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 you 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:

## Adolescent Sexual Development

<table>
<thead>
<tr>
<th>STAGE</th>
<th>FACTS</th>
<th>TIPS</th>
</tr>
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<tbody>
<tr>
<td><strong>EARLY ADOLESCENCE</strong>&lt;br&gt;Females: 9-13 years&lt;br&gt;Males: 11-15 years</td>
<td>- Puberty/Concern with body changes and privacy.&lt;br&gt;- Development of first crush as a milestone to sexual orientation.&lt;br&gt;- Concrete thinking, but beginning to explore new ability to think abstractly.&lt;br&gt;- Sexual fantasies are common.&lt;br&gt;- Masturbation is common.&lt;br&gt;- Movement towards defining sexual identity.&lt;br&gt;- 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)</td>
<td>- Begin discussing healthy relationships using examples from friendships or concepts such as, “what are you looking for in a friend?”&lt;br&gt;- 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.”&lt;br&gt;- 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.&lt;br&gt;- Focus on issues that most concern this age group (weight gain, acne, physical changes).</td>
</tr>
<tr>
<td><strong>MIDDLE ADOLESCENCE</strong>&lt;br&gt;Females: 13-16 years&lt;br&gt;Males: 15-17 years</td>
<td>- Increasing concern with appearance.&lt;br&gt;- Peer influences are very strong in decision making.&lt;br&gt;- Experimentation with relationships and sexual behaviors is common.&lt;br&gt;- Concerned about relationships.&lt;br&gt;- Sexual intercourse is increasingly common. 44% of high school tenth graders and 56% of high school eleventh graders have had sexual intercourse.(^2)&lt;br&gt;- Increased abstract thinking ability.&lt;br&gt;- Full physical maturation is attained.&lt;br&gt;- Dating is common.&lt;br&gt;- Sexual behaviors do not always match sexual orientation.&lt;br&gt;- Often aware of theoretical risk but do not see self as susceptible.</td>
<td>- Listen more and talk less.&lt;br&gt;- Help teens identify the characteristics of a healthy relationship and assess their own relationship quality.&lt;br&gt;- Peer counseling can be effective with this age group.&lt;br&gt;- Focusing on health promotion, prevention and harm reduction is key.&lt;br&gt;- Avoid making assumptions about sexual orientation and behaviors.&lt;br&gt;- Help provide gay and lesbian youth with positive role models and support systems. Assess family response to youth’s sexual orientation.&lt;br&gt;- Be aware youth with disabilities, like their non-disabled peers, may be engaging in sexual behaviors and have questions around their sexual orientation.&lt;br&gt;- Reinforce parent-child communication about sexual decision making and forming healthy relationships.</td>
</tr>
<tr>
<td><strong>LATE ADOLESCENCE</strong>&lt;br&gt;Females: 16-21 years&lt;br&gt;Males: 17-21 years</td>
<td>- Firmer and more cohesive sense of identity.&lt;br&gt;- Attainment of abstract thinking.&lt;br&gt;- Ability to establish mutually respectful/trusting relationships.&lt;br&gt;- Firmer sense of sexual identity.&lt;br&gt;- Concern for the future.&lt;br&gt;- Feelings of love and passion.&lt;br&gt;- Increased capacity for tender and sensual love.</td>
<td>- More abstract reasoning allows for more traditional counseling approaches.&lt;br&gt;- Acknowledge and support healthy relationships or the choice to not be in a relationship.</td>
</tr>
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\(^2\) 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.


Sources:
2) Getting Organized: A Guide to Preventing Teen Pregnancy
**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.

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**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.

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   - 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
**FOR PROVIDERS: PRACTICE READINESS**

**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 talk 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.⁶
- 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**


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Adolescent Sexual and Reproductive Health in the United States

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.

<table>
<thead>
<tr>
<th>% of adolescents who have had sex</th>
<th>100</th>
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<tbody>
<tr>
<td>80</td>
<td></td>
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<tr>
<td>60</td>
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</table>
Contraceptive use at first sexual intercourse among 15–19-year-olds has risen steadily.

% using contraceptives at first sexual intercourse

- 100
- 80
- 60
- 40
- 20
- 0

<table>
<thead>
<tr>
<th>Year</th>
<th>Condom (alone or with other methods)</th>
<th>Other methods alone</th>
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<tbody>
<tr>
<td>1982</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>1988</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>2002</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>2006–2010</td>
<td>10%</td>
<td>90%</td>
</tr>
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**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.

- 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.

- In 2013, about 118 per 1,000 females aged 15–19 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate per 1,000 women</th>
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<td>1978</td>
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<td>1983</td>
<td>100</td>
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<td>1993</td>
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<thead>
<tr>
<th>Age Group</th>
<th>Rate per 1,000 women</th>
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<tr>
<td>15–17</td>
<td>50</td>
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<td>18–19</td>
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**Pregnancies Among U.S. Adolescents and Young Adults**

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

- In 2013, 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.

- In 2015, 50% of males and 50% of females aged 13–17 had received one or more doses of the vaccine against HPV.

- 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;
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.

- 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
125 Maiden Lane
New York, NY 10038
212.248.1111
info@guttmacher.org
www.guttmacher.org
“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.

**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.**


**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

**“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...
What might having sex make me popular?

How do I deal with pressure to have sex?

How will I know I’m in love?

How do I know I am ready for sex?
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.

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.
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 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 confirms 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.


“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
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.

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

“I get my information about sex from my friends and magazines.” Girl, 16

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.
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
Bake a heart-shaped dessert
Go through the car wash together
Rent a romantic movie

Make a handmade gift

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

Write a poem or a love letter

Send a loving text message
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.

Doctors, nurses, and other health care providers can:

diamond Encourage teens not to have sex.

diamond Recognize LARC as a safe and effective choice of birth control for teens.

diamond Offer a broad range of birth control options to teens, including LARC, and discuss the pros and cons of each.

diamond Seek training in LARC insertion and removal, have supplies of LARC available, and explore funding options to cover costs.

diamond 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
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

![Graph showing LARC use among teens ages 15-19](#)

SOURCE: Title X Family Planning Annual Reports, United States, 2005-2013.
FYI, without birth control, over 90 in 100 young women get pregnant in a year.

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 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.
WHAT'S THE RISK?

Risks of Using Birth Control

**Implant**
- **Implanon**

**IUD**
- Stick it in and forget it.

**Depo**
- Depo Provera

**The Pill**
- Birth control pills

**Risks**
- **Infection/Complication at Insertion or Removal**

**Accidental Pregnancy**
- 0.1 women/1,000

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

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

**Perforation**
- 8 women/1,000

**Reversible Bone Loss**
- With quick recovery when stopped, and no increased risk of broken bones

**Accidental Pregnancy**
- 60 women/1,000

**Blood Clots**
- 1 woman/1,000

**Stroke**
- 0.2 women/1,000

**Heart Attack**
- 0.1 women/1,000

**Accidental Pregnancy**
- 90 women/1,000

**C-section**
- 329 per 1,000 women/year

**Serious Cuts/Tears**
- 82 per 1,000 women/year

**Excessive Bleeding**
- 42 per 1,000 women/year

**Gestational Diabetes**
- 1 per 1,000 women/year

**High Blood Pressure**
- 39 per 1,000 women/year

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:
Recommended Actions After Late or Missed Combined Oral Contraceptives

If one hormonal pill is late: (<24 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 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.

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.
- 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.

**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.

**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 removal occurred in the third week of ring use:
  - Omit the hormone-free week by finishing the third week of ring use (keeping the same patch change day) 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.

*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.

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 breastfeeding), 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

<table>
<thead>
<tr>
<th>Contraceptive method</th>
<th>When to start (if the provider is reasonably certain that the woman is not pregnant)</th>
<th>Additional contraception (i.e., back up) needed</th>
<th>Examinations or tests needed before initiation¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copper-containing IUD</td>
<td>Anytime</td>
<td>Not needed</td>
<td>Bimanual examination and cervical inspection²</td>
</tr>
<tr>
<td>Levonorgestrel-releasing IUD</td>
<td>Anytime</td>
<td>If &gt;7 days after menses started, use back-up method or abstain for 7 days.</td>
<td>Bimanual examination and cervical inspection²</td>
</tr>
<tr>
<td>Implant</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 7 days.</td>
<td>None</td>
</tr>
<tr>
<td>Injectable</td>
<td>Anytime</td>
<td>If &gt;7 days after menses started, use back-up method or abstain for 7 days.</td>
<td>None</td>
</tr>
<tr>
<td>Combined hormonal contraceptive</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 7 days.</td>
<td>Blood pressure measurement</td>
</tr>
<tr>
<td>Progestin-only pill</td>
<td>Anytime</td>
<td>If &gt;5 days after menses started, use back-up method or abstain for 2 days.</td>
<td>None</td>
</tr>
</tbody>
</table>

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

¹Weight (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.

²Most 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](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](http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf)).
## Routine Follow-Up After Contraceptive Initiation*

<table>
<thead>
<tr>
<th>Action</th>
<th>LNG-IUD or Cu-IUD</th>
<th>Implant</th>
<th>Injectable</th>
<th>CHC</th>
<th>POP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Follow-Up</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Routine Visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess the woman’s satisfaction with her current method and whether she has any concerns about method use.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>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).</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Consider performing an examination to check for the presence of IUD strings.</td>
<td>X</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Consider assessing weight changes and counseling women who are concerned about weight change perceived to be associated with their contraceptive method.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Measure blood pressure.</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>X</td>
<td>–</td>
</tr>
</tbody>
</table>

**Abbreviations:**
- CHC = combined hormonal contraceptive
- Cu-IUD = copper-containing intrauterine device
- IUD = intrauterine device
- LNG-IUD = levonorgestrel-releasing intrauterine device
- POP = progestin-only pills

*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](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)
**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

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

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.

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.
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.*

---

**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.
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.

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

<table>
<thead>
<tr>
<th>Types of Emergency Contraception</th>
<th>How well does it work?</th>
<th>How soon do I have to use it?</th>
<th>How do I use it?</th>
<th>Where can I get it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>ParaGard IUD</td>
<td>Almost 100% effective</td>
<td>Within 5 days</td>
<td>It’s placed in the uterus by a health care provider</td>
<td>From a health care provider</td>
</tr>
<tr>
<td>ella</td>
<td>Less effective if over 195 pounds. Try a ParaGard IUD.</td>
<td>ASAP (works better the sooner you take it, up to 5 days)</td>
<td>Take the pill as soon as you get it</td>
<td>From a health care provider</td>
</tr>
<tr>
<td>Plan B One-Step or a generic</td>
<td>Less effective if over 165 pounds. Try ella or ParaGard.</td>
<td>ASAP (works better the sooner you take it, up to 3 days)</td>
<td>Take the pill(s) as soon as you get it</td>
<td>At a pharmacy, no prescription needed</td>
</tr>
</tbody>
</table>

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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

<table>
<thead>
<tr>
<th>Method</th>
<th>How well does it work?</th>
<th>How to Use</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Implant</strong>&lt;br&gt;Nexplanon®&lt;br&gt;</td>
<td>&gt; 99%</td>
<td>A health care provider places it under the skin of the upper arm</td>
<td>Long lasting (up to 5 years)</td>
<td>No pill to take daily</td>
</tr>
<tr>
<td><strong>Progestin IUD</strong>&lt;br&gt;Liletta®, Mirena®, Skyla®and others</td>
<td>&gt; 99%</td>
<td>Must be placed in uterus by a health care provider</td>
<td>May be left in place for up to 12 years</td>
<td>No pill to take daily</td>
</tr>
<tr>
<td><strong>Copper IUD</strong>&lt;br&gt;ParaGard®&lt;br&gt;</td>
<td>&gt; 99%</td>
<td>Must be placed in uterus by a health care provider</td>
<td>May be left in place for up to 3 to 7 years, depending on which IUD you choose</td>
<td>No pill to take daily</td>
</tr>
<tr>
<td><strong>The Shot</strong>&lt;br&gt;Depo-Provera®&lt;br&gt;</td>
<td>94-99%</td>
<td>Get a shot every 3 months</td>
<td>Each shot works for 12 weeks</td>
<td>Private</td>
</tr>
<tr>
<td><strong>The Pill</strong></td>
<td>91-99%</td>
<td>Must take the pill daily</td>
<td>Can make periods more regular and less painful</td>
<td>Can improve PMS symptoms</td>
</tr>
<tr>
<td><strong>Progestin-Only Pills</strong>&lt;br&gt;</td>
<td>91-99%</td>
<td>Must take the pill daily</td>
<td>Can be used while breastfeeding</td>
<td>You can become pregnant right after stopping the pills</td>
</tr>
<tr>
<td><strong>The Patch</strong>&lt;br&gt;Ortho Evra®&lt;br&gt;</td>
<td>91-99%</td>
<td>Apply a new patch once a week for three weeks</td>
<td>Can make periods more regular and less painful</td>
<td>No pill to take daily</td>
</tr>
<tr>
<td><strong>The Ring</strong>&lt;br&gt;Nuvaring®&lt;br&gt;</td>
<td>91-99%</td>
<td>Insert a small ring into the vagina</td>
<td>One size fits all</td>
<td>Private</td>
</tr>
</tbody>
</table>

---

*Reproductive Health Access Project / February 2018 [www.reproductiveaccess.org](http://www.reproductiveaccess.org)*
<table>
<thead>
<tr>
<th>Method</th>
<th>How well does it work?</th>
<th>How to Use</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male/External Condom</td>
<td>82-98%</td>
<td>Use a new condom each time you have sex</td>
<td>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</td>
<td>Can decrease sensation  Can cause loss of erection  Can break or slip off</td>
</tr>
<tr>
<td>Female/Internal Condom</td>
<td>79-95%</td>
<td>Use a new condom each time you have sex</td>
<td>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</td>
<td>Can decrease sensation  May be noisy  May be hard to insert  May slip out of place during sex</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>78-96%</td>
<td>Pull penis out of vagina before ejaculation (that is, before coming)</td>
<td>Costs nothing  Can be used while breastfeeding</td>
<td>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</td>
</tr>
<tr>
<td>Diaphragm Caya® and Milex®</td>
<td>88-94%</td>
<td>Must be used each time you have sex  Must be used with spermicide</td>
<td>Can last several years  Costs very little to use  May protect against some infections, but not HIV  Can be used while breastfeeding</td>
<td>Using spermicide may raise the risk of getting HIV  Should not be used with vaginal bleeding or infection  Raises risk of bladder infection</td>
</tr>
<tr>
<td>Fertility Awareness Natural Family Planning</td>
<td>76-95%</td>
<td>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</td>
<td>Costs little  Can be used while breastfeeding  Can help with avoiding or trying to become pregnant</td>
<td>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</td>
</tr>
<tr>
<td>Spermicide Cream, gel, sponge, foam, inserts, film</td>
<td>72-82%</td>
<td>Insert spermicide each time you have sex</td>
<td>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</td>
<td>May raise the risk of getting HIV  May irritate vagina, penis  Cream, gel, and foam can be messy</td>
</tr>
<tr>
<td>Emergency Contraception Pills</td>
<td>58-94%</td>
<td>Works best the sooner you take it after unprotected sex</td>
<td>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 progesterin EC without a prescription</td>
<td>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</td>
</tr>
</tbody>
</table>
Quick Start Algorithm — Patient requests a new birth control method:

1. Pill, Patch, Ring, Injection

First day of last menstrual period (LMP) is:
- < 7 days ago.
  - Start pill/patch/injection today.
  - Unprotected sex since last LMP?
    - yes
      - Urine pregnancy test: negative*
      - Patient understands risk of early pregnancy and wants to start pill/patch/ring/injection today.
    - no
      - Start pill/patch/ring/injection today. Use backup method for 7 days.
      - Unprotected sex in the past 5 days?
        - yes
          - Offer levonorgestrel EC now.**
          - Offer ulipristal EC now.**
        - no
          - Offer levonorgestrel EC now.**
          - Offer ulipristal EC now.**
    - no
      - Two weeks later, urine pregnancy test is negative;* continue pill/patch/ring/injection.

2. Progestin IUD or Implant

First day of LMP is:
- < 7 days ago.
  - Insert IUD/implant today.
  - Unprotected sex since last LMP?
    - yes
      - Urine pregnancy test: negative*
      - Patient prefers pill/patch/ring as a bridge to the IUD/implant.
    - no
      - Two weeks later, urine pregnancy test is negative*

- > 7 days ago.
  - Insert IUD/implant today, 2 weeks after initial visit. Use backup method for 7 days.

* 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:

**3. Copper IUD**

First day of last menstrual period (LMP) is:

- **< 7 days ago.**
  - Insert IUD today.
  - Urine pregnancy test: negative*
    - Unprotected sex since LMP?
      - **< 7 days ago.**
        - Insert IUD today for EC and ongoing contraception.
      - **> 7 days ago or both < and > 7 days ago.**
        - Patient declines pill/patch/ring as a bridge to the IUD, understands risk of early pregnancy, and wants IUD today.
        - Insert IUD today.
      - **None.**
        - Patient prefers pill/patch/ring as a bridge to the IUD.
        - Two weeks later, urine pregnancy test is negative*
          - Insert IUD today, 2 weeks after initial visit.
          - Two weeks later, urine pregnancy test is negative*

- **> 7 days ago.**
  - Insert IUD today.

* 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.
<table>
<thead>
<tr>
<th>Method</th>
<th>How well does it work?</th>
<th>How to Use</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vasectomy</td>
<td>&gt; 99%</td>
<td>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.</td>
<td>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</td>
<td>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.</td>
</tr>
<tr>
<td>Male Condom</td>
<td>85-98%</td>
<td>Use a new condom each time you have sex. Use a non-latex condom if allergic to latex.</td>
<td>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</td>
<td>Can decrease sensation Can cause loss of erection Can break or slip off</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>73-96%</td>
<td>Pull penis out of vagina before ejaculation (that is, before coming).</td>
<td>Costs nothing</td>
<td>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</td>
</tr>
<tr>
<td>Female Condom</td>
<td>79-95%</td>
<td>Use a new condom each time you have sex. Use extra lubrication as needed.</td>
<td>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</td>
<td>Can decrease sensation May be noisy May be hard to insert May slip out of place during sex</td>
</tr>
<tr>
<td>Spermicide</td>
<td>71-85%</td>
<td>Insert spermicide each time you have sex.</td>
<td>Can buy at many stores Can insert as part of sex play/foreplay Comes in many forms: cream, gel, sponge, foam, inserts, film</td>
<td>May raise the risk of getting HIV May irritate vagina, penis Cream, gel, and foam can be messy</td>
</tr>
</tbody>
</table>
The Male Reproductive System

- Urinary bladder
- Pubic symphysis
- Vas deferens
- Penis
- Erectile tissue
- Testis
- Scrotum
- Vertebral column
- Ureter
- Rectum
- Seminal vesicle
- Ejaculatory duct
- Prostate gland
- Urethra
- Epididymus
- Anus
- Prostate gland
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]

<table>
<thead>
<tr>
<th>GIVEN</th>
<th>DUE</th>
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<tbody>
<tr>
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<td>Mar 19-Apr 2</td>
<td>Feb 16</td>
<td>May 4-May 18</td>
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<td>Jun 19-Jul 3</td>
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<td>Jan 2</td>
<td>Mar 20-Apr 3</td>
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</tbody>
</table>

Long-acting, Reversible

**Depo-Provera**

Contraceptive Injection

medroxyprogesterone acetate injectable suspension

4 Times a Year
### Depo-Provera Perpetual Calendar

**4-TIMES-A-YEAR DOSING FLEXIBILITY**

<table>
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<th>GIVEN</th>
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<td>Aug 17</td>
<td>Nov 2-Nov 16</td>
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<tr>
<td>Aug 18</td>
<td>Nov 3-Nov 17</td>
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</tbody>
</table>

GIVEN DUE

- GIVEN: Date of injection
- DUE: Dates when next injection should be scheduled

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

---

**Long-acting, Reversible**

**Depo-Provera Contraceptive Injection**

medroxyprogesterone acetate injectable suspension

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

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c Department of Biostatistics and Epidemiology, College of Public Health, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma
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Keywords: Youth assets; Comprehensive sexuality education; Youth development; Teen pregnancy prevention; Youth reproductive health

ABSTRACT

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.

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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.
(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].


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 (85% 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 (81% 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 continue 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 HIPAA 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 ≤.70 for 4 assets, and >.55 and ≤.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 (86%) were between .30 and .29 [19]. The results indicated there was no multicollinearity 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 contraceptive 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%).

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
to comprehensive sexuality education significantly predicted increased condom use (adjusted odds ratio [AOR] = 2.12, 95% CI = 1.37–2.99) 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 of condom use (AOR = 2.05, 95% CI = 1.32–4.38), but not dual method use (AOR = 1.54, 95% CI = 0.93–2.55).

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 = 2.69, 95% CI = 2.18–3.42) 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 2
Percentage of youth by each contraceptive behavior at last sex at wave 5 according to selected characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Type of contraceptive used last time you had sex</th>
<th>Consistent contraceptive use</th>
<th>No consistent contraceptive use (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No method (%)</td>
<td>Less effective method (%)</td>
<td>Condom use only (%)</td>
</tr>
<tr>
<td>All</td>
<td>40.9</td>
<td>2.5</td>
<td>22.9</td>
</tr>
<tr>
<td>Demographic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>17.4</td>
<td>18.2</td>
<td>17.3</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>42.9**</td>
<td>2.9***</td>
<td>21.0***</td>
</tr>
<tr>
<td>Male</td>
<td>38.0**</td>
<td>2.1***</td>
<td>25.0***</td>
</tr>
<tr>
<td>Race*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic Caucasian</td>
<td>39.4**</td>
<td>3.7**</td>
<td>16.8**</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>50.3**</td>
<td>5.3**</td>
<td>20.9**</td>
</tr>
<tr>
<td>African-American Hispanic</td>
<td>37.4**</td>
<td>2.5**</td>
<td>31.3**</td>
</tr>
<tr>
<td>Hispanic</td>
<td>29.3**</td>
<td>3.5**</td>
<td>29.3**</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$20,000</td>
<td>42.7</td>
<td>2.9</td>
<td>24.0</td>
</tr>
<tr>
<td>$20,000–$30,000</td>
<td>38.0</td>
<td>1.4</td>
<td>24.5</td>
</tr>
<tr>
<td>&gt;$30,000</td>
<td>38.2</td>
<td>2.6</td>
<td>17.8</td>
</tr>
<tr>
<td>Parent education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$15 education</td>
<td>40.0**</td>
<td>3.8**</td>
<td>25.7**</td>
</tr>
<tr>
<td>IS/GED or some college</td>
<td>46.1**</td>
<td>1.7**</td>
<td>21.2**</td>
</tr>
<tr>
<td>Family structure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two parents</td>
<td>37.4</td>
<td>1.8</td>
<td>24.0</td>
</tr>
<tr>
<td>One parent</td>
<td>42.1</td>
<td>2.3</td>
<td>23.4</td>
</tr>
<tr>
<td>Inconsistent</td>
<td>48.1</td>
<td>4.4</td>
<td>19.6</td>
</tr>
<tr>
<td>Parent employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>39.3</td>
<td>2.1</td>
<td>23.1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>45.3</td>
<td>2.9</td>
<td>21.2</td>
</tr>
</tbody>
</table>

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.

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

<table>
<thead>
<tr>
<th>Type of contraceptive used*</th>
<th>AOR for comprehensive sexuality education (95% CI)</th>
<th>AOR for comprehensive sexuality education adjusted for youth assets (95% CI)c</th>
<th>AOR for high asset score (95% CI)</th>
<th>AOR for high asset score adjusted for comprehensive sexuality education (95% CI)d</th>
</tr>
</thead>
<tbody>
<tr>
<td>No method</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Less effective method</td>
<td>1.18 (.36–3.86)</td>
<td>1.19 (.36–3.90)</td>
<td>.86 (.31–2.39)</td>
<td>.68 (.25–1.99)</td>
</tr>
<tr>
<td>Condom use only</td>
<td>2.12 (1.37–3.29)</td>
<td>2.05 (1.32–3.18)</td>
<td>1.51 (1.01–2.28)</td>
<td>1.37 (.90–2.08)</td>
</tr>
<tr>
<td>Hormonal birth control use</td>
<td>1.07 (.63–1.77)</td>
<td>1.00 (.60–1.66)</td>
<td>2.71 (1.69–4.35)</td>
<td>2.09 (1.28–3.42)</td>
</tr>
<tr>
<td>Dual method use</td>
<td>1.65 (1.00–2.75)</td>
<td>1.54 (.93–2.55)</td>
<td>2.35 (1.44–3.82)</td>
<td>2.58 (1.61–4.15)</td>
</tr>
<tr>
<td>Consistent contraceptive use</td>
<td>Reference</td>
<td>Reference</td>
<td>1.97 (1.38–2.82)</td>
<td>1.95 (1.36–2.80)</td>
</tr>
</tbody>
</table>

The sample size was n = 757 for type of contraception use and n = 635 for consistent contraception use. Bold text = p < .05.

* 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 binomial 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 contraceptive 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.

**Funding Sources**

The Youth Asset Study was supported by funding from the Centers for Disease Control and Prevention grant 5 U01 DP000132.

**References**


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.

What does CONFIDENTIAL mean?

1) It means Private

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

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

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*!

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.

VERMONT AGENCY OF EDUCATION
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.

FOR MORE INFORMATION, VISIT WWW.LOVEISRESPECT.ORG

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

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.

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.

This project described was supported by Grant Number 90EV0426 from the Administration on Children, Youth and Families, Family and Youth Services Bureau, U.S. Department of Health and Human Services. The opinions, findings, conclusions and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Administration on Children, Youth and Families, Family and Youth Services Bureau, U.S. Department of Health and Human Services.