–19-year-olds).

- Pregnancies are much less common among females younger than 15. In 2013, four pregnancies occurred per 1,000 females aged 14 or younger. In other words, about 0.4% of adolescents younger than 15 became pregnant that year.

- In 2013, non-Hispanic black and Hispanic adolescents had pregnancy rates of 75 and 61 per 1,000 women aged 15–19, respectively;

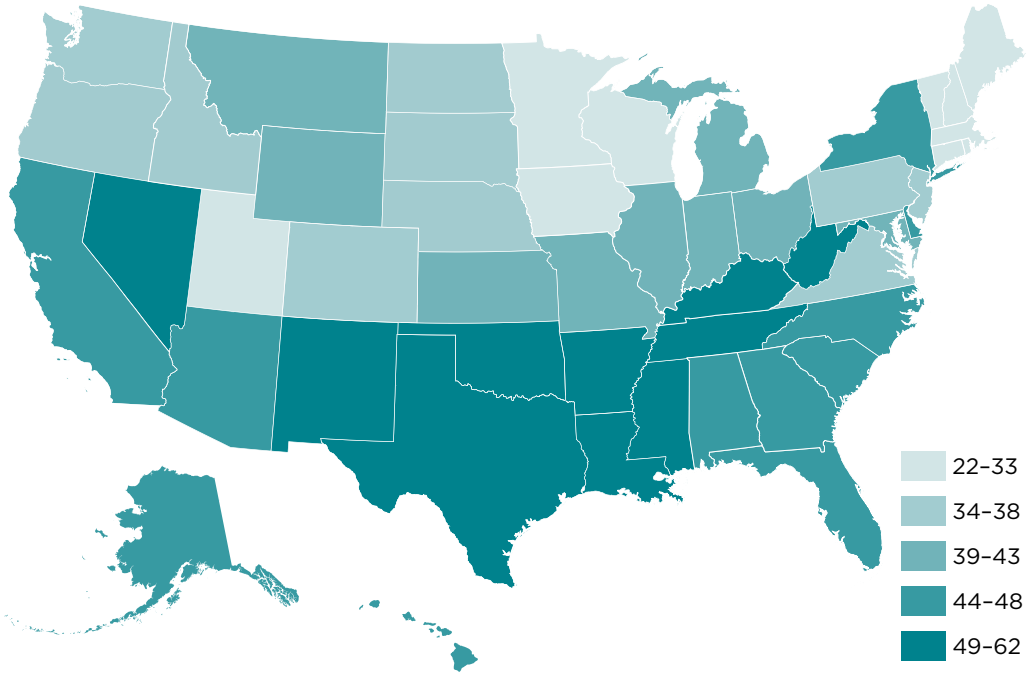
PREGNANCIES AMONG U.S. ADOLESCENTS AND YOUNG ADULTS

Rates of pregnancy among U.S. adolescents and young women reached historic lows in 2013.



Pregnancy rates among U.S. adolescents varied widely by state.

No. of pregnancies per 1,000 women aged 15–19



non-Hispanic white adolescents had a pregnancy rate of 30 per 1,000.

- There are substantial differences in adolescent pregnancy rates at the state level. In 2013, New Mexico had the highest adolescent pregnancy rate (62 per 1,000 women aged 15–19), followed by Arkansas, Mississippi, Oklahoma, Texas and Louisiana. The lowest rate was in New Hampshire (22 per 1,000), followed by Massachusetts, Minnesota, Utah, Vermont and Wisconsin.

- Despite recent declines, the U.S. adolescent pregnancy rate continues to be one of the highest among developed countries. At 43 per 1,000 women aged 15–19 in 2013, it is significantly higher than recent rates found in other developed countries, including France (25 per 1,000) and Sweden (29 per 1,000).

- Nationally, seventy-five percent of pregnancies among 15–19-year-olds were unintended (meaning either mistimed or unwanted) in 2008–2011, and adolescents account for about 15% of all unintended pregnancies annually. Services are needed to support pregnant or parenting young people, regardless of the planned or unintended nature of the pregnancy.

- Sixty-one percent of pregnancies among 15–19-year-olds in 2013 ended in births, while 24% ended in abortions and the rest in miscarriages.

- Unintended pregnancy rates among women younger than 20 were available for 31 states in 2013. The highest unintended pregnancy rates among these states were found in Arkansas (41 per 1,000 women younger than 20), Oklahoma and Tennessee. The states with the lowest unintended pregnancy rates were New Hampshire (16 per 1,000 women younger than 20), Minnesota, Massachusetts, Utah and Vermont.

- The proportion of pregnancies that were unintended among women younger than 20 also varied by state, ranging from 56% in New Mexico to 79% in Maryland and New Jersey.

Abortion

- Although federal funds are not permitted to cover abortion services in most cases, some states and private insurance plans do allow insurance coverage of abortions. However, some minors with coverage may not use insurance to access abortion services because they are not aware that these services are covered or because of confidentiality concerns.

- Women aged 15–19 had just under 110,000 abortions in 2013. About 11% of all abortions that year were obtained by adolescents.

- In 2013, there were 11 abortions for every 1,000 women aged 15–19. This is the lowest rate observed since abortion was legalized nationwide in 1973, and just one-fourth of the peak rate in 1988 (44).

- Between 1985 and 2007, the proportion of pregnancies among 15–19-year-old women (excluding miscarriages) that ended in abortion declined by one-third, from 46% to 31%. This proportion has remained relatively stable since 2007.

- The reasons women younger than 20 most frequently give for having an abortion are concerns about how having a baby would change their lives, inability to afford a baby now and not feeling mature enough to raise a child.

- As of July 2017, laws in 37 states required that a minor seeking an abortion involve one or both parents in the decision.

Childbearing

- In 2013, women aged 19 or younger had 276,000 births, representing 7% of all U.S. births.

- In 2013, there were 26 births per 1,000 women aged 15–19; this rate marked a more than 50% decline from the peak rate of 62 births per 1,000, reached in 1991. Evidence suggests that this decline is primarily attributable to increases in adolescents' contraceptive use; declines in sexual activity played a smaller role.

- Most births to adolescent mothers are first births. In 2013, 17% of births to women aged 15–19 were second or higher-order births.

- Nearly all births among women aged 15–19 occur outside of marriage—89% in 2013, up from 79% in 2000. Yet, over the last several decades, adolescents' share of nonmarital births among all age-groups has declined, from 52% in 1975 to 15% in 2013.

- Between 1991 and 2014, childbearing among young men declined 54%, from 25 births per 1,000 males aged 15–19 to 11 births per 1,000. Among men in this age-group in 2014, 27% reported that the pregnancy was intended.

- The rates of childbearing among young men vary considerably by race. In 2014, the rate among black males aged 15–19 (19 per 1,000) was almost twice that among their white counterparts (10 per 1,000).

SOURCE

These data are the most current available. References are available in the HTML version: https://www.guttmacher.org/fact-sheet/adolescents-sexual-and-reproductive-health-in-united-states

Good reproductive health policy starts with credible research

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CHAPTER 5

SEXUALITY

Understanding sexual development

"If someone wants to accept the consequences of sex, then it is their choice."

Girl, 15

Developing sexually is an expected and natural part of growing into adulthood. Most people have considered or experienced some form of sexual activity by the time they get out of their teens.

Research on adolescent sexuality concentrates on two areas—understanding healthy sexual development and investigating the risks associated with too-early or unsafe sexual activity.

Healthy sexual development involves more than sexual behavior. It is the combination of physical sexual maturation known as puberty, age-appropriate sexual behaviors, and the formation of a positive sexual identity and a sense of sexual well-being. During adolescence, teens strive to become comfortable with their changing bodies and to make healthy and safe decisions about what sexual activities, if any, they wish to engage in.

Expressions of sexual behavior differ among youth, and whether they engage in sexual activity depends on personal readiness, family standards, exposure to sexual abuse, peer pressure, religious values, internalized moral guidelines, and opportunity.

Motivations may include biological and hormonal urges, curiosity, and a desire for social acceptance. There is an added pressure today, especially

with girls, to appear sexy in all contexts throughout their lives—school, leisure time, the workplace, with friends, in the community, and even while participating in sports or exercise.

Decisions to engage in, or limit, sexual activity in ways that are consistent with personal principles and protective of health reflect an adolescent's maturity and self-acceptance.

Healthy sexuality for everyone

Research shows that providing accurate, objective information to adolescents supports healthy sexual development.

All young people need to learn to be comfortable with their sexuality. This task may be especially challenging for teens who are gay, lesbian, bisexual, or transgender. These young people often feel worlds apart from their heterosexual peers, family, or members of their community, and they need support from adults more than ever. Parents and other caregivers may have difficulty providing straightforward information and advice to youth whose sexual orientations or practices diverge from those of the majority of the surrounding society.

Adults may find it helpful to keep in mind that sexual and other stages of development may be different for sexual-minority teens.

Regardless of how young people come to be gay, lesbian or bisexual, it is essential that these youth be loved and cared for during this time of exploring their sexual identity. Perhaps because of the stigma they face, sexual-minority youth are at higher risk than their heterosexual peers for substance abuse, early onset of intercourse, unintended pregnancy, HIV and other STIs, verbal and physical violence, and suicide.

Parents and caregivers of adolescents with disabilities, too, may not know how to respond to their child's sexual maturation and the changes that come with puberty. Young people who live with physical, mental, or emotional disabilities will experience sexual development and must struggle with the same changes and choices of puberty that impact all human beings. This fact might be uncomfortable to some people, who may find it easier to view people with disabilities as "eternal children." In fact, youth with disabilities may need more guidance from adults, not less, because they may frequently feel isolated and quite different from their same-age peers.

Adolescents with disabilities may have some unique needs related to sex education. For example, children with developmental disabilities may learn at a slower rate than do their non-disabled peers; yet their physical maturation usually occurs at the same rate. As a result of the combination of normal physical maturation and slowed emotional and cognitive development, they may need sexual health information that helps build skills for appropriate language and behavior in public.

BRAIN BOX

Common folklore has often assumed that the "raging hormones" of adolescence are responsible for risky behaviors, including unsafe sex. The research, however, shows only small, direct effects of pubertal hormones (androgens and estrogens) on adolescent behavior. Rather, adolescent risk-taking appears to be due to a complex mix of genes, hormones, brain changes, and the environment. Hormones interact with changes occurring in the adolescent brain and in the adolescent's social world to affect adolescent behavior. In fact, psychological and social experiences have been shown to impact brain development and hormone levels, as well as the other way around.

SOURCE: Spear, L.P. (2008). The Psychobiology of Adolescence. In K.K. Kline (Ed.), *Authoritative Communities: The Scientific Case for Nurturing the Whole Child* (263–279). The Search Institute Series on Developmentally Attentive Community and Society (Vol. 5). New York: Springer.

"I believe it is better to have sex while you are young."

Boy, 15

Sexual development through the teen years

The experience of adolescence is a dynamic mixture of physical and cognitive change coupled with social

More media, earlier first sexual activity

In a 2004 longitudinal study funded by the National Institutes of Health, early adolescents who had heavier sexual media diets of movies, music, television, and magazines were twice as likely as those with lighter sexual media diets to have initiated sexual intercourse by the time they were 16.

SOURCE: *The Media as Powerful Teen Sex Educators*, Jane D. Brown, University of North Carolina, March 2007

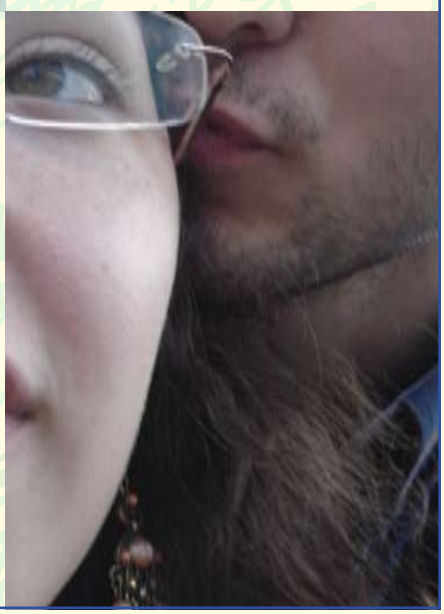
Will having sex make me **popular?**

How do I deal with **pressure** to have sex?

WHAT TEENS MIGHT ASK

How do I know I am ready for **sex?**

How will I know I'm in **love?**



Sexual identity versus gender identity

A person's **SEXUAL IDENTITY** is derived from emotional and sexual attraction to other people based on the other's gender. People may define their sexual identity as heterosexual, homosexual, gay, lesbian, or bisexual. **GENDER IDENTITY** describes a person's internal, deeply felt sense of being male, female, other, or in between. Everyone has a gender identity.

Sexual identity develops across a person's life span—different people might realize at different points in their lives that they are heterosexual, gay, lesbian, or bisexual. Adolescence is a period in which young people may still be uncertain of their sexual identity. Sexual behavior is not necessarily synonymous with sexual identity. Many adolescents—as well as many adults—may identify themselves as homosexual or bisexual without having had any sexual experience. Other people may have had sexual experiences with a person of the same sex but do not consider themselves to be gay, lesbian, or bisexual. This is particularly relevant during adolescence, a developmental stage marked by experimentation.

expectations, all of which impact sexual development. Hormone levels stimulate physical interest in sexual matters, and peer relationships shift toward more adult-style interactions. This section outlines the stages of sexual development.

Pre-adolescence (ages 6-10)

Sexual development begins well before adolescence. Hormonal changes—an elevation of androgens, estradiol, thyrotropin, and cortisol in the adrenal glands—start to emerge between the ages of 6 and 8.

The visible signs of puberty begin to show up between the ages of 9 and 12 for most children. Girls may grow breast buds and pubic and underarm hair as early as 8 or 9. In boys the growth of the penis and testicles usually begins between ages 10 and 11 but can start to occur at the age of 9.

Before age 10, children usually are not sexually active or preoccupied with sexual thoughts, but they are curious and may start to collect information and myths about sex from friends, schoolmates, and family members. Part of their interaction with peers may involve jokes and sex talk.

At this age, children become more self-conscious about their emerging sexual feelings and their bodies, and they are often reluctant to undress in front of others, even a parent of the same gender. Boys and girls tend to play with friends of the same gender and may explore sexuality with them, perhaps through touching. This does not necessarily relate to a child's sexual identity and is more about inquisitiveness than sexual preference.

Early adolescence (ages 11-13)

The passage into adolescence typically begins with the onset of menarche (menstruation) in girls and semenarche (ejaculation) in boys, both of which occur, on average, around age 12 or 13. For girls, menstruation starts approximately two years after breast buds—the first visible sign of puberty—develop, although it can happen anytime between ages 9 and 16.

Hormonal changes generated by the adrenals and testes in boys and the adrenals and ovaries in girls affect brain development. The impact of hormones on brain chemistry results in a larger amygdala in boys (the part of the brain governing emotions and instincts) and a larger hippocampal area in girls (the section of the brain dealing with memory and spatial navigation). The adrenals can also pump some testosterone into girls and estrogen into boys, with 80 percent of boys experiencing temporary breast development during early adolescence.

As physical maturation continues, early adolescents may become alternately fascinated with and chagrined by their changing bodies, and often compare themselves to the development they notice in their peers. Sexual fantasy and masturbation episodes increase between the ages of 10 and 13. As far as social interactions go, many tend to be nonsexual—text messaging, phone calls, email—but by the age of 12 or 13, some young people may pair off and begin dating and experimenting with kissing, touching, and other physical contact, such as oral sex.

The vast majority of young adolescents are not prepared emotionally or physically for oral sex and sexual intercourse. If adolescents this young do have sex, they are highly vulnerable for sexual and emotional abuse, STIs, HIV, and early pregnancy.

Median age at first marriage, 2005

SOURCE: U.S. Census Bureau (2006). *Table: Estimated median age at first marriage, by sex, 1890 to the present, from Current Population Survey, March and Annual Social and Economic Supplements, 2005 and earlier.* http://www.census.gov/population/socdemo/hh-fam/ms2.pdf

High school students who have had sexual intercourse

	1991	1995	2001	2007
Males	57%	54%	48%	50%
Females	51%	52%	43%	46%

SOURCE: Centers for Disease Control and Prevention (2008). *Youth risk behavior surveillance--United States 2007.* Surveillance Summaries, May 9, 2008. Morbidity & Mortality Weekly Report, http:apps.nccd.cdc.gov/yrbss

% ever had sexual intercourse by grade level, 2007

	9th grade	10th grade	11th grade	12th grade
Males	38.1%	45.6%	57.3%	62.8%
Females	27.4%	41.9%	53.6%	66.2%

SOURCE: Centers for Disease Control and Prevention (2007). *Youth risk behavior surveillance—United States, 2007.* Retrieved October 1, 2009 from http://apps.nccd.gov/yrbss

Middle adolescence (ages 14-16)

Testosterone in boys surges between the ages of 14 and 16, increasing muscle mass and setting off a growth spurt. Testosterone levels in boys are usually eight times greater than in girls, and this hormone is the strongest predictor of sexual drive, frequency of sexual thoughts, and behavior.

Middle adolescents exhibit an increased interest in romantic and sexual relationships. The sexual behavior during this time tends to be exploring, with strong erotic interest. Sexual activity at this age varies widely and includes the choice not to have sex.

At this age, both genders experience a high level of sexual energy, although boys may have a stronger sex drive due to higher testosterone levels. Sex drive, commonly known as libido, refers to sexual desire or an interest in engaging in sex with a partner.

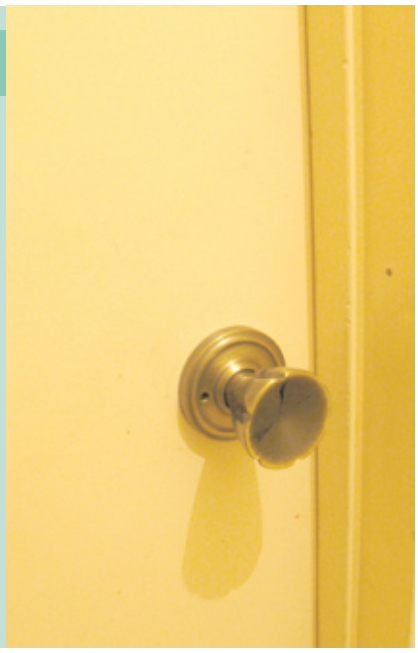
On an abstract level, adolescents ages 14 to 16 understand the consequences of unprotected sex and teen parenthood, if properly taught, but cognitively they may lack the skills to integrate this knowledge into everyday situations or consistently to act responsibly in the heat of the moment.

Before the age of 17, many adolescents have willingly experienced sexual intercourse. Teens who have early sexual intercourse report strong peer pressure as a reason behind their decision. Some adolescents are just curious about sex and want to experience it.

No matter what the motivation, many teens say they regret having had sex as early as they did, even if the activity was consensual. Research published in the journal *Pediatrics* noted that up to one-half of the sexually experienced teenagers in the 2007 study said they felt "used," guilty, or regretful after having sex. The findings indicated that girls were twice as likely as boys to respond that they "felt bad about themselves" after having sex, and three times more likely to say they felt "used."

Masturbation

Masturbation is sexual self-stimulation, usually achieved by touching, stroking, or massaging the male or female genitals until this triggers an orgasm. Masturbation is very ordinary—even young children have been known to engage in this behavior. As the bodies of children mature, powerful sexual feelings begin to develop, and masturbation helps release sexual tension. For adolescents, masturbation is a common way to explore their erotic potential, and this behavior can continue throughout adult life.



Sexual fantasies

Sexual fantasies are usually associated with masturbation, but the two can occur independently. Sexual daydreams and fantasies are common—most people have them, not just teenagers and not just boys.

Fantasies often differ between the sexes. Sexual aggression and dominance are recurring themes in young male fantasies and usually contain very specific and graphic sexual behaviors but little emotional involvement. For adolescent females, sexual fantasies often involve relating to others, and they are more likely to involve sexual activities with which the girl is already familiar. A teenage girl's fantasies also are typically about someone they know—a boyfriend, TV or music stars, friends, casual acquaintances.

The important thing to tell teenagers about sexual fantasies is that thoughts, in and of themselves, are not sick, weird, or wrong. They are just that: thoughts. Making a teenager feel guilty or ashamed or suggesting that their dreams reveal psychological problems can lead to their feeling at odds with their sexuality. It can also make them more vulnerable to becoming obsessed about a particular sexual fantasy.

Late adolescence (ages 17-19)

By the time an adolescent is 17, sexual maturation is typically complete, although late bloomers are not uncommon. Sexual behavior during this time may be more expressive, since cognitive development in older adolescents has progressed to the point where they have somewhat greater impulse control and are capable of intimate and sharing relationships.

Intimate relationships usually involve more than sexual interest. Emotionally, falling in love is powerful and all-consuming, and it involves a greater portion of the adolescent brain.

Brain scientists at University College London scanned the brains of young lovers while they were thinking about their boyfriends and girlfriends and discovered that four separate areas of the brain became very active. This affirms the notion that falling in love is an all-encompassing emotion that engages nearly every part of the mind and body.

"I hear my friends talking about their sex lives, but I don't really care because I am not having sex, so getting information about sex doesn't matter to me."

Girl, 14

Romantic versus sexual relationships

Libido is distinct from romantic interest, which may or may not be sexual in nature. Romantic interest usually emphasizes emotions—love, intimacy, compassion, appreciation—rather than the pursuit of physical pleasure driven by libido.

We may see romance as a feminine tendency, but recent studies indicate that teenage boys are as romantic as girls—a finding that runs counter to the stereotype of adolescent males as "players." Peggy Giordano, a sociology professor at Bowling Green University, conducted interviews with a random sample of 1,316 boys and girls drawn from the seventh, ninth, and 11th grades and found that boys were at least as emotionally invested in their romantic relationships as their partners were.

Both boys and girls in the study agreed, however, that girls in heterosexual romantic relationships hold the power in the decision of when to have sexual intercourse.

What works at what age

EARLY TEEN YEARS (AGES 11-14)

Young teens tend to be concrete and short-term in their thinking, and often do not consider long-term consequences when making decisions. This is a good time to talk about delaying sexual activity but a bad time to hammer home long-term benefits or consequences.

MIDDLE TEEN YEARS (15-17)

Risk peaks during these years, and teens of this age question limits and authority. Scare tactics do not work at this age; rather, emphasize the influence of peers. Talking about how to handle peer pressure and changing social circles (about being associated with certain cliques or groups, and about how hanging around with older and younger teens affects sexual behavior and risk-taking) works best at this age.

LATE TEEN YEARS (17 AND OLDER)

Older adolescents are entering new social situations such as work and college, so talking about sexual behavior in the context of wider relationships can be helpful. For example, one might talk about how sexual behavior helps form a personal identity or define young people, both in how they may see themselves and how they are viewed within an intimate relationship, in their community, or in various peer groups.

Ways teens protect their sexual health

Delaying sexual intercourse is associated with many positive outcomes: less regret about the timing of one's first sexual experience, fewer sexual partners, and a decreased likelihood of being involved in coercive sexual relationships.

Waiting to have sex until one is in a respectful, loving relationship protects a young person's emotional well-being, too. Today's teenagers are postponing their first sexual activity, as compared to young people from prior decades. The proportion of teenagers who reported having sexual intercourse rose steadily through the 1970s and '80s, fueling a sharp rise in teen pregnancy. The trend reversed around 1991 as a result of AIDS, changing sexual mores, and other factors. In 2007 nearly half (48 percent) of high school students ages 15 to 19 reported to the CDC they had had sexual intercourse. This was a minor increase since 2005, but the good news is that teens are initiating sex at older ages today than their counterparts in the 1990s. They also are reporting having fewer sexual partners than high school students in 1991 had.

Sex with multiple partners is not widespread among teenagers. Only 15 percent of adolescents have had sexual intercourse with four or more people during their lives. Teenagers with multiple sex partners are more likely to contract an STI, compared with teenagers who have only one sex partner.

Among those who are sexually active, the majority use contraception. The preferred method of contraception is condoms, although condom use in teens showed a slight drop between 2005 and 2007, from 63 percent to 61 percent who reported having used a condom the last time they had sex.

The younger a teen is at first sex, the less likely is the use of a condom or another form of contraception. Condoms protect teens from sexually transmitted infections and pregnancies when they are used correctly and consistently. Other hormonal forms of contraception for girls like the oral contraceptive pills, the patch, the

Talking to teens about sex

For parents and teens both, talking about sex can be uncomfortable. Teens do not want to see their parents in a sexual light, and parents often do not want to see their children that way, either. That said, teens still report that their parents are the greatest influences on their sexual behavior, and research backs them up. Guidelines for successful teen-parent conversation about sex include the following:

- Engage children in open, honest discussions regarding appropriate dating behavior, emotional and sexual intimacy, sexual identity, and emotional commitment.
- Discuss responsibilities regarding commitment and intimacy in romantic relationships.
- Discuss responsibilities regarding avoiding pregnancy, STIs, and HIV.
- Teach teens not to exploit other people socially, emotionally, or sexually. This is impossible to teach if it is not also modeled. Similarly, teach teens how to recognize abusive and exploitive relationships.
- Set appropriate limits regarding dating, such as the age at which dating will be allowed, curfews, and the age of person your child may date.
- Since teens may be embarrassed to talk with their parents about sex and relationships, try to provide access to other trusted adults (church members, counselors, relatives, etc.)
- Be open to questions and values expressed by the teen.

SOURCE: Beeler, N., Patrick, B., Pedon, S. Normal child sexual development and promoting healthy sexual development. *The Institute for Human Services for the Pennsylvania Child Welfare Training Program 203: Sexuality of Children: Healthy Sexual Behaviors and Behaviors Which Cause Concern.* Handout 3-1. Available at: http://www.pacwcbt.pitt.edu/Curriculum/203%20Sexuality%20of%20Children%20Healthy%20Sexual%20Behaviors%20and/Handouts/HO%203-1.pdf

"It's all right for a person to have sex when they are ready mentally, physically, and emotionally. It is not all right for someone younger than me to have sex."

Girl, 15

injection (Depo-Provera) or the vaginal ring provide higher levels of protection from unintended pregnancies but no protection from sexually transmitted infections (an excellent chart comparing contraceptive methods can be found at www.seasonique.com). When teens become sexually active, ideally, the male partner would use a condom and the female would use a hormonal method of contraception to get double protection. Fewer than one quarter of teens, however, currently do this.

When unprotected sex has already happened, emergency contraception can be used by girls to prevent pregnancy, especially if it is obtained within 72 hours of having sex. Known as Plan B, this concentrated dose of the hormone found in birth control pills is available over the counter in pharmacies for young women ages 17 or older. It is available for younger girls by prescription.

Risky consequences

Early and unsafe sexual activity can result in unintended teenage pregnancy and sexually transmitted infections (STIs).

Research shows that giving birth before age 18 limits the future for both the girl and her baby. Girls who become mothers early are less likely to complete high school and more likely to face poverty as an adult than other teens. Teenage girls who are pregnant often do not get sufficient prenatal care, and are more prone to high blood pressure and preeclampsia, a dangerous medical condition, than pregnant women in their 20s and 30s. Teens also are at greater risk for postpartum depression and having low–birth-weight babies (under five pounds). Low–birth- weight babies can have many medical problems, such as breathing difficulties, as well as developmental or growth delays. In addition, children of teen mothers can experience other health problems and higher rates of abuse or neglect; they are also likely to live in poverty and to receive inadequate health care

compared to children born to mothers aged 18 and over.

For more than a decade, rates of teen pregnancy and birth in the U.S. were down from an all-time peak of 61.8 births per thousand in 1991. This decline has leveled off, and the teen birth rate rose slightly between 2005 and 2007. This translates to about 20,000 more births to teenagers in 2006 compared to the year before. Births have risen slightly among women between the ages of 20 and 24 as well.

Sexually transmitted infections are also a major concern. Sex without condoms puts young people at risk for STIs, including HIV infection. Adolescent cases account for half of all STIs. The latest Centers for Disease Control and Prevention (CDC) statistics tell us that more than 3 million teenage girls in America have an STI. In a national study in 2003, teens aged 14 to 19 were tested for four infections: Human Papillomavirus (HPV), chlamydia, trichomoniasis, and herpes simplex virus. While one-quarter of the girls overall had at least one of these infections, nearly half of the African-American girls were infected.

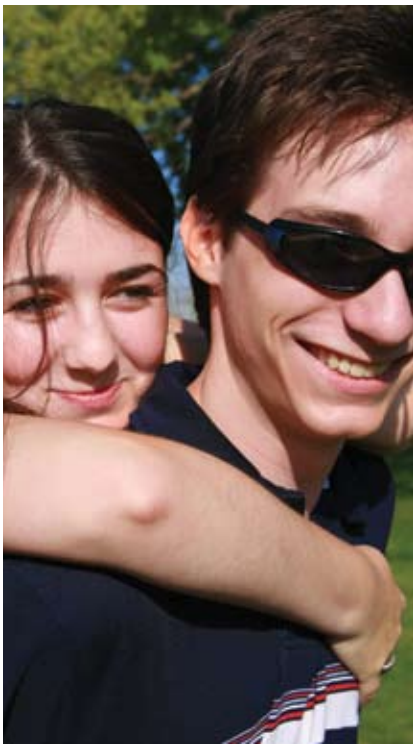
The most common STI found in teen girls ages 14 to 19 is HPV, which can cause genital warts in women and men and is usually not a serious condition. Some HPV viruses can lead to cervical cancer later in life. Fortunately, a vaccine targeting HPV recently became available, and national health organizations recommend the vaccine for 11- and 12-year-old girls, and catch-up shots for females ages 13 to 26. Vaccines for boys are being readied but they are not yet recommended.

"I get my information about sex from my friends and magazines." *Girl, 16*

Chlamydia, another very common infection, can cause pelvic inflammatory disease and infertility. This infection is caused by bacteria and can be easily treated if it is detected. However, many youth with the infection do not have any symptoms and are unaware that they have it. In pregnancy, chlamydia and HIV can infect the growing baby. If these infections are transmitted to babies, they can cause low birth weight, eye

Keeping a cool head on a hot topic

- **Get your zen on**
  When young people bring up sex, try to be calm and reasonable, no matter what the situation. Anger, surprise, and embarrassment are not proper responses, even if your teen is trying to provoke you.
- **Tone is everything**
  Teens may have fears that their sexual thoughts and urges are unnatural or make them freaks. Reassure teens that sexual thoughts and expressions are normal, and it is OK to have these feelings without acting on them.
- **Papa, don't preach**
  Phrases like "But you're only 16!" are not helpful. Teens are looking for someone to listen and to give accurate information about sex, not deliver sermons or make them feel guilty or ashamed.



infection, pneumonia, blood infection, brain damage, lack of coordination in body movements, blindness, deafness, acute hepatitis, meningitis, liver disease, cirrhosis, or stillbirth.

What adults can do

Young people care about what their parents and other important adults in their lives think. When teens—both boys and girls—believe their parents want them to delay having sex, they are more likely to defer first intercourse. When there is a warm relationship, adolescents are even more apt to behave the way their parents wish them to, which often means postponing sexual activity.

Parents and caring adults can foster closeness with their teens and increase the odds of their avoiding risky sexual behavior by establishing an environment in which young people can feel comfortable and respected talking or asking about sexual matters. Clear rules about dating, curfews, and whether adolescents may be alone together in the teen's bedroom are also important but should be negotiated so that they are perceived as fair by the teen.

Parents and those who work with adolescents need to educate themselves about the various factors affecting sexual development. Physical changes make teens appear ready for sexual activities they might not be prepared for emotionally and cognitively. Poor communication about sex, limited or inaccurate information, media influences, and negative attitudes also can impact a young person's sexual health and identity.

An essential way an adult can influence sexual behavior is by being a source of accurate information. Teens need straight talk about how to refuse to have sex if they do not want to have it. They also need to be shown the right way to use condoms. Adult involvement in this regard is more important than ever: 47 percent of teens say their parents are the most important influence in their decisions about sex, and younger teens view parents as even more important. If teenagers cannot get information from their parents or caring adults, they typically will rely on friends and the media, especially the Internet, to answer questions about sexual health.

Sometimes adults wonder how much information is too much. Researchers have found no evidence that either talking about contraception or making contraception available to teens hastens the onset of first sex.

Sex education and social influences

According to the 2002 National Survey of Family Growth (NSFG), only 2 percent of adolescents say they are getting essential information about contraception, sexual safety, and other matters. Research actually suggests that young people who are knowledgeable about sexuality and reproductive health are less likely to engage in early sexual activity or unprotected sex.

Schools do not necessarily provide complete or accurate information to educate adolescents about sexual health and sexuality. Abstinence-only sex education curricula and programs have been widespread in American schools. A recent evaluation of several abstinence-only sex education curricula, which teach young people to postpone sexual intercourse until marriage and include no information about contraception, has shown them to be ineffective. The researchers from Mathematica, Inc. who conducted the evaluation found that the children who took part in sexual-abstinence education classes engaged in sexual intercourse for the first time at the same age as children who did not receive these classes.

The participating students also did not gain more awareness of the dangers of unprotected sex than did their nonparticipating counterparts.

Adults can expand on what is taught in the classroom by welcoming discussions about sexual behavior and risks, relationships, emotions, and sexual urges. This kind of respectful, in-depth communication can positively affect a young person's sexual development.

Sexuality is a vital part of growing up

During adolescence, teens learn how to deal with sexual feelings, experience sexual fantasies, and perhaps enjoy romantic relationships. They may choose to delay sexual activity, or not have sex at all, which falls within the spectrum of normal adolescent behavior.

These choices are all part of sexuality. Healthy sexual development is not simply a matter of sex but involves a young person's ability to manage intimate and reproductive behavior responsibly and without guilt, fear, or shame.

American teenagers grow up in a culture in which sex informs everything from the type of clothes they wear and the music they listen to, to the images and messages they continually absorb through the media.

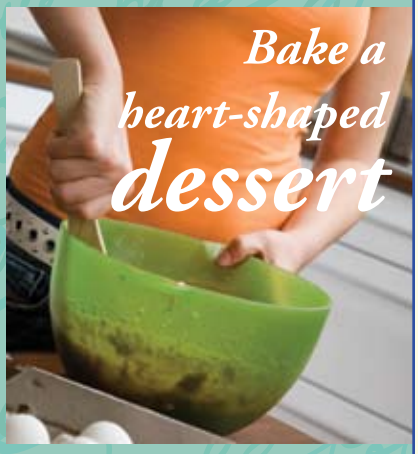
Helping adolescents separate truth from hype and recognize all aspects of sexual development encourages them to make informed and healthy decisions about sexual matters.

10 ways TEENS can express LOVE without SEX

Read to
each other

Contribute or volunteer for a cause he or she cares about

Offer to do a chore



Program their I-Pod or make a CD with songs that are special to both

Go through the car wash together

Rent a romantic movie

CDC Vitalsigns™
April 2015

Preventing Teen Pregnancy

A key role for health care providers

Teen childbearing can carry health, economic, and social costs for mothers and their children. Teen births in the US have declined, but still more than 273,000 infants were born to teens ages 15 to 19 in 2013. The good news is that more teens are waiting to have sex, and for sexually active teens, nearly 90% used birth control the last time they had sex. However, teens most often use condoms and birth control pills, which are less effective at preventing pregnancy when not used consistently and correctly. Intrauterine devices (IUDs) and implants, known as Long-Acting Reversible Contraception (LARC), are the most effective types of birth control for teens. LARC is safe to use, does not require taking a pill each day or doing something each time before having sex, and can prevent pregnancy for 3 to 10 years, depending on the method. Less than 1% of LARC users would become pregnant during the first year of use.

43%

About 43% of teens ages 15 to 19 have ever had sex.

4 in 5

More than 4 in 5 (86%) used birth control the last time they had sex.

5%

Less than 5% of teens on birth control used the most effective types.

Doctors, nurses, and other health care providers can:

- ◇ Encourage teens not to have sex.
- ◇ Recognize LARC as a safe and effective choice of birth control for teens.
- ◇ Offer a broad range of birth control options to teens, including LARC, and discuss the pros and cons of each.
- ◇ Seek training in LARC insertion and removal, have supplies of LARC available, and explore funding options to cover costs.
- ◇ Remind teens that LARC by itself does not protect against sexually transmitted diseases and that condoms should also be used every time they have sex.

→ See page 4

Want to learn more? Visit

www.cdc.gov/vitalsigns

National Center for Chronic Disease Prevention and Health Promotion
Division of Reproductive Health

Problem

Few teens (ages 15 to 19) on birth control use the most effective types.

Use of Long-Acting Reversible Contraception (LARC) is low.

◇ Less than 5% of teens on birth control use LARC.

◇ Most teens use birth control pills and condoms, methods which are less effective at preventing pregnancy when not used properly.

◇ There are several barriers for teens who might consider LARC:

- Many teens know very little about LARC.
- Some teens mistakenly think they cannot use LARC because of their age.

◇ Clinics also report barriers:

- High upfront costs for supplies.
- Providers may lack awareness about the safety and effectiveness of LARC for teens.
- Providers may lack training on insertion and removal.

Providers can take steps to increase awareness and availability of LARC.

◇ Title X is a federal grant program supporting confidential family planning and related preventive services with priority for low-income clients and teens.*

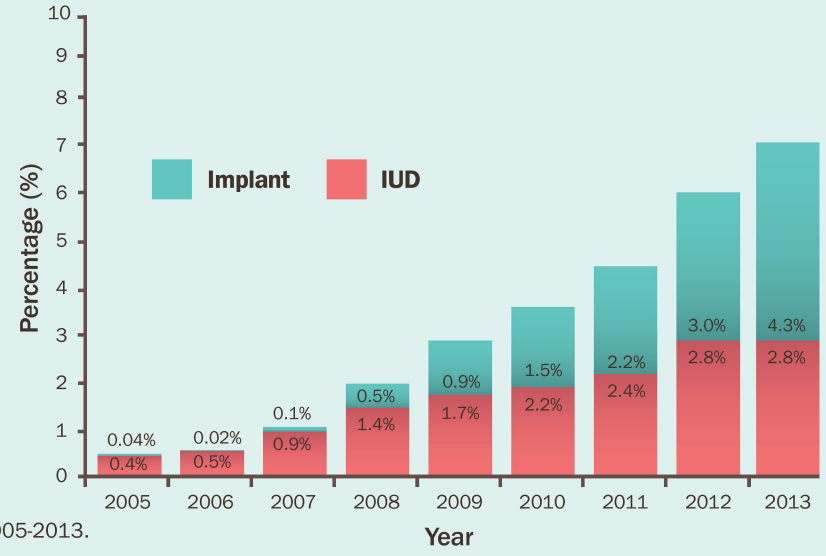
- Title X-funded centers have used the latest clinical guidelines on LARC, trained providers on LARC insertion and removal, and secured low- or no-cost options for birth control.
- Teen use of LARC has increased from less than 1% in 2005 to 7% in 2013.

◇ Other state and local programs have made similar efforts.

- More teens and young women chose LARC, resulting in fewer unplanned pregnancies.

*For more information on Title X, visit: www.hhs.gov/opa/title-x-family-planning/

LARC use among teens ages 15-19 seeking birth control at Title X-funded centers



SOURCE: Title X Family Planning Annual Reports, United States, 2005-2013.

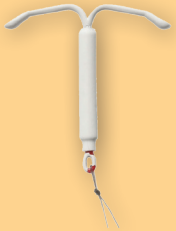
HOW WELL DOES BIRTH CONTROL WORK?

What is your chance of getting pregnant?

Really, really well

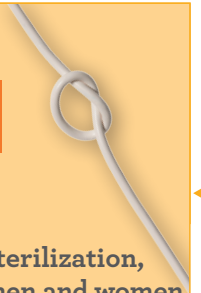
The Implant (Nexplanon)

IUD (Skyla)



IUD (Mirena)

IUD (ParaGard)



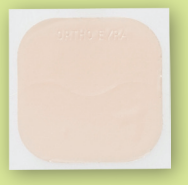
Sterilization, for men and women

Works, hassle-free, for up to... 3 years | 3 years | 5 years | 12 years | Forever

Less than 1 in 100 women

O.K.

The Pill



The Patch

The Ring

The Shot (Depo-Provera)

For it to work best, use it... Every. Single. Day. | Every week | Every month | Every 3 months

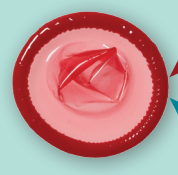
6-9 in 100 women, depending on method

Not as well

Pulling Out

Fertility Awareness

Diaphragm



Condoms, for men or women

For each of these methods to work, you or your partner have to use it every single time you have sex.

12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.

BEDSIDER
Bedsider.org

Bixby Center for Global Reproductive Health

WHAT'S THE RISK?

Risks of Using Birth Control

IMPLANT

RISKS

Infection/ Complication at Insertion or Removal
0.1 women/1,000
0.1

Accidental Pregnancy
0.5
0.5 women/1,000

IUD

RISKS

Expulsion
50 women/1,000 during the first year of use
50

Pelvic Inflammatory Disease
5 women/1,000 within the first 90 days after insertion
5

Perforation
0.5 women/1,000
0.5

Accidental Pregnancy
8
8 women/1,000

DEPO

RISKS

Reversible Bone Loss
with quick recovery when stopped, and no increased risk of broken bones

Accidental Pregnancy
60
60 women/1,000

THE PILL

RISKS

Blood Clots
1 women/1,000
1

Stroke
0.2 women/1,000
0.2

Heart Attack
0.1 women/1,000
0.1

Accidental Pregnancy
90
90 women/1,000

If you're like most people, you probably took a shower this morning, drove to work or school, or took an aspirin.

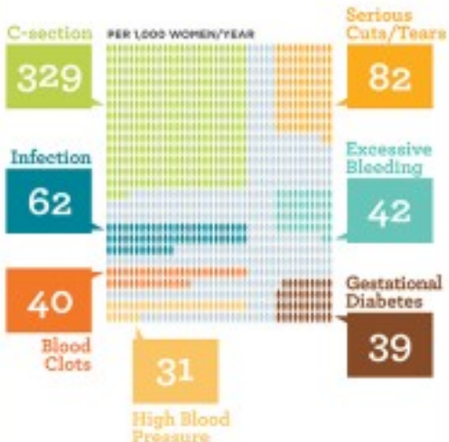
Like many other things in life, using birth control sometimes involves risk.

But, compared to other risks we face on a daily basis, the chance of experiencing a serious health complication from using a contraceptive is low.

Risks of NOT Using Birth Control

Without birth control, 90 in 100 young women will get pregnant each year.

And during pregnancy and birth, half will have a medical problem:



BEDSIDER
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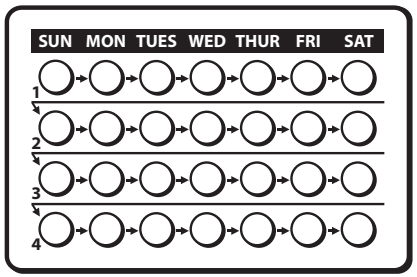
Recommended Actions After Late or Missed Combined Oral Contraceptives

If one hormonal pill is late: (<24 hours since a pill should have been taken)

If one hormonal pill has been missed: (24 to <48 hours since a pill should have been taken)

- Take the late or missed pill as soon as possible.
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- No additional contraceptive protection is needed.
- Emergency contraception is not usually needed but can be considered if hormonal pills were missed earlier in the cycle or in the last week of the previous cycle.



If two or more consecutive hormonal pills have been missed: (≥48 hours since a pill should have been taken)

- Take the most recent missed pill as soon as possible (any other missed pills should be discarded).
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills have been taken for 7 consecutive days.
- If pills were missed in the last week of hormonal pills (e.g., days 15-21 for 28-day pill packs):
  - Omit the hormone-free interval by finishing the hormonal pills in the current pack and starting a new pack the next day.
  - If unable to start a new pack immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills from a new pack have been taken for 7 consecutive days.
- Emergency contraception should be considered if hormonal pills were missed during the first week and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered at other times as appropriate.

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Source: For the full recommendations, see the US Selected Practice Recommendations for Contraceptive Use, 2013 (http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf).

Recommended Actions After Delayed Application or Detachment With Combined Hormonal Patch

Delayed application or detachment* for <48 hours since a patch should have been applied or reattached

- Apply a new patch as soon as possible. (If detachment occurred <24 hours since the patch was applied, try to reapply the patch or replace with a new patch.)
- Keep the same patch change day.
- No additional contraceptive protection is needed.
- Emergency contraception is not usually needed but can be considered if delayed application or detachment occurred earlier in the cycle or in the last week of the previous cycle.

**If detachment takes place but the woman is unsure when detachment occurred, consider the patch to have been detached for ≥48 hours since a patch should have been applied or reattached.*

Delayed application or detachment* for ≥48 hours since a patch should have been applied or reattached

- Apply a new patch as soon as possible.
- Keep the same patch change day.
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until a patch has been worn for 7 consecutive days.
- If the delayed application or detachment occurred in the third patch week:
  - Omit the hormone-free week by finishing the third week of patch use (keeping the same patch change day) and starting a new patch immediately.
  - If unable to start a new patch immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until a new patch has been worn for 7 consecutive days.
- Emergency contraception should be considered if the delayed application or detachment occurred within the first week of patch use and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered at other times as appropriate.

Recommended Actions After Delayed Insertion or Reinsertion With Combined Vaginal Ring

Delayed insertion of a new ring or delayed reinsertion* of a current ring for <48 hours since a ring should have been inserted

- Insert ring as soon as possible.
- Keep the ring in until the scheduled ring removal day.
- No additional contraceptive protection is needed.
- Emergency contraception is not usually needed but can be considered if delayed insertion or reinsertion occurred earlier in the cycle or in the last week of the previous cycle.

**If removal takes place but the woman is unsure of how long the ring has been removed, consider the ring to have been removed for ≥48 hours since a ring should have been inserted or reinserted.*

Delayed insertion of a new ring or delayed reinsertion* for ≥48 hours since a ring should have been inserted

- Insert ring as soon as possible.
- Keep the ring in until the scheduled ring removal day.
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until a ring has been worn for 7 consecutive days.
- If the ring removal occurred in the third week of ring use:
  - Omit the hormone-free week by finishing the third week of ring use and starting a new ring immediately.
  - If unable to start a new ring immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until a new ring has been worn for 7 consecutive days.
- Emergency contraception should be considered if the delayed insertion or reinsertion occurred within the first week of ring use and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered at other times as appropriate.

Source: For the full recommendations, see the US Selected Practice Recommendations for Contraceptive Use, 2013 (http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf).

How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

In situations in which the health-care provider is uncertain whether the woman might be pregnant, the benefits of starting the implant, depot medroxyprogesterone acetate (DMPA), combined hormonal contraceptives and progestin-only pills likely exceed any risk; therefore, starting the method should be considered at any time, with a follow-up pregnancy test in 2-4 weeks. For IUD insertion, in situations in which the health-care provider is not reasonably certain that the woman is not pregnant, the woman should be provided with another contraceptive method to use until the health-care provider can be reasonably certain that she is not pregnant and can insert the IUD.

When to Start Using Specific Contraceptive Methods

Contraceptive method	**When to start** (if the provider is reasonably certain that the woman is not pregnant)	**Additional contraception** (i.e., back up) needed	**Examinations or tests needed before initiation**[1]
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection[2]
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection[2]
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

Abbreviations: BMI = body mass index; IUD = intrauterine device; STD = sexually transmitted disease

[1]Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used or generally can be used among obese women. However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

[2]Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC's STD Treatment Guidelines (available at http://www.cdc.gov/std/treatment). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion and insertion should not be delayed. Women with purulent cervicitis, current chlamydial infection, or gonorrhea should not undergo IUD insertion. Women who have a very high individual likelihood of STD exposure (e.g., those with a currently infected partner) generally should not undergo IUD insertion. For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

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Source: For the full recommendations, see the US Selected Practice Recommendations for Contraceptive Use, 2013 (http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf).

Routine Follow-Up After Contraceptive Initiation*

Action	Contraceptive Method				
	LNG-IUD or Cu-IUD	Implant	Injectable	CHC	POP
General Follow-Up					
Advise a woman to return at any time to discuss side effects or other problems or if they want to change the method. Advise women using IUDs, implants, or injectables when the IUD or implant needs to be removed or when reinjection is needed. No routine follow-up visit is required.	X	X	X	X	X
Other Routine Visits					
Assess the woman's satisfaction with her current method and whether she has any concerns about method use.	X	X	X	X	X
Assess any changes in health status, including medications, that would change the method's appropriateness for safe and effective continued use based on the U.S. MEC (i.e., category 3 and 4 conditions and characteristics).	X	X	X	X	X
Consider performing an examination to check for the presence of IUD strings.	X	–	–	–	–
Consider assessing weight changes and counseling women who are concerned about weight change perceived to be associated with their contraceptive method.	X	X	X	X	X
Measure blood pressure.	–	–	–	X	–

Abbreviations: CHC = combined hormonal contraceptive; Cu-IUD = copper-containing intrauterine device; IUD = intrauterine device; LNG-IUD = levonorgestrel-releasing intrauterine device; POP = progestin-only pills; U.S. MEC = *U.S. Medical Eligibility Criteria for Contraceptive Use,* 2010.

*These recommendations address when routine follow-up is recommended for safe and effective continued use of contraception for healthy women. The recommendations refer to general situations and might vary for different users and different situations. Specific populations that might benefit from more frequent follow-up visits include adolescents, those with certain medical conditions or characteristics, and those with multiple medical conditions.
Source: For the full recommendations, see the US Selected Practice Recommendations for Contraceptive Use, 2013 (http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf).

ABSTINENCE

Choosing not to have partnered sex (until you're married, until you're ready...whatever) is the only method of protection that's 100% effective.

WHAT IT IS

While people might have different definitions of what abstinence is, most people define it as not having sexual intercourse, including oral, vaginal or anal intercourse, for a particular period of time. Some people decide to remain abstinent until they're a certain age or are in a certain kind of committed relationship, like being in love, being with a person for a certain amount of time or married.

HOW IT WORKS

Once you've decided how you define abstinence, make it clear to your romantic partner that you're not interested in getting physical in these specific ways. You also can think about what to do if your partner has a different definition of abstinence than you; that is the point when you can either come to a compromise or decide that your boundaries are not a good fit for the other person. This is part of establishing and being in a healthy relationship.

EFFECTIVENESS

Abstinence is very effective protection against pregnancy. When both partners are completely committed and practice abstinence (no genital contact) 100% of the time, there is no risk of pregnancy.

Abstinence is also very effective protection against STIs. When both partners are completely committed and practice abstinence (no genital contact, including oral vaginal, or anal sex) 100% of the time, there is very little risk of transmitting an STI. Some STIs can infect the mouth, and others can be transmitted through skin-to-skin contact, so it's important to not do any of these behaviors to prevent transmission.

*Note: Studies show that when teens that choose abstinence but don't practice it (meaning they wind up having sex), they often don't use protection. We don't want that to happen to you. So if you decide to be abstinent, also make a promise to yourself to be informed about how to keep yourself healthy if you decide to have sex. Specifically, know how to use a condom, where to find a health center and how to get emergency contraception (EC) if you need it.

Quick Facts

1: *Less than half of high school age kids have had sex- if you're not having sex, you're not alone.*

2: *There are lots of great reasons to wait to have sex- what's yours?*

3: *You can say no to sex- even if you've said yes before.*

4: *Abstinence is the only 100% way to make sure you don't get pregnant/get someone pregnant.*

5: *If you're not ready to have sex and your bf/gf still pressures you, are they really a good partner to you?*

PERKS

- Really effective when used perfectly
- Easy to remember
- Always available & free!
- No visit to a medical provider required
- Non-hormonal

DRAWBACKS

- You have to be perfect every single time.
- It can be tough or feel impossible to say no.
- If you have a partner, you need their cooperation.
- If you change your mind and decide to become sexually active, it is important to plan ahead and use some kind of protection

Content adapted from: Answer, Rutgers University (https://sexetc.org/info-center/post/what-is-abstinence/); Power to Decide (http://stayteen.org/sex-ed/article/abstinence) and (https://www.bedsider.org/methods/not_right_now); Georgia Dept. of Public Health (https://www.gachd.org/ABSTINENCE.pdf)

Planned Parenthood® of Northern New England

Know how to use a condom the right way, every time.

How do you put a condom on correctly?

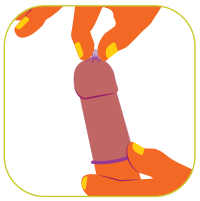
The condom should be put on before any genital contact. Sperm may come out of the penis before the male ejaculates, so put the condom on before any skin-to-skin contact begins. You should also know that some STDs can be transmitted without intercourse, through genital (skin-to-skin) contact. To reduce the risk of pregnancy and STDs (including HIV), males need to wear a condom the entire time from the beginning to the end of genital contact, each and every time.

1 When you are opening the package, gently tear it on the side. Do not use your teeth or scissors because you might rip the condom that's inside. Pull the condom out of the package slowly so that it doesn't tear.

2 Put the rolled up condom over the head of the penis when it is hard.

3 Pinch the tip of the condom enough to leave a half-inch space for semen to collect.

4 Holding the tip of the condom, unroll it all the way down to the base of the penis.



When the condom is on, it should feel snug enough so that it won't fall off during sex, but not too tight.

- If you accidentally put on a condom inside-out, throw it away and get a new one. You can tell a condom is inside-out if it won't roll down the length of the penis easily.
- If the condom ever tears or rips when you are putting it on or when it's being used, throw it away and use a new one.

How do you take off a condom correctly?

The most common mistake is not using condoms from the beginning of sexual contact to the very end, after ejaculation. Immediately after ejaculation, hold the bottom of the condom so it stays on and semen cannot spill out. Then, carefully withdraw the penis while it is still hard. Once the penis is out, you can remove the condom, wrap it in tissue, and throw it in the trash. Do not flush it down the toilet because it might clog.

What if the condom breaks?

If you feel the condom break at any point before or during sex:

Stop immediately! **Withdraw.** **Carefully remove the broken condom and put on a new one.**

If the condom breaks, pregnancy can be prevented with emergency contraception. Emergency contraception (the "Morning-After Pill") works best when it's started as soon as possible after sex, but can be started up to 5 days after sex.

Remember: Emergency contraception helps prevent pregnancy, but it does NOT protect against STDs.

Know your CONDOM DOs & DON'Ts

DO

- Read all the information on the package. Know what you are using.
- Check the expiration date on the package. If it is expired, get a new package of condoms and throw away the old ones.
- Use only condoms that are made of latex or polyurethane (plastic). Latex condoms and polyurethane condoms are the best types of condoms to use to help prevent pregnancy, STDs, and HIV.
- Use a pre-lubricated condom to help prevent it from tearing. If you only have a non-lubricated condom, put a little bit of water-based lubricant ("lube") inside and outside the condom.
- Condoms come in different sizes, colors, textures, and thicknesses. Talk with your partner and choose condoms both of you like.

DON'T

- Do not use two condoms at once.
- Do not use condoms made of animal skin, sometimes called "natural" condoms. Animal skin condoms can help prevent pregnancy but don't work as well as latex or polyurethane condoms to prevent STDs, including HIV.
- Do not keep condoms in a place that can get very hot, like in a car. If you keep a condom in your wallet or purse, be sure you replace it with a new one regularly.
- Do not use any kind of oil-based lubricants (like petroleum jellies, lotions, mineral oil, or vegetable oils). These can negatively affect the latex, making it more likely to rip or tear.
- Do not reuse condoms.
- Do not use condoms that are torn or outdated.

www.cdc.gov/teenpregnancy/Teens.html

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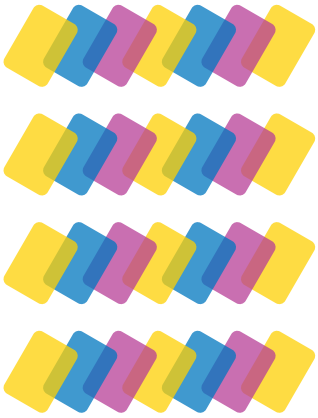


Dental Dams

HOT TIPS

Better sex!

Dental dams are latex or polyurethane sheets used between the mouth and vagina or anus during oral sex.

Used correctly *every* time, dental dams can:

- Protect you from most STDs, including HIV.
- Help you feel relaxed and safe.

Planned Parenthood® of Northern New England

www.ppnne.org | 1-866-476-1321

How to Use a Dental Dam

1. **Carefully open dental dam and remove from package.** Add water or silicone-based lube on the receiver's side, if desired.

2. **Place dental dam flat to cover vaginal opening or anus and have one person hold it in place.** Do not stretch it or pull it tight.

3. **Put it on before starting oral sex and keep it on until finished.** Use a new dental dam every time.

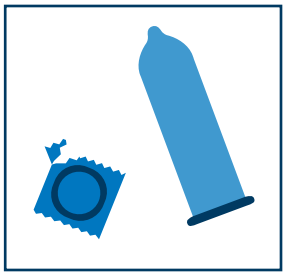
4. **Be sure to *ONLY* use one side.** Do not turn the dam over and continue to use it.

5. **Throw away used dental dam in trash.** Do not flush dental dams down the toilet.

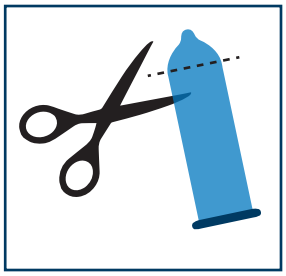
Although oral sex is considered less risky than vaginal or anal sex, there is still a risk of transmitting STDs. To be as safe as possible, use an oral barrier for every act of oral sex to keep fluids from passing from one person to the other.

How to Make a Dental Dam from a Condom

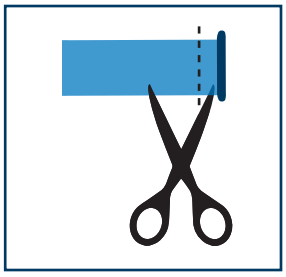
1. **Carefully open package, remove condom, and unroll.**



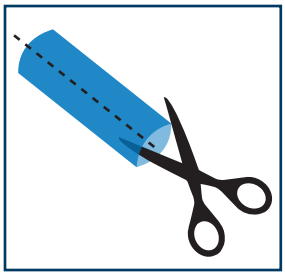
2. **Cut off tip of condom.**



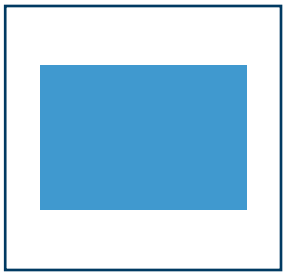
3. **Cut off bottom of condom.**



4. **Cut down one side of condom.**



5. **Lay flat to cover vaginal opening or anus.**



Use lubes!

- **Most dental dams are unlubricated.** They come in different flavors or can be unflavored.
- **Some condoms come with lube.** Read the package to find out.
- **Only use water- or silicone-based lubes** with oral barriers.
- **Lube can help increase the sensation for the receiver.**
- **Never use Vaseline®, hand lotion or oil-based lube.** Oil can break condoms and dental dams.

Try different kinds of lubes to find one you like.

Make it easy

- **Talking about dental dams** can help you feel more comfortable.

- **Think ahead about what you want to say** and how you'll start the conversation.
- **Practice what you'll say** *before* you get in a sexy situation.

Using dental dams is like learning to wear a seat belt all the time– it takes practice to make it a habit.

If you are sexually active and are not ready to become a parent, it is important to use birth control to protect yourself from pregnancy.

It is also important to reduce your risk of getting sexually transmitted diseases (STDs), including HIV.

Condoms are the only birth control that reduces your risk of both pregnancy and STDs, including HIV. But, in order to work, condoms must be used correctly and must be used every time you have sex. It's important to know, however, that they cannot completely protect you and your partner from some STDs, like herpes, syphilis, or human papillomavirus (HPV), the virus that causes genital warts and cervical cancer. Also, condoms can break, slip, or leak, especially if they are not put on and taken off properly.

The only sure way to prevent pregnancy and STDs is NOT to have sex.

If you do have sex, use DUAL PROTECTION.

Even if you or your partner is using another type of birth control, agree to use a condom every time you have sex, to reduce the risk to both of you for HIV and most other STDs.

Condom

+

Birth Control Pill

Patch

Ring

Implant

Injection

IUD

Remember!

- **Use a condom and birth control.**
- **Condoms must be used correctly and used every time you have sex.**
- **Sometimes you or your partner might not know if one of you has an STD.**

OOPS! EMERGENCY CONTRACEPTION: BIRTH CONTROL THAT WORKS AFTER SEX

Types of Emergency Contraception	How well does it work?	How soon do I have to use it?	How do I use it?	Where can I get it?
 ParaGard IUD	Almost 100% effective 	Within 5 days	It's placed in the uterus by a health care provider Keeps working as super effective birth control.	From a health care provider Say it's for EC so you are scheduled quickly.
 ella	 Less effective if over 195 pounds. Try a ParaGard IUD.	ASAP Works better the sooner you take it, up to 5 days.	Take the pill as soon as you get it Remember to use it every time you have unprotected sex.	From a health care provider Get an extra pack for future emergencies.
 Plan B One-Step or a generic	 Less effective if over 165 pounds. Try ella or ParaGard.	ASAP Works better the sooner you take it, up to 3 days.	Take the pill(s) as soon as you get it Remember to use it every time you have unprotected sex.	At a pharmacy, no prescription needed Get an extra pack for future emergencies.

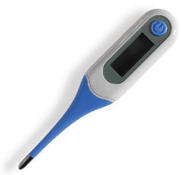
BEDSIDER Bedsider.org

Bixby Center for Global Reproductive Health

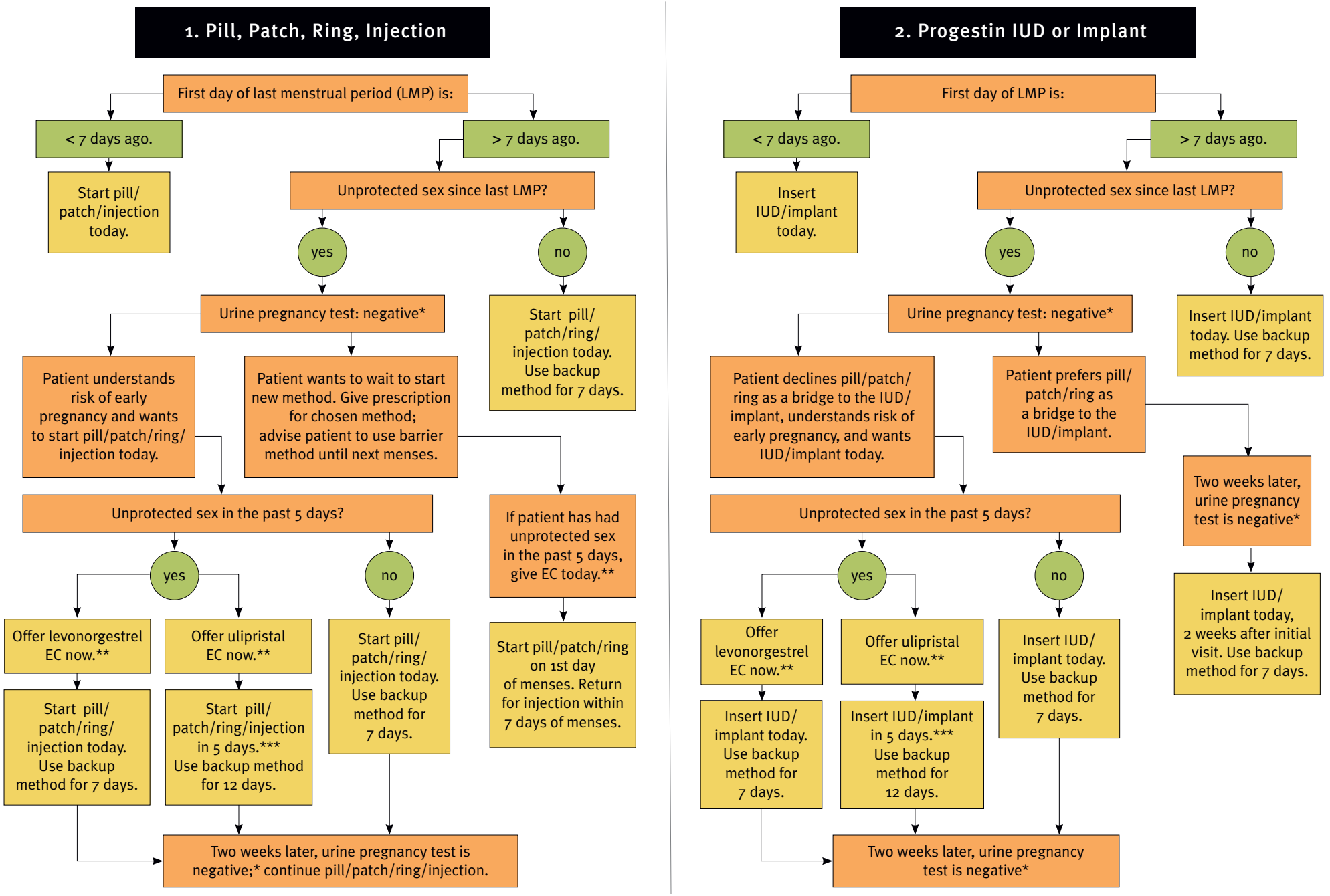
Affordable Emergency Contraception (EC) is always available at Planned Parenthood of Northern New England (PPNNE). Many patients qualify for free or reduced cost EC. Over the counter and prescription options are available. Call 1-866-476-1321 to get an estimate on how much EC might cost you at your nearest PPNNE Health Center.

Your Birth Control Choices

Method	How well does it work?	How to Use	Pros	Cons
The Implant Nexplanon® 	> 99%	A health care provider places it under the skin of the upper arm It must be removed by a health care provider	Long lasting (up to 5 years) No pill to take daily Often decreases cramps Can be used while breastfeeding You can become pregnant right after it is removed	Can cause irregular bleeding After 1 year, you may have no period at all Does not protect against human immunodeficiency virus (HIV) or other sexually transmitted infections (STIs)
Progestin IUD Liletta®, Mirena®, Skyla® and others 	> 99%	Must be placed in uterus by a health care provider Usually removed by a health care provider	May be left in place 3 to 7 years, depending on which IUD you choose No pill to take daily May improve period cramps and bleeding Can be used while breastfeeding You can become pregnant right after it is removed	May cause lighter periods, spotting, or no period at all Rarely, uterus is injured during placement Does not protect against HIV or other STIs
Copper IUD ParaGard® 	> 99%	Must be placed in uterus by a health care provider Usually removed by a health care provider	May be left in place for up to 12 years No pill to take daily Can be used while breastfeeding You can become pregnant right after it is removed	May cause more cramps and heavier periods May cause spotting between periods Rarely, uterus is injured during placement Does not protect against HIV or other STIs
The Shot Depo-Provera® 	94-99%	Get a shot every 3 months	Each shot works for 12 weeks Private Usually decreases periods Helps prevent cancer of the uterus No pill to take daily Can be used while breastfeeding	May cause spotting, no period, weight gain, depression, hair or skin changes, change in sex drive May cause delay in getting pregnant after you stop the shots Side effects may last up to 6 months after you stop the shots Does not protect against HIV or other STIs
The Pill 	91-99%	Must take the pill daily	Can make periods more regular and less painful Can improve PMS symptoms Can improve acne Helps prevent cancer of the ovaries You can become pregnant right after stopping the pills	May cause nausea, weight gain, headaches, change in sex drive – some of these can be relieved by changing to a new brand May cause spotting the first 1-2 months Does not protect against HIV or other STIs
Progestin-Only Pills 	91-99%	Must take the pill daily	Can be used while breastfeeding You can become pregnant right after stopping the pills	Often causes spotting, which may last for many months May cause depression, hair or skin changes, change in sex drive Does not protect against HIV or other STIs
The Patch Ortho Evra® 	91-99%	Apply a new patch once a week for three weeks No patch in week 4	Can make periods more regular and less painful No pill to take daily You can become pregnant right after stopping patch	Can irritate skin under the patch May cause spotting the first 1-2 months Does not protect against HIV or other STIs
The Ring Nuvaring® 	91-99%	Insert a small ring into the vagina Change ring each month	One size fits all Private Does not require spermicide Can make periods more regular and less painful No pill to take daily You can become pregnant right after stopping the ring	Can increase vaginal discharge May cause spotting the first 1-2 months of use Does not protect against HIV or other STIs

Method	How well does it work?	How to Use	Pros	Cons
Male/External Condom 	82-98%	Use a new condom each time you have sex Use a polyurethane condom if allergic to latex	Can buy at many stores Can put on as part of sex play/foreplay Can help prevent early ejaculation Can be used for oral, vaginal, and anal sex Protects against HIV and other STIs Can be used while breastfeeding	Can decrease sensation Can cause loss of erection Can break or slip off
Female/Internal Condom 	79-95%	Use a new condom each time you have sex Use extra lubrication as needed	Can buy at many stores Can put in as part of sex play/foreplay Can be used for anal and vaginal sex May increase pleasure when used for vaginal sex Good for people with latex allergy Protects against HIV and other STIs Can be used while breastfeeding	Can decrease sensation May be noisy May be hard to insert May slip out of place during sex
Withdrawal Pull-out	78-96%	Pull penis out of vagina before ejaculation (that is, before coming)	Costs nothing Can be used while breastfeeding	Less pleasure for some Does not work if penis is not pulled out in time Does not protect against HIV or other STIs Must interrupt sex
Diaphragm Caya® and Milex® 	88-94%	Must be used each time you have sex Must be used with spermicide	Can last several years Costs very little to use May protect against some infections, but **not HIV** Can be used while breastfeeding	Using spermicide may raise the risk of getting HIV Should not be used with vaginal bleeding or infection Raises risk of bladder infection
Fertility Awareness Natural Family Planning 	76-95%	Predict fertile days by: taking temperature daily, checking vaginal mucus for changes, and/or keeping a record of your periods It works best if you use more than one of these Avoid sex or use condoms/spermicide during fertile days	Costs little Can be used while breastfeeding Can help with avoiding or trying to become pregnant	Must use another method during fertile days Does not work well if your periods are irregular Many things to remember with this method Does not protect against HIV or other STIs
Spermicide Cream, gel, sponge, foam, inserts, film 	72-82%	Insert spermicide each time you have sex	Can buy at many stores Can be put in as part of sex play/foreplay Comes in many forms: cream, gel, sponge, foam, inserts, film Can be used while breastfeeding	May raise the risk of getting HIV May irritate vagina, penis Cream, gel, and foam can be messy
Emergency Contraception Pills Progestin EC (Plan B® One-Step and others) and ulipristal acetate (ella®) 	58-94% Ulipristal acetate EC works better than progestin EC if you are overweight Ulipristal acetate EC works better than progestin EC in the 2-5 days after sex	Works best the **sooner** you take it after unprotected sex You can take EC up to 5 days after unprotected sex If pack contains 2 pills, take both together	Can be used while breastfeeding Available at pharmacies, health centers, or health care providers: call ahead to see if they have it People of any age can get progestin EC without a perscription	May cause stomach upset or nausea Your next period may come early or late May cause spotting Does not protect against HIV or other STIs Ulipristal acetate EC requires a prescription May cost a lot

Quick Start Algorithm — Patient requests a new birth control method:

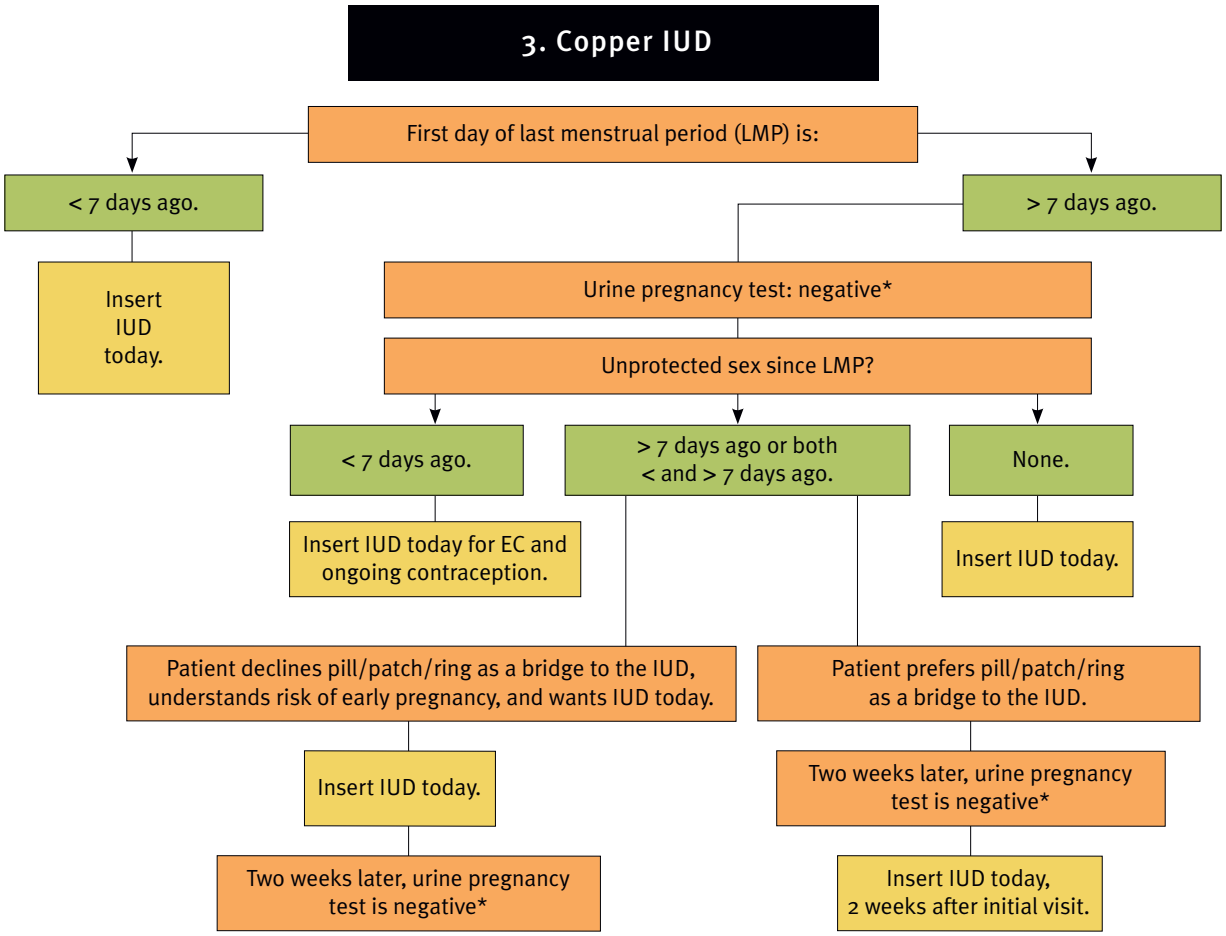


* If pregnancy test is positive, provide options counseling.

** For patients with body mass index over 25, levonorgestrel EC works no better than placebo. For those who had unprotected sex 3-5 days ago, ulipristal EC has higher efficacy than levonorgestrel EC.

*** Because ulipristal EC may interact with hormonal contraceptives, the new method should be started no sooner than 5 days after ulipristal EC. Consider starting injection/IUD/implant sooner if benefit outweighs risk.

Quick Start Algorithm — Patient requests a new birth control method:

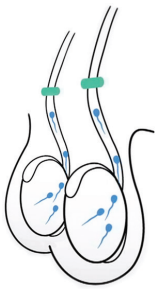


* If pregnancy test is positive, provide options counseling.

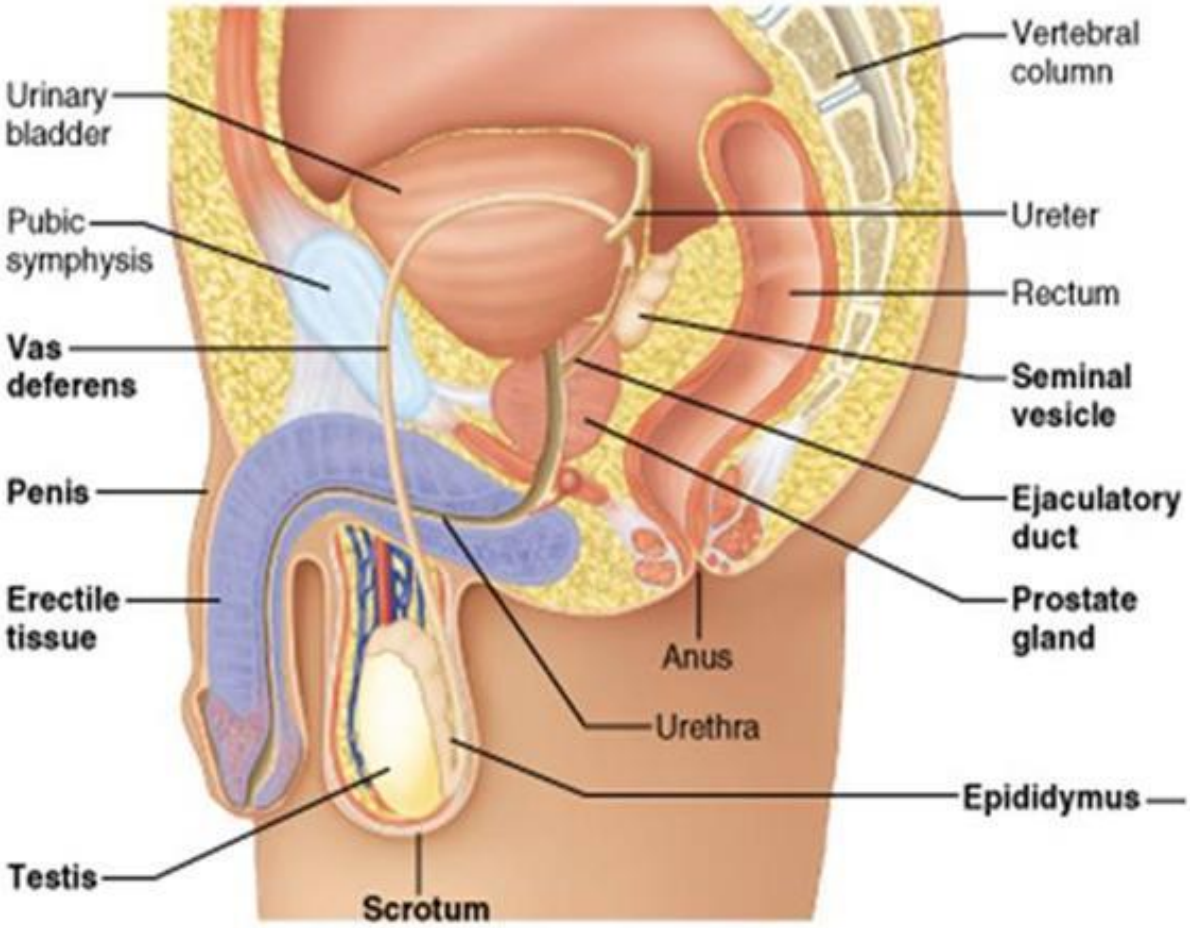
Citation: Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-4):1–66. DOI: http://dx.doi.org/10.15585/mmwr.rr6504a1.

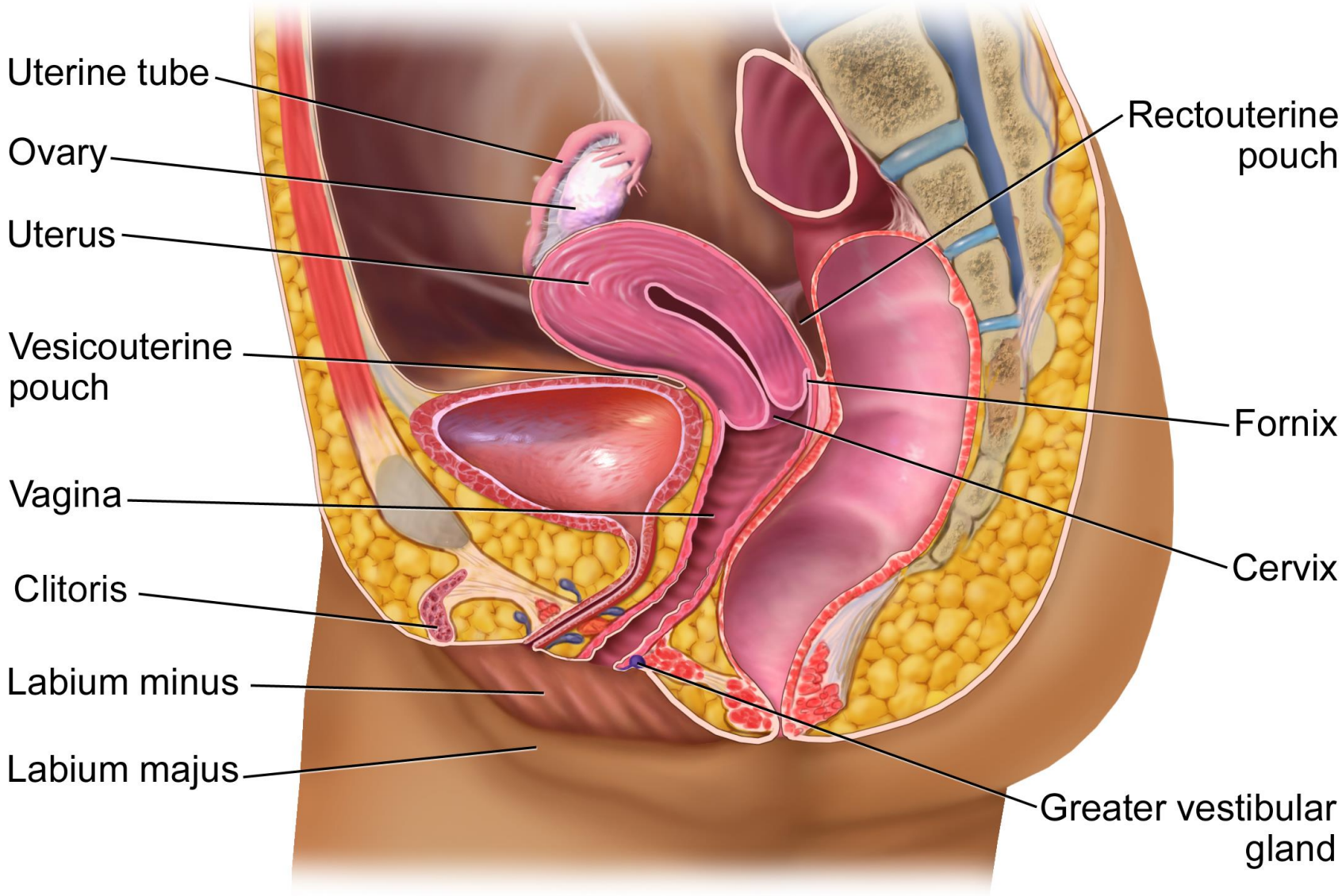
reproductive health access project

Birth Control for Men

Method	How well does it work? *	How to Use	Pros	Cons
Vasectomy 	> 99%	A clinician performs this procedure. It lasts for the rest of your life. Vasectomy works by blocking the tubes that carry sperm from the testes. This prevents sperm from entering the semen (come). After vasectomy, when the semen has no sperm, you don't need to do anything else to prevent pregnancy.	It reduces the worry of pregnancy and provides permanent and highly effective birth control. It can be done in the provider's office in 10-15 minutes. It's covered by most insurance. No general anesthesia No change in sexual function, erections, or feeling Does not affect male hormones	Does not protect against HIV and other sexually transmitted infections (STIs) Sperm may be present for up to 12 weeks after the procedure. Use a backup method until a semen test shows no sperm. Risks include infection and bleeding. Post-procedure pain may occur and you may need a day or two to recover. If you change your mind about wanting to have children, it's hard to reverse vasectomy.
Male Condom 	85-98%	Use a new condom each time you have sex. Use a non-latex condom if allergic to latex.	Can buy at many stores Can put on as part of sex play/ foreplay Can help prevent early ejaculation Can be used for oral, vaginal, and anal sex Protects against HIV and many other STIs	Can decrease sensation Can cause loss of erection Can break or slip off
Withdrawal ("pull out method")	73-96%	Pull penis out of vagina before ejaculation (that is, before coming).	Costs nothing	Less pleasure for some Does not work if the penis is not pulled out in time Does not protect against HIV or STIs Must interrupt sex
Female Condom 	79-95%	Use a new condom each time you have sex. Use extra lubrication as needed.	Can buy at many stores Can put in as part of sex play/ foreplay Can be used for anal and vaginal sex May increase pleasure when used for vaginal sex Good for people with latex allergy Protects against HIV and other STIs	Can decrease sensation May be noisy May be hard to insert May slip out of place during sex
Spermicide Cream, gel, sponge, foam, inserts, film 	71-85%	Insert spermicide each time you have sex.	Can buy at many stores Can insert as part of sex play/ foreplay Comes in many forms: cream, gel, sponge, foam, inserts, film	May raise the risk of getting HIV May irritate vagina, penis Cream, gel, and foam can be messy

The Male Reproductive System





The Female Reproductive System

Depo-Provera Perpetual Calendar

4-TIMES-A-YEAR DOSING FLEXIBILITY

[based on 3-month (13-week) dosing intervals, with the flexibility of dosing between weeks 11 and 13]

GIVEN	DUE
Jan 1	Mar 19 - Apr 2
Jan 2	Mar 20 - Apr 3
Jan 3	Mar 21 - Apr 4
Jan 4	Mar 22 - Apr 5
Jan 5	Mar 23 - Apr 6
Jan 6	Mar 24 - Apr 7
Jan 7	Mar 25 - Apr 8
Jan 8	Mar 26 - Apr 9
Jan 9	Mar 27 - Apr 10
Jan 10	Mar 28 - Apr 11
Jan 11	Mar 29 - Apr 12
Jan 12	Mar 30 - Apr 13
Jan 13	Mar 31 - Apr 14
Jan 14	Apr 1 - Apr 15
Jan 15	Apr 2 - Apr 16
Jan 16	Apr 3 - Apr 17
Jan 17	Apr 4 - Apr 18
Jan 18	Apr 5 - Apr 19
Jan 19	Apr 6 - Apr 20
Jan 20	Apr 7 - Apr 21
Jan 21	Apr 8 - Apr 22
Jan 22	Apr 9 - Apr 23
Jan 23	Apr 10 - Apr 24
Jan 24	Apr 11 - Apr 25
Jan 25	Apr 12 - Apr 26
Jan 26	Apr 13 - Apr 27
Jan 27	Apr 14 - Apr 28
Jan 28	Apr 15 - Apr 29
Jan 29	Apr 16 - Apr 30
Jan 30	Apr 17 - May 1
Jan 31	Apr 18 - May 2
Feb 1	Apr 19 - May 3
Feb 2	Apr 20 - May 4
Feb 3	Apr 21 - May 5
Feb 4	Apr 22 - May 6
Feb 5	Apr 23 - May 7
Feb 6	Apr 24 - May 8
Feb 7	Apr 25 - May 9
Feb 8	Apr 26 - May 10
Feb 9	Apr 27 - May 11
Feb 10	Apr 28 - May 12
Feb 11	Apr 29 - May 13
Feb 12	Apr 30 - May 14
Feb 13	May 1 - May 15
Feb 14	May 2 - May 16
Feb 15	May 3 - May 17

GIVEN	DUE
Feb 16	May 4 - May 18
Feb 17	May 5 - May 19
Feb 18	May 6 - May 20
Feb 19	May 7 - May 21
Feb 20	May 8 - May 22
Feb 21	May 9 - May 23
Feb 22	May 10 - May 24
Feb 23	May 11 - May 25
Feb 24	May 12 - May 26
Feb 25	May 13 - May 27
Feb 26	May 14 - May 28
Feb 27	May 15 - May 29
Feb 28	May 16 - May 30
Mar 1	May 17 - May 31
Mar 2	May 18 - Jun 1
Mar 3	May 19 - Jun 2
Mar 4	May 20 - Jun 3
Mar 5	May 21 - Jun 4
Mar 6	May 22 - Jun 5
Mar 7	May 23 - Jun 6
Mar 8	May 24 - Jun 7
Mar 9	May 25 - Jun 8
Mar 10	May 26 - Jun 9
Mar 11	May 27 - Jun 10
Mar 12	May 28 - Jun 11
Mar 13	May 29 - Jun 12
Mar 14	May 30 - Jun 13
Mar 15	May 31 - Jun 14
Mar 16	Jun 1 - Jun 15
Mar 17	Jun 2 - Jun 16
Mar 18	Jun 3 - Jun 17
Mar 19	Jun 4 - Jun 18
Mar 20	Jun 5 - Jun 19
Mar 21	Jun 6 - Jun 20
Mar 22	Jun 7 - Jun 21
Mar 23	Jun 8 - Jun 22
Mar 24	Jun 9 - Jun 23
Mar 25	Jun 10 - Jun 24
Mar 26	Jun 11 - Jun 25
Mar 27	Jun 12 - Jun 26
Mar 28	Jun 13 - Jun 27
Mar 29	Jun 14 - Jun 28
Mar 30	Jun 15 - Jun 29
Mar 31	Jun 16 - Jun 30
Apr 1	Jun 17 - Jul 1
Apr 2	Jun 18 - Jul 2

GIVEN	DUE
Apr 3	Jun 19 - Jul 3
Apr 4	Jun 20 - Jul 4
Apr 5	Jun 21 - Jul 5
Apr 6	Jun 22 - Jul 6
Apr 7	Jun 23 - Jul 7
Apr 8	Jun 24 - Jul 8
Apr 9	Jun 25 - Jul 9
Apr 10	Jun 26 - Jul 10
Apr 11	Jun 27 - Jul 11
Apr 12	Jun 28 - Jul 12
Apr 13	Jun 29 - Jul 13
Apr 14	Jun 30 - Jul 14
Apr 15	Jul 1 - Jul 15
Apr 16	Jul 2 - Jul 16
Apr 17	Jul 3 - Jul 17
Apr 18	Jul 4 - Jul 18
Apr 19	Jul 5 - Jul 19
Apr 20	Jul 6 - Jul 20
Apr 21	Jul 7 - Jul 21
Apr 22	Jul 8 - Jul 22
Apr 23	Jul 9 - Jul 23
Apr 24	Jul 10 - Jul 24
Apr 25	Jul 11 - Jul 25
Apr 26	Jul 12 - Jul 26
Apr 27	Jul 13 - Jul 27
Apr 28	Jul 14 - Jul 28
Apr 29	Jul 15 - Jul 29
Apr 30	Jul 16 - Jul 30
May 1	Jul 17 - Jul 31
May 2	Jul 18 - Aug 1
May 3	Jul 19 - Aug 2
May 4	Jul 20 - Aug 3
May 5	Jul 21 - Aug 4
May 6	Jul 22 - Aug 5
May 7	Jul 23 - Aug 6
May 8	Jul 24 - Aug 7
May 9	Jul 25 - Aug 8
May 10	Jul 26 - Aug 9
May 11	Jul 27 - Aug 10
May 12	Jul 28 - Aug 11
May 13	Jul 29 - Aug 12
May 14	Jul 30 - Aug 13
May 15	Jul 31 - Aug 14
May 16	Aug 1 - Aug 15
May 17	Aug 2 - Aug 16
May 18	Aug 3 - Aug 17

GIVEN	DUE
May 19	Aug 4 - Aug 18
May 20	Aug 5 - Aug 19
May 21	Aug 6 - Aug 20
May 22	Aug 7 - Aug 21
May 23	Aug 8 - Aug 22
May 24	Aug 9 - Aug 23
May 25	Aug 10 - Aug 24
May 26	Aug 11 - Aug 25
May 27	Aug 12 - Aug 26
May 28	Aug 13 - Aug 27
May 29	Aug 14 - Aug 28
May 30	Aug 15 - Aug 29
May 31	Aug 16 - Aug 30
Jun 1	Aug 17 - Aug 31
Jun 2	Aug 18 - Sept 1
Jun 3	Aug 19 - Sept 2
Jun 4	Aug 20 - Sept 3
Jun 5	Aug 21 - Sept 4
Jun 6	Aug 22 - Sept 5
Jun 7	Aug 23 - Sept 6
Jun 8	Aug 24 - Sept 7
Jun 9	Aug 25 - Sept 8
Jun 10	Aug 26 - Sept 9
Jun 11	Aug 27 - Sept 10
Jun 12	Aug 28 - Sept 11
Jun 13	Aug 29 - Sept 12
Jun 14	Aug 30 - Sept 13
Jun 15	Aug 31 - Sept 14
Jun 16	Sept 1 - Sept 15
Jun 17	Sept 2 - Sept 16
Jun 18	Sept 3 - Sept 17
Jun 19	Sept 4 - Sept 18
Jun 20	Sept 5 - Sept 19
Jun 21	Sept 6 - Sept 20
Jun 22	Sept 7 - Sept 21
Jun 23	Sept 8 - Sept 22
Jun 24	Sept 9 - Sept 23
Jun 25	Sept 10 - Sept 24
Jun 26	Sept 11 - Sept 25
Jun 27	Sept 12 - Sept 26
Jun 28	Sept 13 - Sept 27
Jun 29	Sept 14 - Sept 28
Jun 30	Sept 15 - Sept 29
Jul 1	Sept 16 - Sept 30
Jul 2	Sept 17 - Oct 1
Jul 3	Sept 18 - Oct 2

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Contraceptive Injection
medroxyprogesterone acetate injectable suspension

4 Times a Year

Depo-Provera Perpetual Calendar

4-TIMES-A-YEAR DOSING FLEXIBILITY

[based on 3-month (13-week) dosing intervals, with the flexibility of dosing between weeks 11 and 13]

GIVEN	DUE
Jul 4	Sept 19 - Oct 3
Jul 5	Sept 20 - Oct 4
Jul 6	Sept 21 - Oct 5
Jul 7	Sept 22 - Oct 6
Jul 8	Sept 23 - Oct 7
Jul 9	Sept 24 - Oct 8
Jul 10	Sept 25 - Oct 9
Jul 11	Sept 26 - Oct 10
Jul 12	Sept 27 - Oct 11
Jul 13	Sept 28 - Oct 12
Jul 14	Sept 29 - Oct 13
Jul 15	Sept 30 - Oct 14
Jul 16	Oct 1 - Oct 15
Jul 17	Oct 2 - Oct 16
Jul 18	Oct 3 - Oct 17
Jul 19	Oct 4 - Oct 18
Jul 20	Oct 5 - Oct 19
Jul 21	Oct 6 - Oct 20
Jul 22	Oct 7 - Oct 21
Jul 23	Oct 8 - Oct 22
Jul 24	Oct 9 - Oct 23
Jul 25	Oct 10 - Oct 24
Jul 26	Oct 11 - Oct 25
Jul 27	Oct 12 - Oct 26
Jul 28	Oct 13 - Oct 27
Jul 29	Oct 14 - Oct 28
Jul 30	Oct 15 - Oct 29
Jul 31	Oct 16 - Oct 30
Aug 1	Oct 17 - Oct 31
Aug 2	Oct 18 - Nov 1
Aug 3	Oct 19 - Nov 2
Aug 4	Oct 20 - Nov 3
Aug 5	Oct 21 - Nov 4
Aug 6	Oct 22 - Nov 5
Aug 7	Oct 23 - Nov 6
Aug 8	Oct 24 - Nov 7
Aug 9	Oct 25 - Nov 8
Aug 10	Oct 26 - Nov 9
Aug 11	Oct 27 - Nov 10
Aug 12	Oct 28 - Nov 11
Aug 13	Oct 29 - Nov 12
Aug 14	Oct 30 - Nov 13
Aug 15	Oct 31 - Nov 14
Aug 16	Nov 1 - Nov 15
Aug 17	Nov 2 - Nov 16
Aug 18	Nov 3 - Nov 17

GIVEN	DUE
Aug 19	Nov 4 - Nov 18
Aug 20	Nov 5 - Nov 19
Aug 21	Nov 6 - Nov 20
Aug 22	Nov 7 - Nov 21
Aug 23	Nov 8 - Nov 22
Aug 24	Nov 9 - Nov 23
Aug 25	Nov 10 - Nov 24
Aug 26	Nov 11 - Nov 25
Aug 27	Nov 12 - Nov 26
Aug 28	Nov 13 - Nov 27
Aug 29	Nov 14 - Nov 28
Aug 30	Nov 15 - Nov 29
Aug 31	Nov 16 - Nov 30
Sept 1	Nov 17 - Dec 1
Sept 2	Nov 18 - Dec 2
Sept 3	Nov 19 - Dec 3
Sept 4	Nov 20 - Dec 4
Sept 5	Nov 21 - Dec 5
Sept 6	Nov 22 - Dec 6
Sept 7	Nov 23 - Dec 7
Sept 8	Nov 24 - Dec 8
Sept 9	Nov 25 - Dec 9
Sept 10	Nov 26 - Dec 10
Sept 11	Nov 27 - Dec 11
Sept 12	Nov 28 - Dec 12
Sept 13	Nov 29 - Dec 13
Sept 14	Nov 30 - Dec 14
Sept 15	Dec 1 - Dec 15
Sept 16	Dec 2 - Dec 16
Sept 17	Dec 3 - Dec 17
Sept 18	Dec 4 - Dec 18
Sept 19	Dec 5 - Dec 19
Sept 20	Dec 6 - Dec 20
Sept 21	Dec 7 - Dec 21
Sept 22	Dec 8 - Dec 22
Sept 23	Dec 9 - Dec 23
Sept 24	Dec 10 - Dec 24
Sept 25	Dec 11 - Dec 25
Sept 26	Dec 12 - Dec 26
Sept 27	Dec 13 - Dec 27
Sept 28	Dec 14 - Dec 28
Sept 29	Dec 15 - Dec 29
Sept 30	Dec 16 - Dec 30
Oct 1	Dec 17 - Dec 31
Oct 2	Dec 18 - Jan 1
Oct 3	Dec 19 - Jan 2

GIVEN	DUE
Oct 4	Dec 20 - Jan 3
Oct 5	Dec 21 - Jan 4
Oct 6	Dec 22 - Jan 5
Oct 7	Dec 23 - Jan 6
Oct 8	Dec 24 - Jan 7
Oct 9	Dec 25 - Jan 8
Oct 10	Dec 26 - Jan 9
Oct 11	Dec 27 - Jan 10
Oct 12	Dec 28 - Jan 11
Oct 13	Dec 29 - Jan 12
Oct 14	Dec 30 - Jan 13
Oct 15	Dec 31 - Jan 14
Oct 16	Jan 1 - Jan 15
Oct 17	Jan 2 - Jan 16
Oct 18	Jan 3 - Jan 17
Oct 19	Jan 4 - Jan 18
Oct 20	Jan 5 - Jan 19
Oct 21	Jan 6 - Jan 20
Oct 22	Jan 7 - Jan 21
Oct 23	Jan 8 - Jan 22
Oct 24	Jan 9 - Jan 23
Oct 25	Jan 10 - Jan 24
Oct 26	Jan 11 - Jan 25
Oct 27	Jan 12 - Jan 26
Oct 28	Jan 13 - Jan 27
Oct 29	Jan 14 - Jan 28
Oct 30	Jan 15 - Jan 29
Oct 31	Jan 16 - Jan 30
Nov 1	Jan 17 - Jan 31
Nov 2	Jan 18 - Feb 1
Nov 3	Jan 19 - Feb 2
Nov 4	Jan 20 - Feb 3
Nov 5	Jan 21 - Feb 4
Nov 6	Jan 22 - Feb 5
Nov 7	Jan 23 - Feb 6
Nov 8	Jan 24 - Feb 7
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Nov 12	Jan 28 - Feb 11
Nov 13	Jan 29 - Feb 12
Nov 14	Jan 30 - Feb 13
Nov 15	Jan 31 - Feb 14
Nov 16	Feb 1 - Feb 15
Nov 17	Feb 2 - Feb 16
Nov 18	Feb 3 - Feb 17

GIVEN	DUE
Nov 19	Feb 4 - Feb 18
Nov 20	Feb 5 - Feb 19
Nov 21	Feb 6 - Feb 20
Nov 22	Feb 7 - Feb 21
Nov 23	Feb 8 - Feb 22
Nov 24	Feb 9 - Feb 23
Nov 25	Feb 10 - Feb 24
Nov 26	Feb 11 - Feb 25
Nov 27	Feb 12 - Feb 26
Nov 28	Feb 13 - Feb 27
Nov 29	Feb 14 - Feb 28
Nov 30	Feb 15 - Mar 1
Dec 1	Feb 16 - Mar 2
Dec 2	Feb 17 - Mar 3
Dec 3	Feb 18 - Mar 4
Dec 4	Feb 19 - Mar 5
Dec 5	Feb 20 - Mar 6
Dec 6	Feb 21 - Mar 7
Dec 7	Feb 22 - Mar 8
Dec 8	Feb 23 - Mar 9
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Dec 19	Mar 6 - Mar 20
Dec 20	Mar 7 - Mar 21
Dec 21	Mar 8 - Mar 22
Dec 22	Mar 9 - Mar 23
Dec 23	Mar 10 - Mar 24
Dec 24	Mar 11 - Mar 25
Dec 25	Mar 12 - Mar 26
Dec 26	Mar 13 - Mar 27
Dec 27	Mar 14 - Mar 28
Dec 28	Mar 15 - Mar 29
Dec 29	Mar 16 - Mar 30
Dec 30	Mar 17 - Mar 31
Dec 31	Mar 18 - Apr 1

Contraindicated in patients with known or suspected pregnancy or with undiagnosed vaginal bleeding.

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Original article

Beyond the Effects of Comprehensive Sexuality Education: The Significant Prospective Effects of Youth Assets on Contraceptive Behaviors

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A B S T R A C T

Purpose: The purpose of the study was to prospectively determine if youth assets were significantly associated with contraception use after accounting for the effects of youths' exposure to comprehensive sexuality education programming.
Methods: Prospective associations between youth asset scores, comprehensive sexuality education topics received, type of contraceptive used, and consistent contraceptive use were analyzed using multinomial and binomial logistic regression in a sample of 757 sexually active youth.
Results: Higher youth asset scores were associated with condom use (adjusted odds ratio [AOR] = 1.51, 95% CI = 1.01–2.28), hormonal birth control use (AOR = 2.71, 95% CI = 1.69–4.35), dual method use (AOR = 2.35, 95% CI = 1.44–3.82), and consistent contraceptive use (AOR = 1.97, 95% CI = 1.38–2.82). After controlling for youths' experience with comprehensive sexuality education, higher youth asset scores remained a significant predictor of hormonal birth control use (AOR = 2.09, 95% CI = 1.28–3.42), dual method use (AOR = 2.58, 95% CI = 1.61–4.15), and consistent contraceptive use (AOR = 1.95, 95% CI = 1.36–2.80).
Conclusions: Youth serving organizations that are interested in preventing teen pregnancy should consider widespread implementation of evidence-based youth development programs that focus on building and strengthening specific youth assets.

IMPLICATIONS AND CONTRIBUTION

Public health practitioners should consider widespread implementation of youth programs that develop and strengthen specific youth assets with the goal of increasing contraceptive use and reducing teen pregnancy.

Teen pregnancy has declined in the U.S. over the past 3 decades. Teen pregnancy rates peaked in 1990, with 117.6 pregnancies per 1,000 teens (aged 15–19 years) [1]. The 2011 rate, which is 52.4 pregnancies per 1,000 teens, illustrates the continued downturn of teen pregnancy [1]. However, despite the decline, the rates are still very high for U.S. black (93 pregnancies per 1,000 teens) and Hispanic teens

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(74 pregnancies per 1,000 teens), and the overall U.S. rate is the highest among 21 countries with complete data [1,2]. Researchers largely attribute the decline in the teen pregnancy rate to improvements in teens' contraception behavior rather than to delays in initiation of sexual intercourse [3,4].

Contraceptive behaviors among teens aged 15–19 years have evolved over the years. Declines in the teen pregnancy rate have been linked to moderate increases in the use of hormonal birth control, long-acting reversible contraceptives, and dual method use (the simultaneous use of a condom plus another modern method of contraception) [3,5]. These improvements are notable as hormonal birth control and dual method use have been found to be more effective in reducing pregnancies than condom use alone [6]. The identification of factors that predict contraceptive behavior has been more difficult.

Changes in contraceptive behavior have been attributed to fluctuations in the national economy, changing childbearing norms, availability of online sexuality and reproductive health information, and clinical recommendations from medical groups that make hormonal contraception more accessible to teens [3,4,7,8]. In addition, comprehensive sexuality education and youth development programs that focused on strengthening "youth assets" have been shown to have an impact on youths' contraceptive behavior [9–12].

Comprehensive sexuality education programs can positively influence teen contraceptive behaviors [9–11]. Reviews of teen pregnancy prevention programs from the Office of Adolescent Health and Manlove et al. [10] identified evidenced-based teen pregnancy prevention programs that impacted recent condom or contraceptive use and contraceptive consistency [11].

Despite the evidence supporting the effectiveness of comprehensive sexuality education programs in changing contraceptive behaviors, program implementation varies widely and remains controversial [13,14]. Currently, fewer than half (n = 24) of states require sexuality education programming and just 18 states require that information on contraception be provided in schools [14]. Recent national data reflect the downward trend in the implementation of sexuality education programming as fewer teens are receiving formal sexuality education in a school, church, or a community center setting than in the past [15]. Between 2006–2010 and 2011–2013, significantly fewer ($p < .05$) adolescent females reported receiving formal education regarding birth control (70% vs. 60%), saying no to sex (89% vs. 82%), sexually transmitted diseases (94% vs. 90%), and HIV/AIDS (89% vs. 86%) [15]. Similarly, significantly fewer ($p < .05$) males report receiving formal education regarding methods of birth control than in the past (61% vs. 55%) [15].

As the implementation of sexuality education programming declines and remains contentious, the continued identification of additional approaches that have an impact on youth contraceptive behaviors is critical if the field is to continuing experiencing declines in the teen pregnancy rate. Youth development programs that focus on strengthening youth assets may be one such approach.

More holistic than traditional comprehensive sexuality education programs, effective youth development programs aim to prepare youth for adult life by providing opportunities and experiences that promote prosocial bonding and build cognitive, social, behavioral, and emotional competencies [16–18]. Youth development programs attempt to reduce risky sexual behaviors by strengthening "youth assets." Youth assets are community, family, and individual factors that help youth avoid risk behaviors and increase the likelihood that they will successfully transition into adulthood [19]. Youth asset interventions can reduce youth participation in risky sexual behavior, and they lack the sexuality and reproductive health content typically found in comprehensive sexuality education programming and which some communities find controversial [17]. Research has shown that assets have a positive impact on youth sexual behaviors including delaying sexual initiation, pregnancy, and increasing birth control use [20–24]. For example, results from a longitudinal study indicate that some youth assets, such as aspirations for the future, self-confidence, peer, and nonparent adult role models and the ability to make responsible choices, increased the odds of birth control use (ranging from a 22% to 42% increase in odds) [20].

Youth development programs that focus on improving youth assets can impact youth sexual and contraceptive behaviors; and pregnancy and birth outcomes [10–12,16,17]. Recent reviews from the Office of Adolescent Health, Manlove et al., and Gavin et al. identified 17 youth development programs that impacted at least one reproductive health outcome. Although at least some of these programs address reproductive health topics, there is evidence to suggest youth development programs that do not include controversial sexuality education topics can still affect youth contraceptive behaviors [17]. For example, Raising Healthy Children is a multiyear social development program aimed at promoting bonding to school and peers by providing opportunities to strengthen youths' social competencies [25]. By age 21 years, African-American participants in the study (n = 349, 51% male, mean age = 10.8 years at baseline, 47% African-American) reported more frequent condom use than their single non–African-American peers in the comparison group [25]. Notably, these outcomes were achieved using a youth asset focus rather than sexuality education. Additional research is needed to determine the impact that youth assets can have on contraceptive behaviors in the absence of reproductive health content.

Despite the availability of youth development programs and the many organizations serving youth, relatively few are implementing evidenced-based youth development programs [26]. Additionally, few studies have examined the impact of the core constructs of youth development programs including youth assets such as peer, school, and community connectedness; parental monitoring; and aspirations for the future, on reproductive outcomes [26].

In summary, comprehensive sexuality education and youth development programs have been successful in improving teen contraceptive behaviors. Comprehensive sexuality education programs remain controversial in conservative communities and their implementation is in decline. Regrettably, despite their apparent effectiveness, evidence-based youth development programs that focus on assets have yet to be widely implemented in the teen pregnancy prevention field [13,26,27]. Youth development programs may be an acceptable alternative for communities that are not ready to implement comprehensive sexuality education and could lead to even further declines in teen pregnancy rates in those communities that do.

Data collected in the present study present a unique opportunity to prospectively evaluate the effect of youth assets on contraceptive use behavior of youth after statistically controlling for the effects of the youths' exposure to comprehensive sexuality education programming. The purpose of this is to determine if youth who possess multiple youth assets were significantly more likely to report a reliable contraception method or

consistent contraception use after accounting for the effects of the youths' exposure to comprehensive sexuality education. The results will provide important information to policy makers as well as to practitioners regarding the potential effectiveness of youth asset programming as a noncontroversial approach to preventing teen pregnancy with significant effects beyond those of comprehensive sexuality education.

Methods

Design

A Midwestern city was stratified by income and race/ethnicity using 2000 census data. Twenty census tracts with diverse race/ethnicity and socioeconomic populations were randomly selected. Participants were recruited for the study via door-to-door canvassing in each census tract. Data were collected annually from 2003 to 2008 for a total of five waves of data collected from 1,111 parent and youth dyads. Youth and parents were interviewed in-person, in their homes. The interviews were conducted using a computer-assisted data entry system. Asset data were collected from the youth via interviewer administered methods, whereas all sexual behavior–related data were collected from the youth via self-administered data collection methods. Youth listened to the recorded items on the laptop using headphones and entered responses into the laptop. This method minimized missing data, insured respondent confidentiality, and lessened the impact of potential low-level reading skills [28].

Inclusion criteria for the youth were being between 12 and 17 years old at baseline, living with a parent or guardian, English or Spanish proficiency, and mental competence to answer interview questions. A parent or guardian completed a consent and HIPPA form and youth completed an assent form. The study was approved by the Institutional Review Board at the University of Oklahoma Health Sciences Center. The response rate was 61% [29]. Wave 4 study data were used to predict youth contraceptive behaviors at wave 5. The analysis is limited to youth (n = 757) who were sexually active at wave 5.

Measures

Demographics. Basic demographic data were collected from the adolescents including age (continuous variable), race/ethnicity, and gender. Parent demographic variables included family structure (1, 2, or inconsistent-parent household), income, education, and employment status (yes/no).

Independent measures

Youth Assets. Seventeen youth assets were assessed using multi-item scales. The asset constructs were conceived and developed based on literature reviews, our previous research, and on psychometric testing [19,30]. The assets included responsible choices, educational aspirations for the future, general aspirations for the future, general self-confidence, religiosity, cultural respect, good health practices, family communication, relationship with mother, relationship with father, parental monitoring, nonparental adult role models, community involvement, positive peer role models, use of time (groups/sports), use of time (religion), and school connectedness.

Assets were reported as present (1) or absent (0) based on mean youth responses to the items included in the asset construct. Items that comprised each asset construct were generally scored from 1 to 4 (4 = the most positive response), and a youth was said to have the asset if the mean score was 3 or higher. A mean score of 3 or higher indicated the positive behavior was reported as "usually or almost always," "very important or extremely important," or "agree or strongly agree." The reliability of the asset constructs was adequate (Cronbach's alphas $>.70$ for 11 assets, $>.60$ and $\leq.70$ for 4 assets, and $>.55$ and $\leq.60$ for 2 assets) [19]. A dichotomous variable was created that assigned youth with fewer than the median number (11) of assets a low asset score with youth who possessed the median number of assets or greater a high asset score.

The 17 assets were tested for multicollinearity. Pearson correlation coefficients among the asset constructs ranged from .02 to .49. Only 4% were between .40 and .49; most (69%) were between .10 and .29 [19]. The results indicated there was no collinearity among the assets suggesting that each asset was distinct.

Comprehensive sexuality education. Comprehensive sexuality education was determined by assessing six sexuality education topics. The topics align with those used in previous studies to assess receipt of sexuality education and with topics addressed in the National Sexuality Education Standards [15,31,32]. Youth completed self-administered items that determined if they had ever been taught about the following sexuality education topics: (1) the female menstrual cycle; (2) how to say "no" to sex; (3) methods of birth control; (4) abstinence as a way to prevent sexually transmitted diseases; (5) sexuality as a natural and healthy part of life; and (6) signs and symptoms of sexually transmitted diseases. Response categories were "yes" or "no." Youth also completed items that determined where they received instruction about each sexuality education topic. Consistent with the literature, youth were considered to have received formal sexuality education if they received instruction in their "school"; "church, temple, or mosque"; "home"; or "youth organization" [15,31]. Sexuality education topics received in other informal settings were not considered. A dichotomous comprehensive sex education variable was created comparing youths who received all six sexuality education topics versus youth who received some or none of the sexuality education topics.

Dependent measures

Contraceptive behaviors. Youth self-administered the following items to assess contraceptive behaviors. "The last time you had sexual intercourse, did you or the other person use birth control?" Youth responding "no" were considered "no method users." "The last time you had sexual intercourse, what methods of birth control did you or your partner use?" [33] Method options included: "shot," "birth control pill," "patch," "ring," "condom," "withdrawal," "rhythm," and "other." For each method, response categories were "yes" or "no." Each youth was placed into one category based on their response: condom use only, hormonal birth control use only, dual method use, or less effective method. Youth responding "yes" to "condom," but "no" to other methods were considered condom users only. Youth responding "yes" to "birth control pill," "patch," "ring," or "shot," but "no" to other methods were considered hormonal birth

control users only. Dual method users were those who responded "yes" to condoms and "yes" to at least one of the hormonal birth control methods (birth control pill, shot, patch, or ring). Less effective methods were considered "rhythm" and "withdrawal." Sexual intercourse was defined in the survey as vaginal intercourse.

Consistent contraceptive use. This outcome was assessed by a self-administered item adapted from the literature "In the last 6 months, how often did you use birth control?" Response categories were never (0%), a few times (1%–40%), half the time (41%–60%), most times (61%–99%), or always (100%) used a method [34]. Consistent contraception users were those who indicated they "always" used a method.

Statistical analysis

The analyses for type of contraception method use were limited to youth (n = 757) who reported ever having had sexual intercourse at wave 5. The analysis for consistent contraceptive use was limited to a subset of the 757 youth (n = 635) who reported having had sex in the past 6 months (youth who responded "Have not had sex in the last 6 months" to the item assessing use of any methods in the last 6 months were excluded). All statistical analyses were performed using SAS 9.3 [35]. An alpha of .05 was used to determine statistical significance.

Multinomial logistic regression was performed to determine the relationship between receipt of comprehensive sexuality education and high youth asset scores and type of contraceptive used at last sexual intercourse. Logistic regression was used to determine the relationship between comprehensive sexuality education and high youth asset scores and contraceptive consistency. Next, to determine if youth who possess multiple youth assets were significantly more likely to report condom, hormonal birth control, or dual method use after accounting for the effects of the youths' exposure to comprehensive sexuality education, regression analyses were performed with both independent measures entered into the model, simultaneously. Each regression model was adjusted for potential confounding demographic variables including youth age, gender, race, parent education, family structure, and income that were significant in the bivariate relationship between the demographic variable and the outcome. To reduce type I error, potential interactions between the total asset or comprehensive sexuality education scores and demographic variables were assessed with an alpha of .01. There was no evidence of interaction in the regression models, and therefore, main effects are presented.

Results

Descriptive data

Demographic data for youth and parents (n = 757) at wave 4 are shown in Table 1. The youths' mean age was 17.5 years (SD = 1.6, range = 14–21 years). Youth were racially and ethnically diverse (37% white, 28% Hispanic, 26% African-American, and 8% other). Most youth lived in two-parent homes, had parents who were employed, and had a parental annual income of less than $35,000. The mean number of assets possessed by the youth participants was 11.1 (range = 1–17 assets), and the mean number of sexuality education topics received was 4.2. Most youth had received formal instruction about the female menstrual cycle (85%), how to say no to sex (83%), abstinence (77%), and birth control (75%). Fewer youth received formal instruction about sexually transmitted diseases (66%) and sexuality being a natural part of life (51%).

Table 1
Parent and youth demographic, asset total, comprehensive sexuality education, and descriptive data at wave 4

Measure	All (%)
Mean age (SD)	17.5 (1.6)
Gender	
Female	52.8
Race	
Non-Hispanic Caucasian or white	37.1
Non-Hispanic, African-American or black	26.4
Hispanic	28.3
Non-Hispanic, other	8.2
Family structure	
Two parent	54.6
One parent	23.8
Inconsistent	21.7
Parental education	
<High school education	16.3
High school education, general educational development, or some college	58.8
>High school education	25.0
Parental employment status	
Employed	74.7
Parental income	
<$35,000	51.3
$35,000–$62,000	27.9
>$62,000	20.7
Mean number of youth assets (SD), (range = 1–17)	11.1 (3.0)
Mean number of sex education topics (SD), (range = 0–6)	4.2 (1.8)
Female menstrual cycle	84.7
How to say no	83.0
Birth control	75.2
Abstinence	76.6
Sexuality as a natural part of life	52.2
Signs and symptoms of sexually transmitted diseases	66.4
Received all topics	29.8

Sample size was n = 757.

Among all sexually active youth, 41% did not use any method of protection at their last sexual intercourse (Table 2). At last sexual intercourse, most youth reported using condoms only (23%) or hormonal birth control only (18%). Fewer youth reported dual method use (16%) or using less effective methods (3%). Among youth who had sex in the last 6 months, 42% reported consistent contraceptive use. As anticipated from the literature, there were significant differences in type of contraceptive used by youth gender, race/ethnicity, and parent education and also in regard to consistent contraceptive use by youth race/ethnicity, income, parent education and income, and family structure (Table 2) [36]. These characteristics were statistically controlled for in the regression analyses.

Sexuality education and youth assets

As shown in Table 3, the regression models included comprehensive sexuality education and youth assets assessed at wave 4 predicting the type of contraceptive method used and contraceptive consistency assessed at wave 5 with the referent groups being no method used and inconsistent contraceptive use, respectively. After controlling for demographic factors, exposure

Table 2
Percentage of youth by each contraceptive behavior at last sex at wave 5 according to selected characteristics

Characteristic	Type of contraceptive used last time you had sex					Consistent contraception use	
	No method (%)	Less effective method (%)	Condom use only (%)	Hormonal birth control only (%)	Dual method use (%)	Yes, consistent contraception use (%)	No, inconsistent contraception use (%)
All	40.9	2.5	22.9	17.9	15.9	41.7	58.3
Demographic							
Age	17.4	18.2	17.3	17.8	17.5	17.6	17.4
Gender							
Female	42.9***	2.9***	21.0***	21.6***	11.7***	43.0	57.0
Male	38.6***	2.1***	25.0***	13.6***	20.8***	40.0	60.0
Race**							
Non-Hispanic Caucasian	39.4**	3.7**	16.8**	22.3**	17.9**	48.4**	51.7**
Non-Hispanic African-American	50.3**	.5**	20.9**	12.3**	16.0**	31.4**	68.6**
Hispanic	37.4**	2.5**	31.3**	16.2**	12.6**	41.4**	58.6**
Non-Hispanic other	29.3**	3.5**	29.3**	20.7**	17.2**	42.2**	57.8**
Income							
<$35,000	43.7	2.9	24.9	15.2	13.3	34.8**	65.2**
$35,000–$62,000	38.0	1.4	24.5	19.7	16.4	43.2**	56.8**
>$62,000	38.2	2.6	17.8	21.0	20.4	51.1**	48.9**
Parent education							
<HS education	40.0*	3.8*	25.7*	17.1*	13.3*	39.6**	60.4**
HS, GED, or some college	46.1*	1.7*	21.2*	16.5*	14.5*	36.3**	63.7**
Bachelor degree or>	30.4*	3.8*	23.9*	21.7*	20.1*	47.2**	52.8**
Family structure							
Two parent	37.4	1.8	24.0	21.1	15.7	46.4**	53.6**
One parent	42.1	2.3	23.4	14.6	17.5	38.2**	61.8**
Inconsistent	48.1	4.4	19.6	13.3	14.6	33.3**	66.7**
Parent employment							
Employed	39.3	2.1	23.1	18.9	16.6	42.9	57.1
Unemployed	45.3	2.9	21.2	16.5	14.1	36.8	63.2

Numbers are percentages except where noted.
Sample size was n = 757 for type of contraception use and n = 635 for consistent contraception use.
*$p < .05$, **$p < .01$, ***$p < .001$.

to comprehensive sexuality education significantly predicted increased condom use (adjusted odds ratio [AOR] = 2.12, 95% CI = 1.37–3.29) and it approached significance in regard to predicting an increase in dual method use (AOR = 1.65, 95% CI = 1.00–2.73). After controlling for demographic factors and assets, comprehensive sexuality education remained a significant predictor condom use (AOR = 2.05, 95% CI = 1.32–3.18), but not dual method use (AOR = 1.54, 95% CI = .93–2.55).

After adjusting for demographic factors, a high asset score significantly predicted condom use (AOR = 1.51, 95% CI = 1.01–2.28), hormonal birth control use (AOR = 2.71, 95% CI = 1.69–4.35), and dual method use (AOR = 2.35, 95% CI = 1.44–3.82). After controlling for demographic factors and receiving comprehensive sexuality education, a high asset score remained a significant predictor of hormonal birth control use (AOR = 2.09, 95% CI = 1.28–3.42) and dual method use (AOR = 2.58, 95% CI = 1.61–4.15).

In addition, a high asset score significantly predicted consistent contraceptive use (AOR = 1.97, 95% CI = 1.38–2.82). A high asset score remained a significant predictor of consistent contraceptive use (AOR = 1.95, 95% CI = 1.36–2.80) after controlling for demographic factors and receiving comprehensive sexuality education.

Table 3
Adjusted odds ratio (AOR) from multinomial and binomial logistic regression models for asset total and comprehensive sexuality education on youth contraceptive behavior outcomes

	AOR for comprehensive sexuality education (95% CI)	AOR for comprehensive sexuality education adjusted for youth assets (95% CI)c	AOR for high asset score (95% CI)	AOR for high asset score adjusted for comprehensive sexuality education (95% CI)[d]
Type of contraceptive used[a]				
No method	Reference	Reference	Reference	Reference
Less effective method	1.18 (.36–3.86)	1.19 (.36–3.90)	.86 (.31–2.39)	.68 (.23–1.99)
Condom use only	**2.12 (1.37–3.29)**	**2.05 (1.32–3.18)**	**1.51 (1.01–2.28)**	1.37 (.90–2.08)
Hormonal birth control use only	1.07 (.65–1.77)	1.00 (.60–1.66)	**2.71 (1.69–4.35)**	**2.09 (1.28–3.42)**
Dual method use[b]	1.65 (1.00–2.73)	1.54 (.93–2.55)	**2.35 (1.44–3.82)**	**2.58 (1.61–4.15)**
Consistent contraception use[c]				
Inconsistent contraceptive use	Reference	Reference	Reference	Reference
Consistent contraception use	.80 (.55–1.17)	.76 (.52–1.11)	**1.97 (1.38–2.82)**	1.95 (1.36–2.80)

The sample size was n = 757 for type of contraception use and n = 635 for consistent contraception use. Bold text = $p < .05$.
[a] Multinomial logistic regression adjusted for youth race and gender and parent education.
[b] Defined as participants responding "yes" to condoms and "yes" to at least one of the hormonal birth control methods (birth control pill, shot, patch, or ring).
[c] Binomial logistic regression adjusted for youth race, family structure, parent employment, income, and education.
[d] Multinomial and bionomial logistic regression models including assets and comprehensive sexuality education and adjusted for demographic characteristics.

Discussion

This study investigated the prospective associations of youth assets and comprehensive sexuality education and type of contraceptive method used and contraceptive consistency among youth who were sexually active. This study extends previous research of comprehensive sexuality education and youth assets, by considering the impact youth assets have on contraceptive behaviors after considering youths' experience with comprehensive sexuality education. After considering exposure to comprehensive sexuality education, a high asset score remained a significant predictor of hormonal birth control use (AOR = 2.09) and dual method use (AOR = 2.58) (relative to using no method) and consistent contraceptive use (AOR = 1.95).

These findings suggest that the odds of using the most effective methods of birth control and doing so consistently are significant even after considering youths' exposure to comprehensive sexuality education. The findings are particularly salient as improvements in the use of hormonal birth control and dual method are driving the declines in the teen pregnancy rate according to some researchers [3]. These results indicate that positive youth development programs that can help youth build assets can be an important part of improving the most effective contraceptive behaviors and helping youth use contraception more consistently even in the absence of reproductive health content.

The present study also extends the research of Oman et al. [20] by examining the association between multiple youth assets and other types of contraceptive methods used and contraceptive consistency. Sexually active youth with a high asset score had increased odds of condom use (AOR = 1.51), hormonal birth control use (AOR = 2.71), and dual method use (AOR = 2.35) (relative to using no method) compared to their peers who possessed fewer assets. A high asset score also increased the odds of consistent contraception use (AOR = 1.97).

Youth exposed to comprehensive sexuality education were twice as likely (AOR = 2.12) to use condoms (relative to using no method) as youth who did not receive comprehensive sexuality education. These findings agree with previous research that suggests comprehensive sexuality education programs and asset building programs can have a positive effect on youth contraceptive behaviors [9–12,17,22–24]. However, surprisingly, this study also found that comprehensive sexuality education was not associated with the use of more effective types of contraceptives including hormonal methods or consistent contraceptive use. This suggests a need for comprehensive sexuality education programs to not only provide instruction about condoms, but also to address the low-maintenance methods such as birth control implants, intrauterine devices, or injectables (Depo-Provera) that are more effective than condom use alone.

Limitations of this study include that it did not consider the quality of sexuality education received or which sexuality education topics best predict the use of the most effective forms of birth control or contraceptive consistency. Similarly, the setting and the person responsible for delivering the sexuality education were not considered in the study. Additionally, the findings of this study may be limited by the validity of self-reported contraceptive behaviors. Youth may report socially desirable behaviors that indicate responsible sexual activity, resulting in an over-reporting of contraceptive use. To reduce social desirability bias, teen respondents used a computer to self-report all sexual behaviors, without the interviewer present. Also, birth control implant and intrauterine device were not included as possible "other" forms of birth control, and therefore, dual method contraceptive use and hormonal birth control use may have been underestimated. Another limitation was that a few of the asset measures had low reliability which may have affected interpretation of the results. Finally, the 61% response rate may have introduced bias; for example, families with youth who possessed fewer assets or who engaged in more sexual risk behaviors may have been less likely to participate.

This research has important implications for additional research as well as practice. Continued research is necessary, using experimental research designs, to investigate the effectiveness of interventions intended to strengthen and increase youth assets. If the results of such studies are positive, youth development programs that do not include reproductive health topics may provide conservative communities with a socially acceptable strategy to improve teen contraceptive behaviors in their community. Additionally, public health practitioners may consider implementing traditional comprehensive sexuality education programs within a positive youth development framework by including mentorship activities, opportunities to belong and make a difference, provision of supportive relationships, and integration of family, school, and community efforts [37,38].

In conclusion, this study found that youth assets are positively associated with the use of effective forms of birth control (hormonal birth control and dual method use) and consistent contraceptive use, even after considering youths' experience with comprehensive sexuality education. Public health practitioners should consider widespread implementation of youth development programs that help build youth assets and ultimately promote contraceptive.

Human participant protection

This study underwent and received full review and approval from the Institutional Review Board of the University of Oklahoma Health Sciences Center.

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What does CONFIDENTIAL mean?

1) It means Private

2) You can trust that it will not be shared with others*

*Unless you talk about abuse, neglect, harming yourself or others, or other acts that must be reported to DCF by law

So what?

This means that if you go to the health office for condoms, answers to questions, or to find out about medical services, the conversation **remains private***!

Did you know?

In Vermont anyone 12 or older has the right to receive sexual & reproductive health services without parental permission. (18 V.S.A. § 4226)

While parental permission is not needed for these services, parents may find out if you use your health insurance.

We encourage all young people to have an adult that they trust to talk to about sexual health and relationships.

You have the right to birth control, STD testing and care, pregnancy tests, and more.

For more information, speak to _____ or visit us between:

_____a.m. and _____p.m.

This poster is intended to be customized by school nurses, health offices, and others who work with youth to identify when and to whom they can ask questions or have conversations about sexual health services.

VERMONT
AGENCY OF EDUCATION

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Healthy Relationship Quiz

EVERYONE DESERVES TO BE IN A SAFE AND HEALTHY RELATIONSHIP. DO YOU KNOW IF YOUR RELATIONSHIP IS HEALTHY? ANSWER YES OR NO TO THE FOLLOWING QUESTIONS TO FIND OUT. MAKE SURE TO CHECK THE BOXES TO RECORD YOUR RESPONSES. AT THE END, YOU'LL FIND OUT HOW TO SCORE YOUR ANSWERS.

THE PERSON I'M WITH	YES	NO
1. Is very supportive of things that I do.	○	○
2. Encourages me to try new things.	○	○
3. Likes to listen when I have something on my mind.	○	○
4. Understands that I have my own life too.	○	○
5. Is not liked very well by my friends.	○	○
6. Says I'm too involved in different activities.	○	○
7. Texts me or calls me all the time.	○	○
8. Thinks I spend too much time trying to look nice.	○	○
9. Gets extremely jealous or possessive.	○	○
10. Accuses me of flirting or cheating.	○	○
11. Constantly checks up on me or makes me check in.	○	○
12. Controls what I wear or how I look.	○	○
13. Tries to control what I do and who I see.	○	○
14. Tries to keep me from seeing or talking to my family and friends.	○	○
15. Has big mood swings, getting angry and yelling at me one minute but being sweet and apologetic the next.	○	○
16. Makes me feel nervous or like I'm "walking on eggshells."	○	○
17. Puts me down, calls me names or criticizes me.	○	○
18. Makes me feel like I can't do anything right or blames me for problems.	○	○
19. Makes me feel like no one else would want me.	○	○
20. Threatens to hurt me, my friends or family.	○	○
21. Threatens to hurt themselves because of me.	○	○
22. Threatens to destroy my things (Phone, clothes, laptop, car, etc.).	○	○
23. Grabs, pushes, shoves, chokes, punches, slaps, holds me down, throws things or hurts me in some way.	○	○
24. Breaks or throws things to intimidate me.	○	○
25. Yells, screams or humiliates me in front of other people.	○	○
26. Pressures or forces me into having sex or going farther than I want to.	○	○

love is respect org

Healthy Relationship

SCORING

GIVE YOURSELF ONE POINT FOR EVERY NO YOU ANSWERED TO NUMBERS 1-4, ONE POINT FOR EVERY YES RESPONSE TO NUMBERS 5-8 AND FIVE POINTS FOR EVERY YES TO NUMBERS 9 AND ABOVE.

NOW THAT YOU'RE FINISHED AND HAVE YOUR SCORE, THE NEXT STEP IS TO FIND OUT WHAT IT MEANS. SIMPLY TAKE YOUR TOTAL SCORE AND SEE WHICH OF THE CATEGORIES BELOW APPLY TO YOU.

0pts

You got a score of zero? Don't worry -- it's a good thing! It sounds like your relationship is on a pretty healthy track. Maintaining healthy relationships takes some work -- keep it up! Remember that while you may have a healthy relationship, it's possible that a friend of yours does not. If you know someone who is in an abusive relationship, find out how you can help them by visiting loveisrespect.org.

1-2pts

If you scored one or two points, you might be noticing a couple of things in your relationship that are unhealthy, but it doesn't necessarily mean they are warning signs. It's still a good idea to keep an eye out and make sure there isn't an unhealthy pattern developing.
The best thing to do is to talk to your partner and let them know what you like and don't like. Encourage them to do the same. Remember, communication is always important when building a healthy relationship. It's also good to be informed so you can recognize the different types of abuse.

3-4pts

If you scored five or points, you are definitely seeing warning signs and may be in an abusive relationship. Remember the most important thing is your safety — consider making a safety plan.
You don't have to deal with this alone. We can help. Chat with a trained peer advocate to learn about your different options at loveisrespect.org.

5pts

If you scored five or points, you are definitely seeing warning signs and may be in an abusive relationship. Remember the most important thing is your safety -- consider making a safety plan.
You don't have to deal with this alone. We can help. Chat with a trained peer advocate to learn about your different options at loveisrespect.org.

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