

National Survey of Reproductive and Contraceptive Knowledge:

Request for Proposals

I. Introduction

The National Campaign to Prevent Teen and Unplanned Pregnancy is seeking proposals to conduct a nationally representative survey on knowledge, beliefs and myths pertaining to fertility and contraception among unmarried, young adults, age 18 to 29. On the basis of this solicitation, the Campaign intends to award a firm fixed price contract in early 2008 for the fielding of this survey, the creation of a documented data file that is sharable and user-friendly, the completion of basic descriptive analyses, and a final report that describes the data collection efforts and discusses the descriptive findings.

This survey will include a range of questions to assess respondents' understanding of the circumstances that can lead to a pregnancy, the likelihood a pregnancy will occur and the factors that may influence this outcome. In addition, respondents will answer a range of questions that identify the types of contraception they have heard of or are familiar with, their beliefs about method effectiveness and what constitutes effective use, and their fears of potential side effects. Finally, there will be a limited number of questions to identify respondents' basic socio-demographic characteristics, number of prior pregnancies and births, and contraceptive status, as well as their primary sources of information on reproductive health issues.

In assessing knowledge gaps, it will be critical to uncover not only topics for which the respondent has no information, but also the respondents' certainty in their own beliefs, and awareness of their own knowledge gaps. Also, it will be important for the survey to be grounded in a coherent conceptual/theoretical framework, rather than simply based on an ad hoc collection of questions.

The purpose of the National Campaign in commissioning this survey is to assess whether there are critical gaps in understanding with respect to sex, contraception and pregnancy, and *specifically, gaps that could place an individual at risk of an unplanned pregnancy.*¹ The Campaign anticipates that results from this project will in turn inform the development of concrete strategies, including specific and targeted public health education efforts, that strengthen individual understanding in these areas and ultimately help reduce the incidence of unplanned pregnancy in the United States.

We are interested in gathering data on both men and women, given that both genders obviously contribute to unplanned pregnancy. However, we recognize that the types of questions and efforts one would pursue in surveying men and women may differ widely, and we believe that the level of questions we can answer for men may be at a more preliminary stage. Furthermore, we cannot fully gauge whether the resources we anticipate having available for this project will be sufficient to support rigorous data collection for both men and women. Therefore, offerors are

¹ Note that, for purposes of this solicitation, unplanned pregnancy is used as a synonym for unintended pregnancy, even though the Campaign recognized in other forums these terms are sometimes defined differently.

instructed to first propose the efforts and costs needed to gather data on women, and secondly propose the additional efforts and costs needed to also bring men into the sample. Please see below for more detail.

II. Background

Founded in 1996, the National Campaign has, until recently, focused exclusively on preventing teen pregnancy. Since the 1990s, teen pregnancy and birth rates have decreased dramatically (even taking into account the uptick in the teen birth rate in 2006). But outcomes among young adults have been considerably more discouraging: their rate of unplanned pregnancy in 2001 is virtually identical to the 1995 level and is almost as high as the teen rate. While the *rate* of unplanned pregnancy is highest among teens, the largest *number* of such pregnancies is found among women 20 and over, and over 80 percent of abortions are to women 20 and above as well. As a result, the National Campaign has recently expanded its mission to address unplanned pregnancy, particularly among single, young adults, while retaining its intense focus on preventing teen pregnancy as well.

The National Campaign's goal is to improve the lives and future prospects of children and families and, in particular, to help ensure that children are born into stable, two-parent families who are committed to and ready for the demanding task of raising the next generation. Our specific strategy for reaching this goal is to prevent teen pregnancy and unplanned pregnancy among single, young adults. We support a combination of responsible values and behavior by both men and women and responsible policies in both the public and private sectors. If we are successful, child and family well-being will improve. There will be less poverty, more opportunities for young men and women to complete their education or achieve other life goals, fewer abortions, and a stronger nation.

Knowledge of fertility and contraception alone are not sufficient for preventing unplanned pregnancy, but clearly knowledge is an important and necessary element. Approximately half of all unplanned pregnancies occur to women who report using a method of contraception in the month of conception—about nine in 10 of these are estimated to result from inconsistent or incorrect method use. Moreover, among young women who had an unplanned pregnancy and were *not* using a method of contraception in the month they became pregnant, nearly half said that they did not think they could get pregnant.

However, we have little detailed data on young women and men's knowledge and perceived knowledge about fertility and contraception. The majority of existing surveys are limited to adolescents, and those surveys that do include adult respondents are either outdated or not nationally representative.

Please see Appendix A for a list of relevant articles and links to publications that speak to these issues. More about the National Campaign and its mission can be found at:

<http://www.thenc.org/>

III. Project Overview

Introduction. The efforts covered under this solicitation include the design and implementation of a nationally representative survey of unmarried young adults on knowledge and myths pertaining to fertility and contraception, all necessary efforts to assess and ensure data quality and respondent confidentiality, the construction and documentation of a data file that is sharable and user-friendly, and the tabulation of descriptive statistics on key summary measures. The project will last for 12 months, with preliminary results due within nine months.

Level of Funding. When contemplating survey designs and developing their proposals, offerors should consider that we anticipate funding this project at a level of approximately \$400,000. This should, however, be considered a general guide rather than an absolute amount. It signals, for example, that the Campaign does not intend to fund a large-scale survey based solely on in-person interviews. As a general rule, offerors should understand that the Campaign will view cost-effective proposals more favorably. However, our primary goal is to get scientifically credible data that support the level of analyses described below, and we will consider proposals above or below \$400,000 to the extent the offeror clearly demonstrates these are the costs necessary to meet this goal.

Target Population. It is the Campaign's hope that we can survey both young women and men; however, through this solicitation, we are seeking further guidance as to whether the cost of surveying both can be accommodated within our anticipated available funding, and how the proposed content for women and men might differ. Therefore, offerors are instructed to first describe the efforts and costs necessary to gather sufficiently detailed data on unmarried women (aged 18 to 29), and then describe the additional costs and efforts to also bring unmarried men (aged 18 to 29) into the sample. To the extent that bringing men into the sample far exceeds the general range of \$400,000, the Campaign may either dedicate the additional funds needed, or limit the scope of the project to strictly women. If sufficient funds are not available to cover both men and women in the detail described below, the project will focus on gathering highly reliable and sufficiently detailed data on women, rather than gathering less reliable and detailed data on men and women.²

Additional Details and Key Considerations. The list below describes other key considerations pertaining to the design and implementation of this project that should be addressed when developing proposals for this solicitation:

- Given that the level of resources available for this project is not sufficient to rely primarily on in-person interviews, it will be important to select a survey mode or combination of modes (e.g. web-based, mail-out or telephone) that is cost effective while also capable of producing reliable and representative data. Special consideration should be given to whether certain modes are particularly effective or ineffective in gathering sensitive information or in reaching particular subgroups of the population.

² Even if men are not a part of this survey sample, the Campaign would like to stress the critical importance of strengthening the focus on males in efforts to prevent teen and unplanned pregnancies. The Campaign has worked extensively to target adolescent males in its teen pregnancy prevention efforts, and we are planning a number of other efforts to further strengthen the focus on young men, including additional data gathering efforts, discussions with practitioners, and reviews of lessons learned from other fields working closely with men on public health issues.

- The survey sample will include unmarried women (and possibly men) age 18 to 29. The sample of women must support reliable estimates by key subgroups. These include groups defined by gender, race/ethnicity, socio-economic status, and possibly groups defined by other measures such as source of information, contraceptive status, prior births/pregnancies, and meta-cognition. Offerors are encouraged to propose other subgroups they feel are critical as well, keeping in mind that our ultimate goal is to target interventions and messages that will improve knowledge and prevent unplanned pregnancies. To the extent we also include men in the survey, we foresee that sample being less detailed, perhaps simply representative at the national level. This is because we believe the level questions we can answer for men at this stage is more preliminary.
- We anticipate a survey lasting 30 to 40 minutes (possibly shorter for men), including roughly 10 to 15 minutes of basic questions on demographic characteristics, number of prior pregnancies and births and current contraceptive status, although this is approximate and will depend on the mode of interview. The use of existing, field-tested, survey questions is encouraged to the extent appropriate, however the final instrument must be suitable to the survey mode, the audience targeted and the goals of this project. To the extent men are included in the survey, we anticipate the male survey content would differ substantially from that of women, and would be less detailed overall, but we encourage offerors to discuss what content they feel is appropriate for men and why (keeping in mind that the primary focus of this survey is fertility and contraceptive knowledge.)
- Overall, data quality and scientific rigor are a critical focus of this project. This includes sufficient efforts to address nonresponse and assess nonresponse bias, as well as careful attention to ensure that tabulation of weights and summary statistics appropriately reflect sample design.
- Survey design and implementation must meet rigorous standards for protecting data confidentiality and protection of human subjects, and must meet IRB approval. Contractor will be responsible for identifying an IRB they will work with, and should include the time and effort associated with applying for and obtaining IRB approval in their work plan and budget.
- The contractor should anticipate working closely and collaboratively with the Campaign as well as members of its research advisory panel during all phases of work, and particularly with respect to questionnaire design.

IV. Instructions for Submitting Proposal

Due Date: Proposals must be received by 4:30 pm, eastern standard time, February 19, 2008.

Point of Contact: Questions regarding this solicitation may be directed to Katy Suellentrop at: 202-478-8515 or ksuellentrop@thenc.org.

Method of Submission: Proposals may be submitted via hard-copy or electronic file. However, the Campaign is not responsible for any difficulties encountered by the applicant in transmitting electronic files.

Hard copy files may be mailed to or delivered to:

The National Campaign to Prevent Teen and Unplanned Pregnancy
Attn: Katy Suellentrop
1776 Massachusetts Ave., NW
Washington, DC 20036

Offerors submitting hard copy proposals are requested to provide four (4) copies at the time of submission, including one unbound.

Electronic files must be in Word or PDF format and may be e-mailed to:

ksuellentrop@thenc.org

E-mail submissions should include the words “National Survey” in the subject line.

Available References: Offerors are encouraged to consult the references listed in Appendix A or other materials related to reproductive health and knowledge in preparing their proposals.

Content of Proposal: Proposals shall include:

- A cover page, clearly stating the name and contact information of the applicant and any proposed partners, a one paragraph summary of the proposed survey and the total cost.
- A table of contents that clearly identifies each section and each attachment.
- A proposal narrative of no more than 30 pages double spaced (1 inch margins, 12 point font). Note that only the first 30 pages of proposal narrative will be considered in reviewing the application. Proposal narrative must include the following sections:
 - Description of proposed survey design and methodology, including justification for the proposed approach.
 - Work plan for all proposed efforts, including a time line for key milestones and deliverables, based on a 12 month performance period overall and a 9 month period for delivering preliminary results.
 - Budget and budget justification for the proposed work, broken out by major task and cost category (e.g. labor, other direct and indirect costs).
 - Staffing plan, including summary of qualifications for key personnel, their role and proposed time commitment to this project.
 - Description of institutional capabilities relevant to this project, including: (a) capacity to field major, high quality survey with limited start-up time; and (b) demonstrated knowledge of topics related to reproductive health and knowledge.
 - The additive costs and efforts for also including men in the sample. Offerors may

either discuss men separately within each section of the narrative, or include a final, separate section on men, so long as the information on women vs. women and men is clearly delineated and identified. Discussion of including men in the survey must include any issues related to the basic conceptual framework, sampling frame, sample mode, sample size, survey content, and costs.

- All necessary attachments. Attachments shall include:
 - CV's for all key personnel proposed for this project
 - Letters of commitment for any outside organization proposed to play a role
 - One-page summaries of other major survey efforts completed successfully

Additional guidance on presenting survey design and methodology. The National Campaign recognizes that designing a major survey requires significant effort, and expects that some of this effort will occur *post-award*. Therefore, applicants are *not* expected to submit as part of their proposals complete specifications for questionnaires, sample designs or survey plans. However, the proposal must describe the structure and scope of proposed survey data collection in sufficient detail for reviewers to assess whether it meets the Campaign's project objectives and satisfies the key considerations described above, and whether it is reasonable relative to the budget proposed. Furthermore, offerors must clearly demonstrate in their proposals that they possess the level of expertise and thorough understanding of activities necessary to implement such a survey. As noted above, offerors should first discuss these efforts with respect to gathering data on women, and then with respect to the additive efforts of also including men in the sample. Specifically, applicants should include in their discussion sufficient detail on:

- Proposed survey content. While this does *not* have to include fully specified survey questions, it should include a description of the types of items that would be included within the following general content areas. Offerors should present their description within a coherent conceptual/theoretical framework that is grounded in the existing literature, and are encouraged to include any other content areas they feel are critical:
 - Basic demographics including age, race/ethnicity, gender and SES
 - Number of prior pregnancies and births
 - Whether sexually active, current contraceptive use and method, and general source of contraceptive supplies (e.g., pharmacy, public clinic, etc)
 - Awareness of what contraceptive methods are available, how they're used and their effectiveness
 - Perceptions about the risk of side effects associated with various contraceptive methods and, in particular, how these risks are viewed in the relative context of other salient life events or risky behaviors (e.g. having an unplanned pregnancy).
 - Beliefs about the likelihood of getting pregnant in various situations
 - Confidence in one's own beliefs and awareness of knowledge gaps (do they know what they don't know?)
 - Primary sources of information on reproductive issues
- Proposed efforts to pilot test and finalize survey instrument

- The number of respondents to be sampled, expected number of completed interviews and evidence of sufficiency for subgroup analyses
- Proposed survey mode(s) with justification of the mode(s), implications for representativeness, and discussion of trade-offs compared to other possible modes
- Proposed sampling frame and design, including detail on clustering or stratification, and implications for data reliability and representativeness.
- Proposed efforts to enhance response/address nonresponse, and expectations for response rates and sampling error (with reference to a particular AAPOR standard for calculating response rates, www.aapor.org).
- Proposed efforts to safeguard data confidentiality and protect human subjects, including plans to secure IRB approval (note that offerors are responsible for identifying an IRB to work with).
- Proposed efforts to ensure data quality.
- Proposed efforts to transform survey responses into reliable and user-friendly data set, including creation of statistically appropriate weights.

V. Scope of Work

Below is the list of tasks the National Campaign anticipates will be completed under this project. Note that all deliverables under this contract will be subject to project officer approval. These tasks should factor into applicants' proposals and budgets accordingly:

Task 1. Project Initiation, Planning, and Management.

- 1.1 Review of background materials, particularly research findings or questionnaires on reproductive knowledge that the contractor it is not already familiar with.
- 1.2 Hold meetings with the National Campaign, including an initial project meeting as well as interim and final briefings in Washington DC, monthly conference calls between the contractor and the National Campaign, and additional correspondence with the Campaign as needed.
- 1.3 Submit final project work plan, based on plan submitted in original proposal and subsequent revisions agreed to by the National Campaign and contractor.
- 1.4 Monthly reports listing progress toward milestones and challenges encountered. Approximately 1 page and can be submitted via e-mail.

Task 2. Finalize Survey Design based on original proposal and subsequent discussions or developments post award.

- 2.1 Finalize sampling plan. Contractor shall submit fully a specified draft sampling plan that makes clear the implications for subsequent data quality and discusses trade-offs of different possible strategies. Contractor shall revise and resubmit as needed.
- 2.2 Finalize survey procedures. Contractor shall submit a detailed description of survey procedures, including interview mode(s), and methods to enhance response, ensure data quality and representativeness, and safeguard data confidentiality. Contractor shall revise and resubmit as needed.
- 2.3. Obtain IRB approval. Contractor shall complete all efforts necessary to identify an IRB, prepare and submit applications materials, and revise as needed until IRB approval is received. Contractor shall submit copies of the application package and final approval to the Campaign.

Task 3. Develop Survey Instruments and Modify as Needed

- 3.1 Develop survey instruments for women (and possibly men), based on proposed conceptual/theoretical model and drawing from existing surveys of fertility and contraceptive knowledge, as well as input from the National Campaign and other advisors. Survey questionnaire shall be appropriate for chosen interview mode(s) and target population.
- 3.2 Field test and revise survey instrument as needed.
- 3.2 Program any computer assisted interviewing technology as needed depending on survey mode(s), and revise as needed.

Task 4. Train Interviewers

- 4.1 Recruit (if necessary) and train interviewers to ensure they have the necessary skills to conduct interviews, including familiarity with questionnaire and survey mode, computer-assisted technology, issues related to gathering sensitive information, and other skills as relevant.
- 4.2 Provide ongoing assessment of interviewer quality and implement any corrective action needed.

Task 5. Implement Survey

- 5.1 Field survey, and conduct all activities necessary as agreed to in Tasks 2 and 3,
- 5.2 Assess data quality and non-response, as agreed to in Tasks 2 and 3, and take corrective action as appropriate, including efforts to follow up with non-respondents.
- 5.3 Provide detailed field report to project officer approximately mid-way through field efforts, outlining progress, concerns thus far, and any recommendations for corrective actions. Include report on participant and item nonresponse.

Task 6. Preparation and Delivery of Data File and Documentation

- 6.1 Data entry of all survey responses into machine readable file, to the extent data were not already entered through computer-assisted interviewing.
- 6.2 Data editing efforts to include review of all respondent records for completeness and any potential problems (e.g., inappropriate skips, out-of-range values, input errors and logical inconsistencies), and appropriate corrective actions.
- 6.3 Data conversion efforts to include the design and implementation of all necessary steps to convert survey data to a file that can be analyzed using major statistical packages such as STATA or SAS. File shall include sample weights, identifiers for missing observations, and recodes to identify key subpopulations and analyze key concepts. Efforts shall also include any steps necessary to protect confidentiality of respondents, such that data can be shared publicly.
- 6.4 Data documentation to define each variable on the file, specify its location on the file and state the number of missing and nonmissing values. Documentation shall also include the code necessary to input data into SAS and STATA, complete with formatting and label statements. Items shall also include the final questionnaire. While the Campaign does *not* expect to receive a highly polished codebook, the documentation must be sufficient to enable Campaign staff or other researchers to use the data reliably and independently.

Task 7. Tabulation of Key Summary Measures.

- 7.1 Produce table shells specifying a limited number of key measures and subgroups for which summary statistics such as weighted and unweighted counts, means, standard errors and significance of differences across groups will be calculated. Revise as agreed to by the Campaign and contractor.
- 7.2 Produce summary statistics as specified in final table shells.

Task 8. Project Summary Document

- 8.1 Submit draft outline describing how the project summary document will be organized. Content areas should include, at a minimum, a brief overview of existing research on fertility and contraceptive knowledge as it relates to this project, the conceptual framework that guided this survey, summary information on the survey design and methodology, results from the tabulation of summary measures, and a discussion of those results highlighting findings of note and suggested implications. Revise as needed.
- 8.2 Submit draft report based on final outline.
- 8.3 Submit final report in response to comments on draft, and revise as needed.

VI. Period of Performance and Contract Structure:

The anticipated performance period under this contract will be 12 months from date of award, with initial summary tabulations of data expected within 9 months. This will be a firm fixed price contract.

VII. Project Officer

Katy Suellentrop, Senior Manager of Research Programs, will be the Project Officer for this contract. Questions about this solicitation may be directed to Ms. Suellentrop at 202-478-8515 or ksuellentrop@thenc.org.

VIII. Evaluation Criteria For Award

In reviewing applications, methodology and approach, staffing and personnel, budget and workplan, and organizational capacity will all factor prominently. The criteria to be used in reviewing applications and their relative importance are listed here and summarized in more detail below:

	Points
Methodology and Conceptual Approach	35
Staffing/Personnel Expertise and Experience	35
Budget and Work Plan	15
Organizational Capacity, Facilities and Equipment	15
TOTAL	100

Methodology and Conceptual Approach (35 Points Maximum)

Proposal should describe all activities related to survey content and design, data collection and file construction in sufficient detail to demonstrate that the proposed effort would result in a successful survey that meets the National Campaign’s project goals and addresses the key considerations described above. Discussion of proposed survey content and design should be grounded in a coherent conceptual/theoretical framework. Proposal must include discussion of efforts to secure IRB approval and protect data confidentiality.

Staffing/Personnel Expertise and Experience (35 Points Maximum)

Applicant’s staffing plan and description of key personnel should clearly reflect an understanding of the type of team needed to carry out this project at all personnel levels, and should demonstrate that key personnel collectively have expertise not only with respect to fielding a high quality, nationally representative survey but also with respect to reproductive health issues and cognitive theory. Staffing plan should clearly state the role and time commitment of all key personnel and summarize their relevant expertise. CV’s for all key personnel should be included as attachments.

Budget and Work Plan**(15 Points Maximum)**

Proposed budget and work plan should include sufficient detail to demonstrate that applicant understands the resources and efforts needed to successfully complete a survey of this scope. Budget narrative should delineate costs by major task and category of expense (e.g. labor, other direct and indirect) and demonstrate that they are reasonable and proposal is cost-effective. As noted above, the Campaign anticipates funding of approximately \$400,000 for this project, but this should serve as a general guide only, and proposals above or below this amount will be considered provided the costs are fully justified. Work plan should include a timeline and demonstrate that applicant can successfully complete all project deliverables within a 12 month period and can provide summary tabulations within nine months.

Organizational Capacity, Facilities and Equipment (15 Points Maximum)

Proposal should clearly demonstrate that the applicant and any partnering organizations collectively have the capacity necessary to develop, test and field the survey instrument, process the data, deliver a documented data file, and provide summary tabulations of results. If applicant is partnering with other organizations, the unique role of each partner should be described and letters of commitment for each partner should be included as attachments. Demonstrating that the requisite capacity for fielding a survey of this magnitude is already in place will be a plus. Proposal narrative should include a brief summary of other relevant survey efforts the applicant or partners have completed and include a one page description of each effort in the attachments.

XI. Further Considerations in the Award Process

The National Campaign will only consider those applicants receiving high scores under all four criteria described above. However, the Campaign will not necessarily choose the recipient based on exact rank ordering of scores. While the National Campaign anticipates awarding a survey contract pursuant to this solicitation in 2008, it reserves the right to make no award if no suitable applications are received or if other unforeseen circumstances arise.

Rights in Data: All data collected and findings tabulated from those data during the contract period become the property of the Campaign. However, upon the contract's completion and the Campaign's initial public release of findings, it is the Campaign's intent that the contractors would then have full discretion to complete and submit for publication further analyses they feel are informative. Following these activities and within a reasonable period following the data collection, the Campaign intends to make the data available to the public more generally.

Appendix A

General Information about Teen and Unplanned Pregnancy and Contraceptive Use

Finer, LB and Henshaw, SK (2006). Disparities in Rates of Unintended Pregnancy in the United States, 1994-2001. *Perspectives in Sexual and Reproductive Health*, 38 (2): 90-96;
<http://www.guttmacher.org/pubs/psrh/full/3809006.pdf>

Frost, JJ, Singh, S, and Finer, LB (2007). Factors Associated with Contraceptive Use and Nonuse, United States, 2004. *Perspectives in Sexual and Reproductive Health*, 39(2): 90-99;
<http://www.guttmacher.org/pubs/psrh/full/3909007.pdf>

Kost, K., Singh, S., Vaughan, B., Trussell, J., Bankole, A. (2008) Estimates of Contraceptive Failure from the 2002 National Survey of Family Growth, *Contraception*, 77(1): 10-21;
http://www.ncbi.nlm.nih.gov/pubmed/18082661?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum

Mosher, WD, Martinez, GM, Chandra, A, Abma, J, and Wilson, S. (2004). Use of Contraception and Use of Family Planning Services in the United States: 1982-2002, Advance Data from Vital and Health Statistics, Number 350; <http://www.cdc.gov/nchs/data/ad/ad350.pdf>

Abma JC, Martinez, GM, Mosher, WD., Dawson BS. (2004). Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, 2002. *Vital Health Statistics*, 23(24).
http://www.cdc.gov/nchs/data/series/sr_23/sr23_024.pdf

Contraceptive Knowledge and Behavior

Holmbeck, GN, Crossman, RE., Wandrel, ML., and Gaslewski, E. (1994). Cognitive development, egocentrism, self-esteem, and adolescent contraceptive knowledge, attitudes, and behavior. *Journal of Youth and Adolescence*, 23 (2) 169
http://www.ncbi.nlm.nih.gov/pubmed/12319314?ordinalpos=36&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum

Ryan, S, Franzetta, K, and Manlove, J (2007) Knowledge, Perceptions, and Motivations for Contraception: Influence on Teens' Contraceptive Consistency; *Youth Society* 39; 182;
<http://yas.sagepub.com/cgi/content/abstract/39/2/182>

Scott-Jones, D and Turner, S.L. (1988). Contraceptive Use among Black Adolescent Females Sex Education, Contraceptive and Reproductive Knowledge. *Journal of Adolescent Research* 3; 171

Biddlecom A; Munthali A; Singh S; Woog V (2006). Adolescents' knowledge, use of and barriers to sexual and reproductive health information and services in Burkina Faso, Ghana, Malawi and Uganda. Presented at the Population Association of America, 2006 Annual Meeting, Los Angeles, California, March 30 - April 1, 2006. 4 p. **Website:**
<http://paa2006.princeton.edu/download.aspx?submissionId=61071>

Other Surveys

Kaiser Family Foundation National Survey of Adolescents and Young Adults (2003)
<http://www.kff.org/youthhivstds/upload/National-Survey-of-Adolescents-and-Young-Adults.pdf>

Badan Pusat Statistik (BPS-Statistics Indonesia) and ORC Macro. (2004). *Indonesia Young Adult Reproductive Health Survey 2002-2003*. Calverton, Maryland, USA: BPS-Statistics Indonesia and ORC Macro. <http://www.cspro.org/pubs/pdf/FR157/00FrontMatter%2Epdf> (Please refer to Chapter 4 for specific questions about Knowledge)

Federal Ministry of Health, Nigeria (2003). *National HIV/AIDS and Reproductive Health Survey*. http://hivaidsclearinghouse.unesco.org/ev_en.php?ID=4258_201&ID2=DO_TOPIC (Please refer to pages 57-147)

Kaiser Family Foundation and SELF Magazine (2003). A National Survey of Women about Their Sexual Health <http://www.kff.org/womenshealth/3341-index.cfm>

Myths about fertility and contraception: A number of sources have listed common myths pertaining to sex and pregnancy and we've summarized those myths and the expert responses below.

Myth. "No" means "Yes." Expert's response: Many guys feel that they must take advantage of every sexual opportunity to prove their masculinity. In addition, they believe that most women who say "no" really mean "yes." As a result, "date rape" is very prevalent, though most cases go unreported. In fear of offending the man, some women may actually *smile* while saying "no," giving him conflicting messages. Others find it extremely difficult to openly say "no" and wind up in passively squirming and retreating without saying anything. The most effective and assertive response to an unwanted sexual advance would be to say, "Although I like you, I definitely do not want to have sexual intercourse." This does not damage the fellow's ego, and it indicates her wishes clearly and firmly. (Gershaw, David A., Ph.D. (1989) Adapted from Byer, Shainberg & Jones' *Dimensions of Human Sexuality*, Wm. C. Brown Publishers, 1988, page 397-399. A LINE David A., Ph.D. *Adolescent Sex Myths* <http://virgil.azwestern.edu/~dag/lol/Myths.Adolescent.htm>)

Myth. I can't get pregnant. Expert's response: Typically because of guilt feelings about sex, many sexually active teenagers make no (or inadequate) attempts at contraception. This myth is based on the lack of factual information plus the use of denial (unconsciously refusing to see a stressful situation) as a defense against anxiety. As may occur with driving, drugs or pregnancy, many adolescents have an illusion of invulnerability. Although it may happen to others, "it won't happen to me." In contrast, some unconsciously want a pregnancy — as proof of masculinity or femininity, desire for adult status, revenge toward parents or a former lover, or a fantasy that a baby will fulfill their need to be loved. (Gershaw, David A., Ph.D. (1989) Adapted from Byer, Shainberg & Jones' *Dimensions of Human Sexuality*, Wm. C. Brown Publishers, 1988, page 397-399. A LINE David A., Ph.D. *Adolescent Sex Myths* <http://virgil.azwestern.edu/~dag/lol/Myths.Adolescent.htm>)

Myth. Condoms allow no feelings. Expert's response: Many sexually active teenagers are resistant to using condoms (rubbers) for birth control. This is primarily true for those who have never used condoms. The younger boys listen to the older boys, mimic their words, and come to believe that "real men" are not supposed to like condoms. The reality is that they detract somewhat from the man's physical stimulation, but not from the woman's. However, anything that is perceived psychologically as unpleasurable (including condoms) can reduce the satisfaction in any interaction. Even so, this relates more to expectations of the situation rather than the physical effects of the condom. As an added feature, the latex condom (used correctly) is the best protection against sexually transmitted diseases — including AIDS — outside of abstaining from sex. (Gershaw, David A., Ph.D. (1989) Adapted from Byer, Shainberg & Jones' *Dimensions of Human Sexuality*, Wm. C. Brown Publishers, 1988, page 397-399. A LINE David A., Ph.D. *Adolescent Sex Myths* <http://virgil.azwestern.edu/~dag/lol/Myths.Adolescent.htm>)

Myth. Having sex in water (swimming pool, hot tub, shower) will kill sperm. Expert's response: Some of your swimmers may die, but it isn't an effective method of birth control, according to Dr. Pryor. Though a hot tub can overheat your testicles and kill sperm, there should be plenty left for the egg hunt.

(Van Bodegraven, Amy Jo:

<http://www.menshealth.com/cda/article.do?site=MensHealth&channel=sex.relationships&category=couples&conitem=184a99edbbbd201099edbbbd2010cfe793cd>)

Myth: There is nothing I can do *after* [unprotected sex](#) to prevent [pregnancy](#). Expert's response: *To prevent pregnancy, you can take EC up to 120 hours (five days!) after unprotected sex. EC may still be somewhat effective even after five days. You may have heard of EC as 'the morning-after pill' or 'postcoital contraception.'* EC is about 80 to 85 percent effective at preventing pregnancy (depending on the kind of EC you take, how soon you take it, and when during your cycle you had unprotected sex).

(<http://www.advocatesforyouth.org/youth/health/ec/mythsfacts.htm>)

Myth: EC causes [abortion](#). Expert's response: *EC does not cause abortion. EC will not affect an established pregnancy. Prominent medical associations agree that you are not pregnant until implantation—the time when a fertilized egg implants itself in the wall of your [uterus](#). Thus, emergency contraceptive pills cannot cause abortion because they have no effect on an implanted egg (or [embryo](#)). Then, too, the Society for Adolescent Medicine asserts that there is *no* evidence that EC has an effect on a fertilized egg, even before implantation. You can use EC after unprotected sex to *prevent*—but *not* to end—a pregnancy. EC pills use the same hormones as regular [oral contraceptives](#), including [progesterin](#) and, sometimes, [estrogen](#). By contrast, mifepristone (or RU 486), also known as the 'abortion pill,' is an *entirely different medication*. It contains [antiprogesteron](#)e in combination with other steroidal hormones.*

(<http://www.advocatesforyouth.org/youth/health/ec/mythsfacts.htm>)

Myth: EC is unsafe. Expert's response: *EC is very safe. EC works exactly the same as do regular oral contraceptives. In fact, emergency contraceptive pills are simply oral contraceptive pills, re-packaged for use in a specific way. Oral contraceptives are among the best-studied and safest drugs available today. The [Food & Drug Administration](#) (FDA) approved the [Yuzpe regimen](#) and [Plan B](#)[®] as safe and effective methods of emergency contraception. [Plan B](#)[®] currently is available in pharmacies and many family planning clinics. Some women experience mild side effects—like nausea, diarrhea, and fatigue—for a short period of time after taking EC. Even women who cannot take regular oral contraceptives for medical reasons are usually able to use EC. EC has few [contraindications](#):*

- Like regular oral contraceptives, EC causes *no* increased risk of [ectopic pregnancy](#) or of [birth defects](#).
 - EC does *not* interact negatively with other drugs and cannot cause addiction or drug dependency.
 - EC is not recommended if you are pregnant *only* because it will not prevent the pregnancy. EC will *not* harm the [embryo](#) or [fetus](#).
 - EC is not recommended if you have undiagnosed [vaginal bleeding](#) or suffer severe migraine headaches that interfere with your ability to carry on regular activities.
- (<http://www.advocatesforyouth.org/youth/health/ec/mythsfacts.htm>)

Myth: I need a parent's permission to get EC. Expert's response: *You don't need your parent's permission to get EC. In fact, teens in every state have the right to obtain emergency contraception without parental consent or notification. While some private physicians' offices and health clinics may require parental consent, all [Planned Parenthood clinics](#) and most health department clinics offer confidential contraceptive services to teens.* (<http://www.advocatesforyouth.org/youth/health/ec/mythsfacts.htm>)

Myth: EC can affect my future fertility. Expert's response: *Neither oral contraceptives nor EC affects your ability to get pregnant when you choose. EC is, in fact, regular oral contraception. After taking EC, you could have heavier or lighter bleeding, your cycle might start sooner or later than you expect, or you might see a difference in the length of your cycle. All these effects are temporary—after a month or so,*

your menstrual cycle should return to normal. If your period starts more than 21 days late, think about whether you might be pregnant and get a pregnancy test. Remember, EC will not affect a pregnancy that is already established, and it will not harm you or your baby.

(<http://www.advocatesforyouth.org/youth/health/ec/mythsfacts.htm>)

Myth: Using EC over and over is dangerous. Expert's response: *EC pills contain the same hormones as oral contraceptives and are similar to those your body produces naturally throughout life. While no one has specifically studied the effects of repeated use of EC (mostly because it occurs rarely), you can use regular oral contraceptives safely for extended periods of time without any negative effects. Your health care provider should be willing to prescribe EC for you when you need it, regardless of whether and how often you've needed it before.* (<http://www.advocatesforyouth.org/youth/health/ec/mythsfacts.htm>)

Myth: If I take EC, I am protected against pregnancy until my next period. Expert's response: *EC will only prevent pregnancy when it is taken within 120 hours (five days) AFTER unprotected sex. If you have unprotected sex after taking EC, you are again at risk for pregnancy. Be sure you use a barrier method of protection (a latex or polyurethane male or female condom) when having sex after taking EC. When your next cycle begins, choose a form of contraception that will be best for you and your partner.*

(<http://www.advocatesforyouth.org/youth/health/ec/mythsfacts.htm>)

Myth: EC is only effective up to 72 hours after unprotected sex. Expert's response: *EC is effective in preventing pregnancy up to 120 hours (five days) after unprotected sex. It may still be effective for even longer than five days. Still, it is very important you begin EC as soon as possible after unprotected sex.*

(<http://www.advocatesforyouth.org/youth/health/ec/mythsfacts.htm>)

Myth: I can't get EC until it is an emergency. Expert's response: *If you are age 18 or older, you can now get EC without a prescription from a pharmacy that carries it. You will need to show a government issued proof of age such as a driver's licence, passport or birth certificate. If you are under age 18, you can ask your health care provider for a prescription for EC at any time. Having a prescription or a supply of EC on hand before you need it helps ensure that you can take it as soon as possible after unprotected sex or contraceptive failure. When you get a prescription for EC filled, remember to check the expiration date. EC may have a short shelf life, and you shouldn't be stuck with something that is about to expire.*

(<http://www.advocatesforyouth.org/youth/health/ec/mythsfacts.htm>)

Myth: A woman can not get pregnant the first time she engages in coitus. Expert's response: A female can become impregnated during any form of sexual contact where sperm is able to reach the egg – even on the first time (<http://www.soc.ucsb.edu/sexinfo/?article=pregnancy&refid=002>)

Myth: Infrequent sexual intercourse will eliminate the chances of pregnancy. Expert's response: All it takes is once (<http://www.soc.ucsb.edu/sexinfo/?article=pregnancy&refid=002>)

Myth: It's risky to stop your period. Expert's response: Studies show it's safe to suppress your period using various methods: Seasonale, a pill that limits you to four periods a year; Seasonique, a similar pill that may help fight PMS; or others like Depo-Provera injections that may eliminate your period. "The hormones keep the lining of your uterus thin, so nothing builds up," says Rebecca Gould, M.D., an OB-GYN at Delaware County Memorial Hospital in Drexel Hill, Pennsylvania. Side effects that usually go away include breakthrough bleeding. Menstrual suppression is great for women with particularly heavy flows, painful cramps and menstrual migraines (Tiger, Caroline (2007). *10 myths about the pill busted*. Health.com (<http://www.cnn.com/2007/HEALTH/03/13/healthmag.pill/index.html>)

Myth: The pill ups your cancer risks. Expert's response: Actually, the risk of endometrial and ovarian cancers goes down the longer you're on the pill. After one year, endometrial-cancer risk decreases by 50

percent, and after just three to six months, ovarian-cancer risk decreases by 40 percent. After 10 years, the risks are 80 percent lower than normal. "The longer you keep the endometrium thin and the ovaries inactive, you are reducing the chance of the inappropriate cell division that characterizes cancer," says Katharine O'Connell, M.D., assistant clinical professor of OB-GYN at Columbia University. The pill may also lower the risk of colon cancer. What about breast cancer? The research is inconclusive. A recent review of previous studies, published in the Mayo Clinic Proceedings, suggests a tiny elevation in risk among current users, which disappears when you quit. (There's no debate for women who have -- or have had -- breast cancer: They should steer clear because the hormones can stimulate some cancerous cells. (Tiger, Caroline (2007). *10 myths about the pill busted*. Health.com <http://www.cnn.com/2007/HEALTH/03/13/healthmag.pill/index.html>)

Myth: The pill makes you fat (and frigid). Expert's response: Most women link the pill to weight gain, but only breakthrough bleeding is a proven side effect. (Women often put on pounds after getting the Depo-Provera injection.) As for libido, while some studies show a decreased sex drive, others show an increase -- a lower chance of pregnancy can be quite an aphrodisiac (Tiger, Caroline (2007). *10 myths about the pill busted*. Health.com <http://www.cnn.com/2007/HEALTH/03/13/healthmag.pill/index.html>).

Myth: An IUD ruins your fertility. The Dalkon Shield, pulled from the market in the 1970s, may have contributed to infections that led to infertility. It was also linked to 17 deaths. But not the new and safe IUDs, such as ParaGard and Mirena. Plus, they're more effective and cheaper than the pill. Cons? Pain during insertion (for about three minutes you'll feel a sensation akin to intense menstrual cramps), and cramps and bleeding that can occur for a week afterward. Also, there's an increased chance of infection during the first three weeks, usually because bacteria have been introduced during insertion; this can be easily treated with an antibiotic, though (Tiger, Caroline (2007). *10 myths about the pill busted*. Health.com <http://www.cnn.com/2007/HEALTH/03/13/healthmag.pill/index.html>)

Myth: The sponge is as good as the pill. Expert's response: The birth control sponge, which blocks the cervix and contains a spermicide, leaves much to chance. Its failure rate is 32 percent for women who have delivered a child vaginally (because the cervix is larger after childbirth); for those who haven't, the failure rate is 16 percent. For better protection, pair it with condoms (Tiger, Caroline (2007). *10 myths about the pill busted*. Health.com <http://www.cnn.com/2007/HEALTH/03/13/healthmag.pill/index.html>)

Myth: Long-term use of the pill is a no-no. Expert's response: Believe this myth and you may risk getting pregnant if you take a break. "This is how my brother was conceived," Gould says. There's no medical reason to stop. It's possible to get pregnant right away after quitting. Half of women get pregnant within three months -- a good reason not to take that break (Tiger, Caroline (2007). *10 myths about the pill busted*. Health.com. <http://www.cnn.com/2007/HEALTH/03/13/healthmag.pill/index.html>)

Myth: Pill side effects last forever. Expert's response: The first three months of any new hormonal birth control method bring side effects that eventually go away, Gould says. It's past month three and your doctor's telling you to "gut it out"? Time for a second opinion (Tiger, Caroline (2007). *10 myths about the pill busted*. Health.com <http://www.cnn.com/2007/HEALTH/03/13/healthmag.pill/index.html>)

Myth: It's OK to take any medicine with the pill. Expert's response: St. John's Wort, a popular supplement used for depression, cuts the pill's effectiveness. Researchers think the herb makes your body speed up the metabolism of the pill, preventing the hormones from doing their job. On the flip side, the pill may exaggerate antidepressant effects (Tiger, Caroline (2007). *10 myths about the pill busted*. Health.com. <http://www.cnn.com/2007/HEALTH/03/13/healthmag.pill/index.html>).

Myth: The pill makes migraines worse. Expert's response: No, but birth control pills may increase stroke risk in women who suffer from migraines with aura (added symptoms that include numbness, weakness, hallucinations, or blurred vision). For them, the mini-pill and other estrogen-free hormonal methods are OK (Tiger, Caroline (2007). *10 myths about the pill busted*. Health.com. <http://www.cnn.com/2007/HEALTH/03/13/healthmag.pill/index.html>)

Myth: A woman can't get pregnant if she doesn't have an orgasm. Expert's response: Getting pregnant has nothing to do with a woman having an orgasm. Conception occurs when a man's sperm fertilizes a woman's egg (<http://www.fertilitylifelines.com/fertilityhealth/myths.jsp>)

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