

The Odyssey Years

*Preventing Teen Pregnancy
Among Older Teens*

September 2010

By Katherine Suellentrop

Board of Directors

CHAIRMAN

The Honorable Thomas H. Kean

Chairman, The Robert Wood Johnson Foundation
CEO, THK Consulting
Chairman, The Carnegie Corporation of New York
former Governor of New Jersey

PRESIDENT

Isabel V. Sawhill, Ph.D.

Senior Fellow, Economic Studies
The Brookings Institution
CEO & Treasurer
Sarah S. Brown

MEMBERS

Robert Wm. Blum, M.D., Ph.D.

William H. Gates Sr. Professor and Chair
Department of Population and Family Health Sciences
Johns Hopkins University

Thomas S. Chappell

Senior Manager
Goodman & Company, LLP.

Linda Chavez

Chairman
Center for Equal Opportunity

Vanessa Cullins, M.D., M.P.H., M.B.A.

Vice President for Medical Affairs
Planned Parenthood Federation of America, Inc.

Susanne Daniels

Media Consultant

Amanda Deaver

Partner
Prism Public Affairs

Maria Echaveste

Senior Fellow
Center for American Progress

Daisy Expósito-Ulla

Chairman and CEO
d'expósito & partners

William Galston, Ph.D.

Senior Fellow, Governance Studies
The Brookings Institution

Ron Haskins, Ph.D.

Senior Fellow, Economic Studies
Co-Director, Center for Children and Families
The Brookings Institution
Senior Consultant, The Annie E. Casey Foundation

Nancy L. Johnson

Senior Public Policy Advisor
Federal Public Policy and Healthcare Group
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC

Judith E. Jones

Clinical Professor
Mailman School of Public Health
Columbia University

Jody Greenstone Miller

President and CEO
The Business Talent Group

Reverend Father Michael D. Place, STD

Senior Vice President
Social Mission & Ministerial Development
Resurrection Health Care

Bruce Rosenblum

President
Warner Bros. Television Group

Diane Rowland , Sc.D.

Executive Director
Kaiser Commission on Medicaid and the Uninsured

Victoria P. Sant

President
The Summit Foundation

Sara Seims, Ph.D.

Director, Population Program
The William and Flora Hewlett Foundation

Matthew Stagner, Ph.D.

Executive Director
Chapin Hall at the University of Chicago

Mary C. Tydings

Managing Director
Russell Reynolds Associates

Roland C. Warren

President
National Fatherhood Initiative

Stephen A. Weiswasser

Partner
Covington & Burling

Gail R. Wilensky, Ph.D.

Senior Fellow
Project HOPE

Kimberlydawn Wisdom, M.D.

Surgeon General, State of Michigan
Vice President, Community Health, Education & Wellness
Henry Ford Health System

Judy Woodruff

Senior Correspondent
PBS News Hour



The Odyssey Years

*Preventing Teen Pregnancy
Among Older Teens*

September 2010

By Katherine Suellentrop



Acknowledgements

The National Campaign to Prevent Teen and Unplanned Pregnancy wishes to acknowledge the Centers for Disease Control and Prevention (CDC), whose support made this publication possible through grant number U58/CCU324968-05. The contents of this report are solely the responsibility of the author and do not necessarily represent the official views of the CDC. I also gratefully acknowledge the input from numerous individuals who contributed their ideas and lessons learned for working with older teens along with insightful comments that strengthened this report. In particular I would like to thank Sharon Rodine from the Oklahoma Institute for Child Advocacy; Shannon Flynn, Polly Edwards, and Sarah Kershner from the South Carolina Campaign to Prevent Teen Pregnancy; Janet Realini and Yvette Sanchez from Healthy Futures of Texas; and Andrea Kane, Kelleen Kaye, and Bill Albert from The National Campaign to Prevent Teen and Unplanned Pregnancy. Thank you as well to Laetitia Lemoine from the University of North Carolina – Chapel Hill for her assistance identifying programs targeted to older teens and with the charts and other aspects of the report more broadly. The findings, conclusions, and opinions presented in this report are solely the responsibility of The National Campaign to Prevent Teen and Unplanned Pregnancy and do not necessarily represent the views of our funders or the individuals who commented on this report.

Katherine Suellentrop is the Assistant Director of Research at The National Campaign, where she oversees the daily activities of the department's research projects, helps shape its portfolio, and contributes to numerous Campaign publications. Prior to joining the Campaign, Ms. Suellentrop was an Association of Schools of Public Health Fellow with the Centers for Disease Control and Prevention. Ms. Suellentrop received a Bachelor of Arts in Biology from Northwestern University and a Masters of Public Health from Emory University.

© 2010 The National Campaign to Prevent Teen and Unplanned Pregnancy.
All rights reserved.

ISBN: 1-58671-079-6

Suggested citation: Suellentrop, K. (2010). *The Odyssey Years: Preventing Teen Pregnancy Among Older Teens*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.

This publication was designed by Nancy Bratton Design:
www.nancybrattondesign.com

Contents

4	Introduction
6	Section 1. Pregnancy and Childbearing Among Older Teens
12	Section 2. Setting the Stage: The Lives and Context of Older Teens
22	Section 3. Sexual and Contraceptive Behavior, Knowledge, and Attitudes
34	Section 4. Working With Older Teens and Young Adults
51	Conclusion
52	References
54	Appendix 1: Data Sources

Introduction

Despite a 39 percent decrease in the teen pregnancy rate and a one-third reduction in the teen birth rate since the early 1990s, recent data suggest that progress has stalled. Between 2005 and 2006 both the teen pregnancy and teen birth rate increased for the first time since the early 1990s [1, 2]. Teen birth rates continued to increase in 2007 (data on teen pregnancy rates are not available beyond 2006) before declining slightly in 2008. Teen birth and pregnancy rates in the United States remain among the highest of all industrialized countries and it remains the case that three in 10 girls in the United States get pregnant by age 20. These trends are worrisome because the majority of teen pregnancies in this country are unplanned, are to unmarried mothers, and are associated with serious hardship for both child and parent.

Older teens (ages 18–19) account for the vast majority of teen pregnancies and births, and their trends have been more discouraging than for younger teens overall. Compared to their younger peers, older teens experienced smaller declines in teen pregnancy and birth rates through 2005, and recent increases in their teen birth rates are larger. Yet, few efforts have addressed teen pregnancy prevention specifically among this age group. This lack of attention may be due to the challenges reaching this group, lack of political and/or community will to address pregnancy prevention among this age group, and limited evidence of effective programs for teens in this age group.

Approximately two-thirds of all teen pregnancies and births are to older teens.

This report:

- documents the importance of increasing the focus on older teens within teen pregnancy prevention efforts,
- provides a detailed portrait of their characteristics, attitudes, and behavior that any such efforts will need to address, and
- summarizes the experiences and lessons learned by those in the field who have worked with older teens.

In addition to trends in teen pregnancy and birth rates, this report provides detailed new information on older teens' knowledge, attitudes, behavior, and expectations related to relationships, sex, and contraception. The final section of this report includes lessons learned and examples from organizations who have actively sought to increase pregnancy prevention efforts among this age group, and takes a closer look at strategies that have been developed and found to effectively change behavior related to teen pregnancy prevention among older teens.

Why Care About Pregnancies and Births to Older Teens?

Fully eight in ten pregnancies to older teens are unplanned, and the vast majority of births to older teens are to unmarried women. In fact, in 2008 there were nearly 250,000 births to unmarried older teen women—83 percent of all births to 18–19 year-olds [3]. Pregnancy and childbearing among older teens is closely linked to a host of other critical social issues, including poverty and income disparity, overall child

KEY FACTS

- Pregnancy rates for older teens are more than *three* times the rate for younger teens.
- Approximately two-thirds of all teen pregnancies and births are to older teens.
- The majority of older teens have had sex, and approximately half are currently involved in a sexual relationship.
- Most teens use some form of birth control, but many do not use it very well.
- Older teens are aware of a wide variety of birth control options, but misinformation and misperceptions about these options are widespread.
- Many older teens have concerns about the side effects of various contraceptive methods. They also tend to underestimate the potential benefits of contraception, including its effectiveness for preventing pregnancy.
- Children born to older teen mothers fare worse than those born to mothers in their early twenties.
- While older teens are technically adults, few report that they have reached adulthood as they define it—most older teens are still attending school and many still live at home with their parents.
- Romantic relationships are an important aspect of older teens' lives and might influence the type of contraceptive methods that they use, as well as their consistency of contraceptive use.
- Working with and reaching older teens requires a slightly different strategy than one used for younger teens. Some states and communities have focused on this population and have important lessons learned that are helpful for those interested in including older teens in teen pregnancy prevention work.
- While few programs have been developed that focus specifically on 18–19 year-olds, there are evidence-based programs that have been developed for young adults more broadly that have been found to effectively change behavior among older teens.

well-being, and education to name just a few. While the risks tend to be more severe for young teen mothers, they remain significant for older teen mothers as well [4]. For example, compared to children of mothers age 20–21, children born to older teen mothers are more likely to be placed in foster care or to have a report of abuse or neglect in the first five years after birth. Children of mothers age 18–19 are also slightly less likely to graduate from high school themselves compared to their peers who are born to mothers age 20–21. Other research suggests that the children born to 18–19 year-old mothers also fare worse than children born to older mothers on early educational indicators such as cognition and knowledge, language and communication, social skills and emotional well-being, and physical and motor development [5]. Sons of mothers age 18–19 are

more likely to be incarcerated and spend more time in prison compared to sons of mothers age 20–21, and daughters of older teen mothers are more likely to become mothers themselves compared to daughters of mothers age 20–21 [4]. While older teen mothers are more likely than younger teen mothers to graduate from high school, they are still less likely than their peers who delay childbearing until after their teen years to have a high school diploma or GED [6]. In addition, they are much less likely to pursue post secondary education as compared to their peers who delay childbearing a few more years [4]. Taken together, research makes clear that although older teen mothers might technically be adults, teens themselves and their children fare better when mothers are slightly older. These outcomes improve further if the pregnancy was wanted and welcomed.

Section 1. Pregnancy and Childbearing Among Older Teens

KEY FACTS

- Pregnancy rates for older teens are more than *three* times the rate for younger teens.
- Approximately two-thirds of all teen births and pregnancies are to older teens.
- The vast majority of pregnancies and births to older teens are to unmarried teens.

The vast majority of all teen pregnancies and births in the United States occur to older teens.^a In fact, more than six in ten pregnancies (64 percent) and fully two-thirds of births (67 percent) to girls under age 20 are to older teen girls—accounting for nearly half a million pregnancies and more than 300,000 births each year [2, 3].

Pregnancies

In 2006, most pregnancies to older teens resulted in a live birth (60 percent); less than one-third (26 percent) resulted in an abortion, and 15 percent resulted in a miscarriage [2]. The pregnancy rate is higher for older teens than for younger teens and has decreased less among older teens than among younger teens in the past two decades. In 2006, the pregnancy rate for 18–19 year-olds was 122.3 (per 1,000) compared to 38.9 (per 1,000) among younger teen girls [2]. Put another way, approximately 12 percent of girls age 18–19 became pregnant in 2006 alone compared to approximately 4 percent of girls

age 15–17. Between 1991 and 2006, the pregnancy rate for girls age 18–19 decreased 30 percent [2]. During the same time period, the pregnancy rate among girls age 15–17 decreased 47 percent (Chart 1) [2]. However, for the first time since 1991, the pregnancy rate for older teens increased 4 percent between 2005 and 2006 [2].

Pregnancy rates among older teens and their trends over time differ by race/ethnicity (Chart 2). In 2005 (the most recent year for which these data are available by age and race/ethnicity), the pregnancy rates among Hispanic and non-Hispanic black older teen girls (210 and 203 per 1,000 respectively)^b were more than double the pregnancy rate among non-Hispanic white older teens (79 per 1,000) [7]. The declines in the teen pregnancy rate among older teens also vary according to race/ethnicity. Between 1991 and 2005, the teen pregnancy rate among older non-Hispanic black and non-Hispanic white teens declined substantially (falling by 36 percent and 40 percent respectively). However, the teen pregnancy rate among older Hispanic teens decreased only 19 percent during that same period [7].

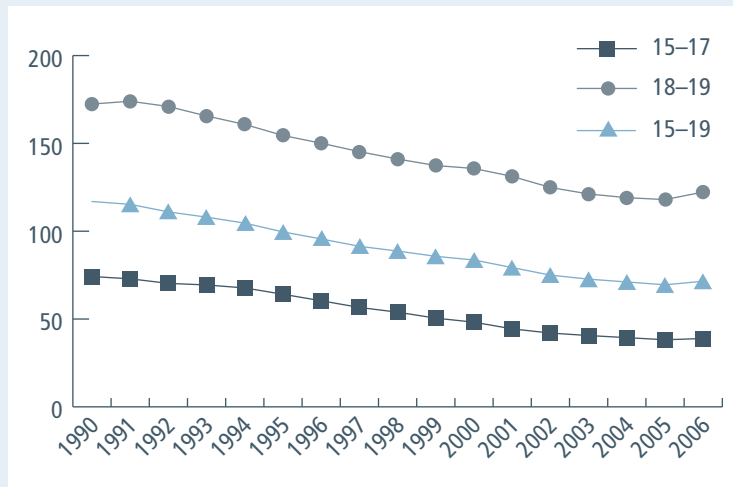
Pregnancy rates to older teens also vary considerably by state (Figure 1) [2]. In fact, the pregnancy rate among older teens in the state with the lowest rate is

12 percent of girls age 18–19 became pregnant in 2006 alone.

^a Data on birth rates are available through 2008, and data on pregnancies are available through 2006.

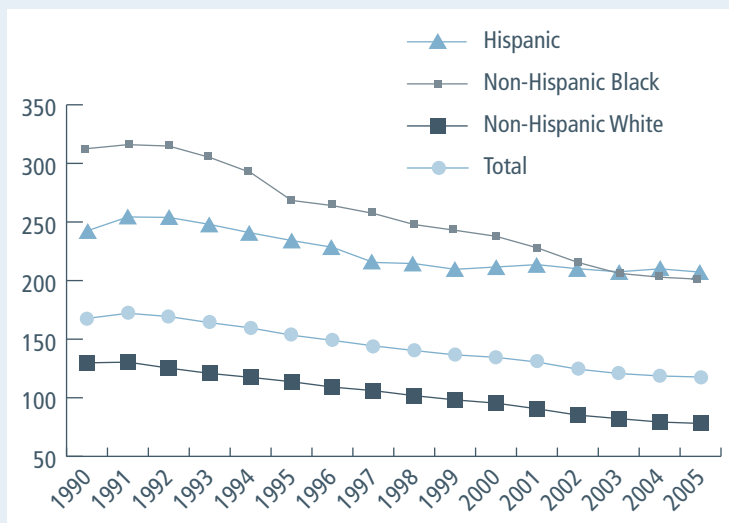
^b Pregnancy data for American Indian and Alaska Natives and Asian and Pacific Islander teens are not available. Note that 2006 data are not available by race/ethnicity and age group.

Chart 1. Teen Pregnancy Rates by Age Group, 1990–2006



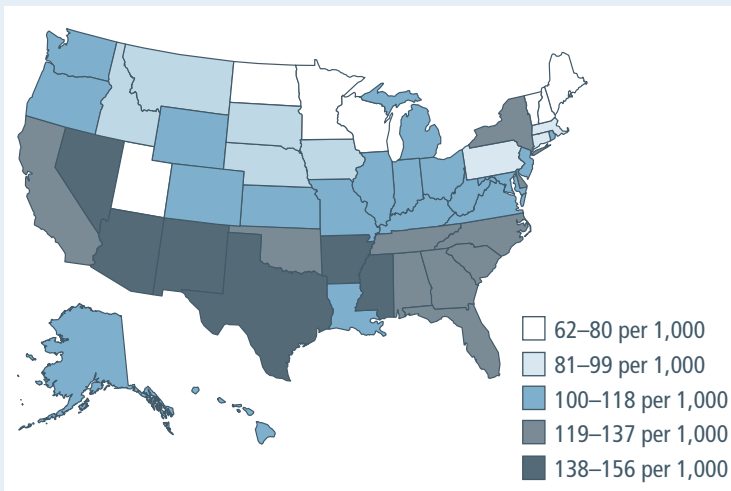
Source: Guttmacher Institute (2010). *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends by Race and Ethnicity*. New York, NY: Author.

Chart 2. Pregnancy Rates Among Teens Age 18–19 by Race/Ethnicity, 1990–2005



Source: Ventura, S.J., Abma, J.C., Mosher, W.D., and Henshaw, S.K. (2009). Estimated Pregnancy Rates for the United States, 1990-2005: An Update, *National Vital Statistics Reports*, 58(4).

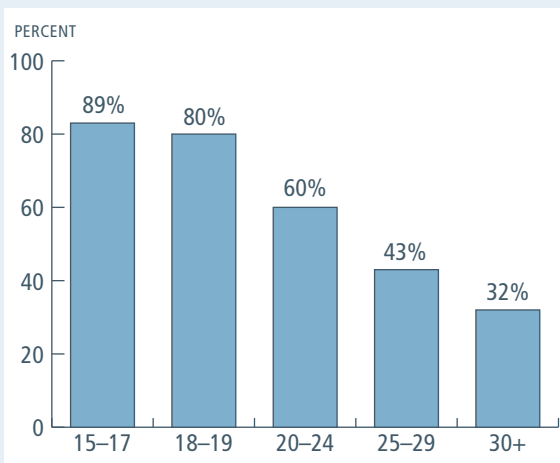
Figure 1. Pregnancy Rates Among Teens Age 18–19 by State, 2005



Nearly one-quarter of births to older teens are to teens who already have one child.

Source: Guttmacher Institute (2010). U.S. Teenage Pregnancies, Births and Abortions: National and State Trends by Race and Ethnicity. New York, NY: Author.

Chart 3. Proportion of Pregnancies that Are Unplanned by Age Group, 2001

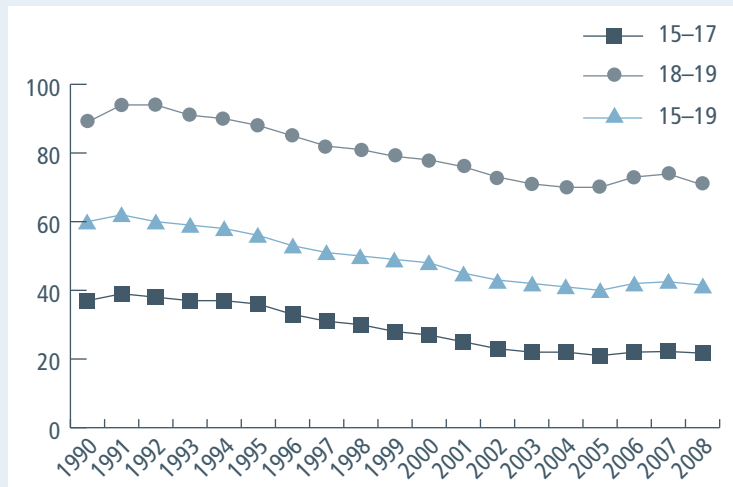


Source: Special Tabulations of data from Finer, L. and Henshaw, S. (2006). *Perspectives on Sexual and Reproductive Health*, 38(2):90-96.

less than half that of the state with the highest rate (62 per 1,000 in New Hampshire compared to 155 per 1,000 in Nevada). The difference in pregnancy rates between states is due in part to differences in the racial/ethnic composition across states in addition to other factors such as educational opportunities, poverty, and policies related to reproductive health and family planning.

The vast majority of pregnancies to older teens—fully eight in ten—are unplanned, accounting for nearly half a million unplanned pregnancies each year (Chart 3) [8]. That so many pregnancies among this age group are unplanned is in direct opposition to the wishes of older teens. In addition, in a nationally representative survey of unmarried young adults age 18–29, 81 percent of 18–19 year-olds report that it is very important to avoid pregnancy right now, and 94 percent agree that pregnancy is something that should be planned [9]. Given that the pregnancy rate among older teens is so high and that the overwhelming majority of these pregnancies are unplanned there is clearly an opportunity and need

Chart 4. Teen Birth Rates by Age Group, 1990–2008



Source: Centers for Disease Control and Prevention. National Center for Health Statistics. VitalStats. <http://www.cdc.gov/nchs/vitalstats.htm>

to work with this population to reduce the high rates of unplanned pregnancy.

Births

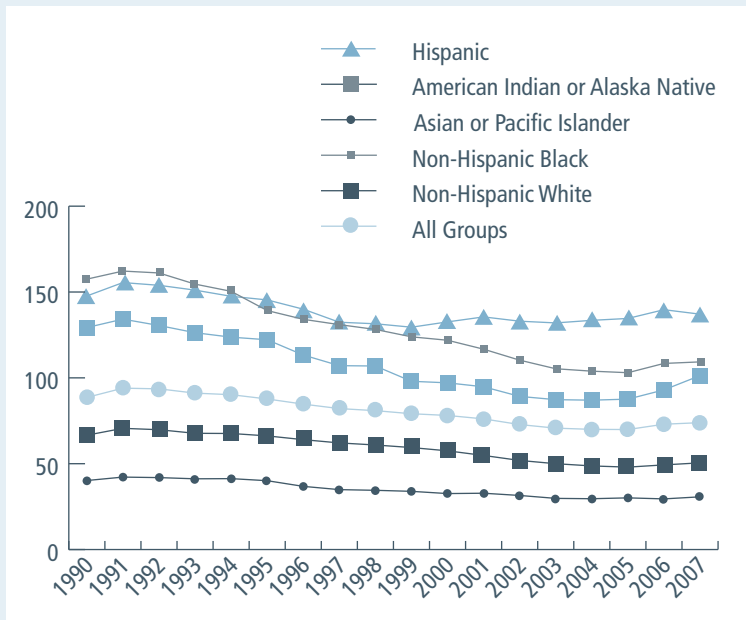
Birth rates among older teen girls are three times higher than the rates for younger teen girls. In 2008, the birth rate among older teen girls was 70.7 (per 1,000) compared to 21.7 (per 1,000) among younger teen girls [3]. Birth rates have declined more slowly among older teens than they have among younger teens (Chart 4). Between 1991 and 2008, the birth rate among those aged 18–19 decreased 25 percent. At the same time the birth rate among 15–17 year olds decreased 44 percent.

An analysis of the increase in the teen birth rate between 2005 and 2007 indicates that the increase in the birth rate among older teens accounts for approximately 80 percent of the increase in the overall teen birth rate [10].

There are large racial/ethnic differences in the birth rate among older teens as well as in the trends over time (Chart 5). Historically, rates for African American and Hispanic older teens have been among the highest and rates for Asian and Pacific Islanders have been the lowest. This remains the case in recent years as well although the gap has narrowed considerably. The largest declines in the birth rate through 2005 were among African American older teens, (36 percent). Changes since 2005 have been most worrisome among American Indian or Alaskan Native older teens (rate up 10 percent). Notably, the birth rate among older Latina teens and among older Asian or Pacific Islander teens decreased 7 percent between 2007 and 2008.

Birth rates to older teens vary by state as well—ranging from 35.8 (per 1,000) in Massachusetts to 119.5 (per 1,000) in Mississippi (for 2007) (Figure 2) [1]. Note that some of the differences in the older teen birth rate across states are due to the racial/composition of the state. As Chart 5 illustrates, there are large differences in the older teen birth rate by race/

Chart 5. Birth Rates Among Teens Age 18–19 by Race/Ethnicity, 1990–2008

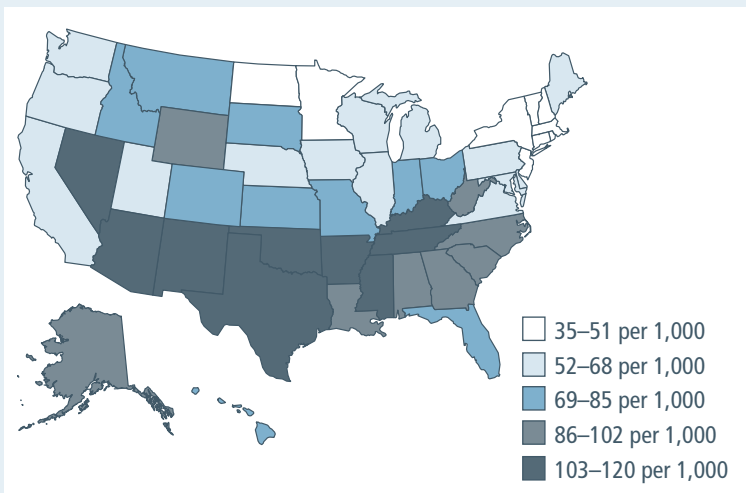


Source: Centers for Disease Control and Prevention. National Center for Health Statistics. VitalStats. <http://www.cdc.gov/nchs/vitalstats.htm>

A NOTE ABOUT THE INCREASE IN THE TEEN BIRTH RATE

The teen birth rate increased for the first time in 14 years between 2005 and 2006. This increase continued in 2007 (for a total increase of 5 percent), but then declined 2 percent between 2007 and 2008. A closer look at the population changes and the increase in the teen birth rate reveals that 80 percent of the increase in the teen birth rate between 2005 and 2007 was accounted for by an increase in the birth rate among older teens. Clearly progress, or lack of progress, made in reducing teen pregnancy and births among this group, impacts greatly the overall teen pregnancy and birth rates in the United States.

Figure 2. Birth Rates to Teens Age 18–19 by State, 2007



Source: Centers for Disease Control and Prevention. National Center for Health Statistics. VitalStats. <http://www.cdc.gov/nchs/vitalstats.htm>

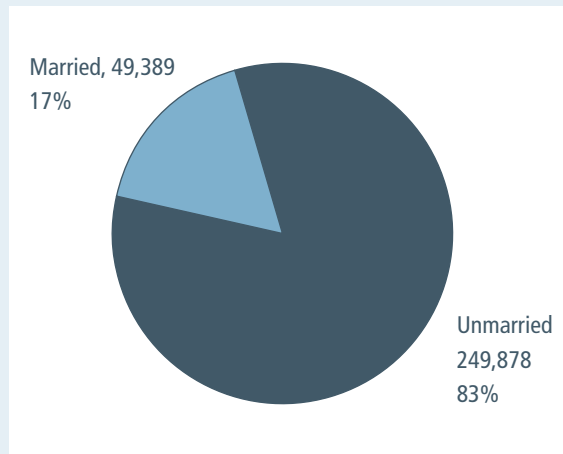
ethnicity, and these differences contribute to differentially high rates in states with racial/ethnic compositions that are different than that of the United States overall.

Similar to pregnancies among older teens, most births to older teens are reported by the mother herself to be unplanned. Approximately seven in ten births to older teens (72 percent) were reported to be either unwanted or mistimed at the time of conception [11]. In addition, the vast majority of births to older teens are to unmarried teens. In 2008, 83 percent of births to teens age 18–19 were to unmarried mothers accounting for nearly a quarter million births (Chart 6) [3].

Subsequent Pregnancies and Births

Many older teens also have subsequent pregnancies and births. At present, nearly one-quarter of births to older teens are to teens who have had at least one child [1]. Studies have found that having two or more births as a teenager is particularly detrimental to educational attainment and economic self-sufficiency [12]. For example, one study followed teen mothers 24 months after the birth of their first child and found that those mothers who experienced a second pregnancy within the 24 month period were less likely to be in school, less likely to have completed school, and less likely to be working than teen mothers who delayed a second pregnancy and birth [13]. Another follow-up study of teen mothers, conducted 20-years after the first birth, found that being in school with no additional pregnancies 26 months after the birth of the first child was associated with long term outcomes of being employed or supported by a spouse or partner and having completed high school or a GED [14]. Additional births to teen mothers also have important consequences for their children. One study determined that compared to children born to teen mothers who delayed a subsequent pregnancy and birth, those children born to teen mothers who experienced an additional pregnancy and birth as a teen were significantly less likely to be prepared for school, were less well behaved, and were less outgoing and happy five years after their birth [15]. Clearly working with teen mothers (many of whom are older teens) to

Chart 6. Number and Percent of Births to Teens Age 18–19 by Marital Status, 2008



Source: Hamilton, B.E., Martin, J.A., Ventura, S.J (2010). Births: Data for 2008. *National Vital Statistics Reports*, 58(16).

delay a subsequent birth during the teen years can have important long term benefits for both the teen mother and her child.

What it All Means

Pregnancies and births to older teens account for the vast majority of all teen pregnancies and births, and, as evidenced above, older teen mothers and their children are far from immune to the health and social risks attached to teen pregnancy. Consequently, if progress on reducing teen pregnancy and childbearing is to continue, practitioners, policymakers, and others should consider ways to increase the focus on older teens in the efforts to prevent teen pregnancy. The sections that follow detail the lives of older teens, highlighting numerous characteristics that could inform strategies for preventing teen pregnancy among this age group. Findings draw on an array of existing and newly-available data pertaining to the lives of older teens, as well as their knowledge, attitudes, behavior, and expectations related to sex, relationships, and contraception. More information about the data sources used in this report is available in Appendix 1.

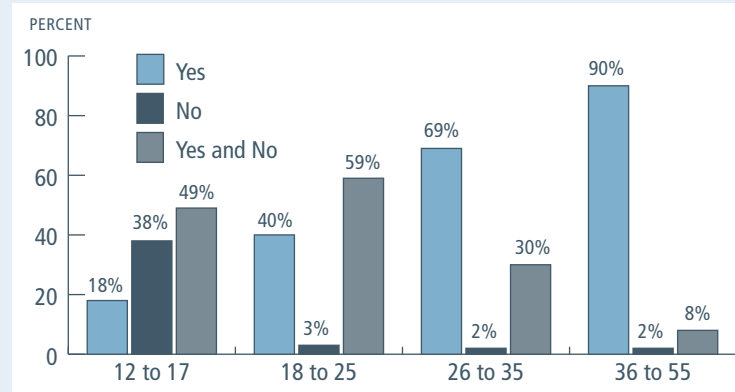
Section 2. Setting the Stage: The Lives and Context of Older Teens

KEY FACTS

- Older teens are just beginning what has become known as the “emerging adulthood” stage of life—a stage marked by many transitions in terms of education, family structure, peers, and romantic partners.
- Most older teens are attending school (either high school or post-secondary) and many still live at home with their parents.
- Romantic relationships are an important aspect of older teens’ lives and might influence the type of contraceptive methods that they use, as well as their consistency of contraceptive use.

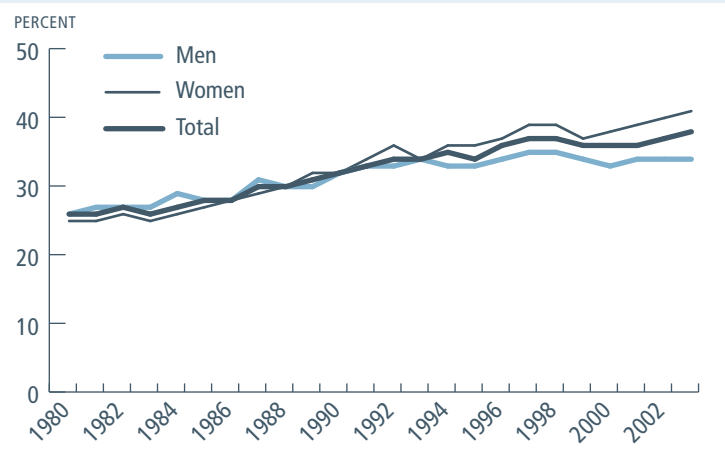
There are more than 8 million 18–19 year-olds in the United States—about 3 percent of the total population [16]. Adolescents in this age group are part of a life stage of growing interest for researchers and practitioners often referred to as “emerging adulthood”—a period spanning from the end of adolescence to adulthood. Many observers have suggested that this period of life is unique from either adolescence or adulthood [17]. Older teens age 18–19 are just beginning to enter this new stage of development that is marked by transition; perhaps from one school to another, from one job to another, from one romantic or sexual partner to another, or from one level to another with the same partner. Teens are legally defined as adults at age 18 and no longer need parental consent for their actions. However, many older teens, and even those in their early twenties, themselves do not believe that they have

Chart 7. Responses to the Question: “Do You Feel That You Have Reached Adulthood?”, by Age Group



Source: Arnett, J.J., *Emerging Adulthood: The Winding Road from the Late Teens Through the Twenties*. 2004, New York, NY: Oxford University Press.

Chart 8. Proportion of Young Adults Who Enroll in Post-Secondary Education by Gender, 1980–2003



Source: Galston, W.A., *The Changing Twenties*. 2007, The National Campaign to Prevent Teen and Unplanned Pregnancy: Washington, DC.

reached adulthood quite yet. In fact, nearly six in ten 18–25 year-olds report “yes and no” in response to the question: “Do you feel that you have reached adulthood?” suggesting that while they are legally adults, in their own minds they still have plenty of growing up to do (Chart 7) [17].

Scholars suggest that it is this particular life stage that has undergone the most change in the past several decades. To illustrate, there has been a large increase in the proportion of young adults who enroll in post-secondary education, particularly among women (Chart 8), and in the proportion of women who participate in the labor force (outside of the home) [18]. This clearly has implications on pregnancy planning and childbearing expectations for women who may want to attain more education before starting a family.

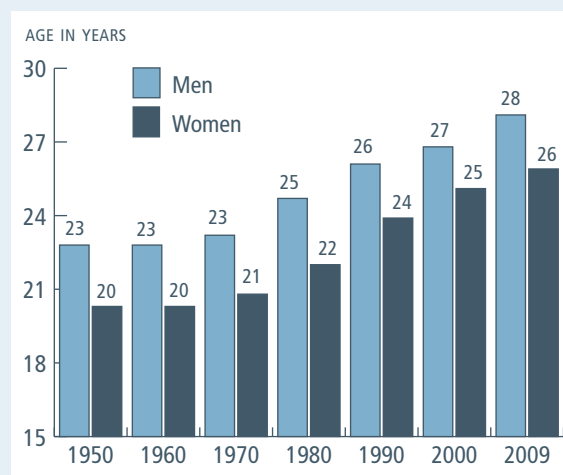
Over the past several decades, the median age of marriage has also increased dramatically for both men (28.1 years) and women (25.9 years) (Chart 9) [18]. However, the median age of premarital sex has remained about the same over the last several decades—approximately age 17—thus the time during which unmarried young adults are “at risk” of a non-marital pregnancy has increased over the past several decades as well [19].

I thought that this was going to be my husband, my baby’s father, the one I was going to be with. So we did have unprotected sex, not always, but sometimes.

Older Teens’ Connection to School and Work

In order to focus teen pregnancy prevention efforts on older teens, it is important to understand the circumstances of their lives. While most older teens have had sex, and many have been involved in

Chart 9. Median Age of First Marriage, 1950–2009



Source: Galston, W.A., *The Changing Twenties*. 2007, The National Campaign to Prevent Teen and Unplanned Pregnancy: Washington, DC.

Table 1. Current Educational/Occupational Status of Older Teens			
	Unmarried Older Teens (Age 18–19)		
Occupational Status	Men	Women	Total
Working	24%	13%	19%
In School	41%	50%	45%
Working and In School	24%	22%	23%
Something Else	15%	11%	13%
Total in School	65%	72%	68%

Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

romantic relationships, few are married by this age (approximately 3 percent). In addition, although older adolescence and young adulthood is a life stage marked by almost overwhelming transition, the majority of unmarried 18–19 year-olds—68 percent—are attending some kind of school, either high school or post-secondary schooling (Table 1). Given that so many older teens are still connected to some type of education system, there are opportunities to reach these young people in formalized settings with age appropriate information about how they can best manage their relationships as well as their sexual and reproductive health.

Older teens’ connection with school and work, their living situation, and their financial situation influence the type of health care, including reproductive health

care, that they access. Much of this access is governed by their health insurance status. As the table below indicates, most older teens have some type of health insurance (Table 2). About half are privately insured and one-quarter have Medicaid or a combination of Medicaid and private insurance. However, more than one in five have no health insurance.

Those older teens who lack health insurance might not routinely access preventive care, such as family planning, because it is cost prohibitive. At the same time, those older teens who have private health insurance might have a range of coverage. As discussed below, some might be covered under their parents’ plan but may avoid accessing sexual and reproductive health services for fear that their parents will know they are sexually active. Others might have

Table 2. Current Insurance Status of Older Teens			
	Unmarried Older Teens (Age 18–19)		
Insurance Status	Men	Women	Total
Medicaid Only	7%	18%	12%
Medicaid Plus Private	12%	15%	13%
Private Only	55%	42%	49%
Something Else	4%	4%	4%
Not Insured	22%	22%	22%

Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

their own coverage if they are connected through their work or school, but the deductibles or co-pays included in their plan could be barriers to care.

Parents and Peers

In addition to considering access to health care, older teens' living situations are important to consider when thinking about who might influence their decisions about sex and contraceptive use. Data from the National Survey of Reproductive and Contraceptive Knowledge (NSRCK) indicate that the majority of unmarried older teens live with their parents, about one-quarter live with other people (besides parents or a partner), and nearly one in ten report living alone or with a partner (Table 3).

Teens overall consistently report that when it comes to their decisions about sex and contraception, their parents are a very important influence. This is true of older teens as well—nearly one-third report that when it comes to their decisions about sex parents are most influential [20]. This is similar to the proportion who say that friends most influence their decisions about sex, much more than the media, teachers, or others. A qualitative study with community college students provides additional support for these findings. Consider the following exchange between an interviewer and an 18-year-old female:

INTERVIEWER: ...So what type of role do you feel like your mom has played in your use of birth control?

RESPONDENT: She was my first go-to person, before a doctor or anything. Just to get the basic information, to see if it's a good idea, or a bad idea. Before you get the details—the disadvantages or the side effects or things like that.

Nearly six in ten older teens in the qualitative study reported that they have had open communication with their parents about birth control. Even so many older teens report that they can't or don't talk to their parents about these issues. In fact, 15 percent said that discussing birth control with their parents was off-limits, 22 percent said they could talk with parents but don't, and 5 percent said they don't want to talk to parents. Other teens reported that they avoided using a method of contraception specifically because they didn't want their parents to discover they were sexually active. The statements from focus group participants presented below illustrate that many older teens and young adults are very concerned about their parents' reactions.

INTERVIEWER: Would your parents rather you be using something for birth control or not? Or would they not? Or would they just be so upset that you are having sex that they're not...

RESPONDENT: Yeah. They'll get really upset...

RESPONDENT: Yeah. Even if you are using protection or not, no. Just the fact that you are doing it is like no... oh no no no.

Table 3. Current Living Situation of Older Teens			
Living Situation	Unmarried Older Teens (Age 18–19)		
	Men	Women	Total
With Parents	58%	57%	58%
With Others	27%	25%	26%
With Partner	5%	13%	9%
Alone	10%	5%	8%

Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

RESPONDENT: I mean, what parent wants to imagine their kid having sex? Like that's just the worst of the worst, you know. It's just weird.

Some students also talked about hiding birth control from their parents. As the following quotes illustrate, some older teens might hide birth control from their parents because they are worried their parents will find out that they are sexually active.

19-year-old Male

RESPONDENT: I have to hide it, like, in the back of my drawers, like in the bottom under clothes, or whatever. Or when I have it in my backpack, I have to make sure it's zipped up tight so that nothing will fall out.

INTERVIEWER: Do you ever worry that she [your mother] might find it?

RESPONDENT: Yeah.

INTERVIEWER: What do you think they would do if they found birth control on you?

RESPONDENT: Well, I guess she would automatically assume, or would realize that I'm not a virgin anymore, and probably talk to me more about it and be more cautious with me.

18-year-old Male

INTERVIEWER: What do you think would happen if your parents found out you were having sex?

RESPONDENT: I don't know... I've been raised with a lot of values and morals. I guess I'd be punished, probably for the rest of my life. I don't know.

Recent research with older teens and young adults in Massachusetts found that many older teens and young adults rely on their parents to help them make decisions about their health insurance plans [21]. While older teens and young adults appreciated their parents' help in the decision about health insurance, many also felt that it limited their ability to select a plan that truly met their needs especially when it

came to sensitive issues such as sexual and reproductive health services. Some participants also worried that their parents might receive a bill or a statement from an insurer indicating that their daughter or son had accessed a sexual or reproductive health service. Consequently, some participants reported seeking care at places outside of their health care network where they could pay for these services themselves while others were frustrated that additional options weren't available.

Clearly parents play an important role in their teens' decisions about sex and birth control. This role may be more or less influential depending on whether the teen is living at home or not, and this role may be supportive or not depending on the teens' relationship with his or her parents, and their perceptions of how their parents might react should they discover that their child is sexually active.

About one-quarter of older teens report that they currently live with a roommate(s). Not surprisingly, peers also play an important role in the lives of older teens and are often a source of information—although not always an accurate one—about sexual and reproductive health. In a qualitative study of community college students, participants reported that their friends were a trusted source of information about contraception. While national surveys suggest that doctors are older teens' most trusted source of information about contraception, personal sources, such as friends, are used most often. As data from the qualitative study of community college students indicate, a reliance on personal sources of information such as friends could be good or bad, depending on whether the students' friends have accurate information about contraception, whether they promulgate popular myths and misconceptions about birth control methods, or whether they might discourage or encourage a pregnancy. The following exchange between students in a focus group illustrates how misinformation might be spread.

Female Focus Group

RESPONDENT: I heard birth control gets you fat...

RESPONDENT: Makes you gain weight. [Laughter].

INTERVIEWER: When you say birth control, you mean...

RESPONDENT: The pill and the shot. Also, something I heard, some like patch or something. I don't know how that works. But yeah, I heard birth control gets you fat.

INTERVIEWER: The patch, too, gets you fat?

RESPONDENT: I don't know about that, I just heard about it.

RESPONDENT: Also that it is like bad for you. And I don't know if it is true, but I heard that it can affect you if you want to get pregnant in the future. And sometimes maybe girls get scared because they don't want to go through something like that if they get put on birth control.

Friends can also support teens' decisions to avoid a pregnancy at this time in their lives and encourage them to use an effective method of birth control.

19-year-old Female

RESPONDENT: [O]ne of my friends, she told me I should really get on [the Pill], 'cause I need to.

INTERVIEWER: Do you remember what you were specifically talking about, or was she just recommending that you use birth control?

RESPONDENT: Yeah, 'cause, I had a, I thought I had a pregnancy scare, 'cause I thought I was [pregnant], and then I took a test, and it said I wasn't, and she was like, "You need to start using birth control, 'cause you don't want to end up getting pregnant."

Peers might also serve as motivators when it comes to decisions about pregnancy. If someone has an unplanned pregnancy and subsequent birth, his or her friends might be more likely to take the necessary steps to avoid being in the same situation. However, friends

also might pressure their friends to get pregnant and have a baby, especially if they are parents themselves.

19-year-old Female

INTERVIEWER: [Y]ou seem like you got the control [in the relationship] and you want people to be using condoms, but you seem likely to—you seem to think that it's likely that you could have a kid before [you want to]?

RESPONDENT: Because it's [not] that I'd lose control, but all of my friends have kids...Like, I just came back from seeing my little god-daughter and it's like, "Aw, I want one!"...and I might even be more motivated, not even by my partner, but just by like people around that have kids. I might be more lenient and be like, "Ok, we can do it without a condom this time." I might be more like that...

Romantic Relationships

Not surprisingly, romantic relationships play an important role in the lives of older teens. The majority of older teens have had sex and many sexually experienced teens have had more than one sexual partner suggesting that quite a few have experience forming and ending sexual and romantic relationships. Research indicates that romantic relationships take on increasing importance during adolescence, and that teens tend to spend an increasing amount of time with romantic partners as they age [22]. In addition, it is usually in the context of these romantic relationships in which sexual activity occurs [22]. Approximately one in ten unmarried older teens are living with a partner.

Over half of older teens who are currently in a relationship—55 percent—expect to marry their partner.

National data indicate that many older teens take their relationships seriously, and this might have implications for their contraceptive use and plans for pregnancy and childbearing. In fact, data from the NSRCK indicate that over half of older teens who are currently in a relationship—55 percent—expect to marry their partner (Chart 10). This expectation is slightly higher among women age 18–19 (62 percent) than men in this age group (48 percent). In addition, three-quarters of older teens who believe it is likely that they will marry their current partner also expect to have a baby with their current partner. Given these relationship and childbearing expectations, many older teens might view an unplanned pregnancy as the early arrival of an otherwise anticipated event. However, longitudinal research suggests that an unplanned pregnancy and birth usually does not lead to a more stable relationship, in fact only 30 percent of couples who are unmarried (and not living together) and experience an unplanned pregnancy and birth move into a more formal union (cohabitation or marriage) two years after the child's birth [23].

Information gathered from college students in Wisconsin also highlights the importance of romantic

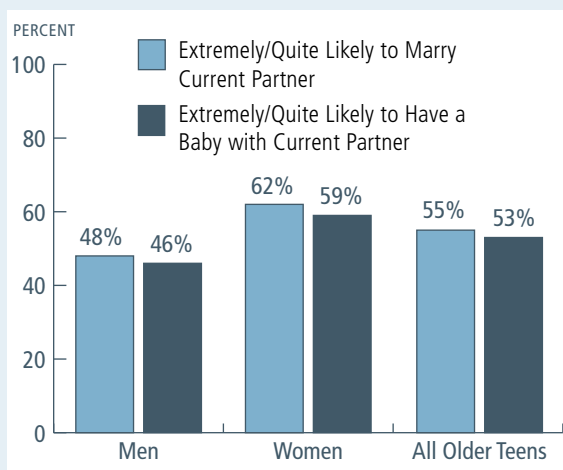
relationships in students' lives [24]. Nearly all of the students surveyed (96 percent) reported that having a healthy relationship is important or very important for a person's well-being and success. However, nearly half (44 percent) disagreed or strongly disagreed with the statement that "college students know what they need to do in a relationship in order to make them successful," and more than half (55 percent) felt that students would benefit from expert knowledge of how to develop and maintain healthy relationships.

Data from the qualitative study of community college students provide a more in-depth look at how the type and length of romantic relationships can influence older teens' decisions about sex and contraceptive use, and, in turn, their risk of pregnancy. Most students in the qualitative study report that they were involved in some kind of romantic relationship, and about two-thirds were in a relationship at the time of follow-up (approximately six months after the first interview). The vast majority of students dated one person at a time, and nearly half reported that their romantic relationships were long-term—that is, at least one year in duration. Nonetheless, many of these students experienced a change in their relationship, which has important implications for contraceptive use.

Many students reported that they sometimes did not use birth control despite their intention to avoid a pregnancy. Inconsistent use often depended on the type of relationship they were in. Key factors that influenced whether or not contraception was used or even discussed were the type and length of the relationship, relationship stability, and partner characteristics such as age and student status.

Students in self-identified long-term relationships tended to report a higher level of trust and intimacy with their partner than students in more casual or short-term relationships. While it might be expected that this increased trust and intimacy could lead to more in-depth discussions of pregnancy planning and contraceptive use, it often meant that students would stop using some methods of birth control, such as condoms, because they trusted that their partner wouldn't have a sexually transmitted infection (STI). This was particularly the case if they were

Chart 10. Future Marriage and Childbearing Plans Among Unmarried 18–19 Year-Olds Who are Currently in a Relationship, 2009



Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

using more than one method at the beginning of the relationship. For example, many students reported that, as the relationship progressed, they stopped using condoms if they were using both condoms and a hormonal method. Students also indicated that they might start using a less effective method over time (i.e. switching from condoms to withdrawal), or be more inconsistent in their contraceptive use because they trusted that their partner would be around and involved should an unplanned pregnancy occur. Some students reported that, in the context of their long-term relationships, they would purposely *not* use a method of contraception on special occasions in order to increase intimacy with their trusted partner.

19-year-old Male

RESPONDENT: Because... she's never allowed a person inside her without protection.... And so that makes what we do a little more special. Especially considering that the both of us have had multiple partners, and you know, when you have another partner, you strive to make it different. To make it unique.

Relationships with more casual partners are often viewed differently than longer term, more serious relationships. Like contraceptive use in longer term relationships, contraceptive use in casual relationships varies. Some students reported being more consistent about contraceptive use with casual partners, particularly in regards to condom use, because they didn't know the partner as well. Some students also said their contraceptive use with more casual partners was more inconsistent because they didn't have time to discuss birth control, weren't concerned about pregnancy in the heat of the moment, and/or because they simply wanted to have sex without considering any potential outcomes.

Focus Group Discussion

RESPONDENT: You in the mood, just don't care, know what I'm saying? It's not that you forget, 'cause at the same time, you in the mood, you don't care...regardless what you got in your system, you think about it, but it is the fact at the

moment, you just don't care, like, "Hmm, I don't feel like doing this now. I just want to do what I'm doin' right now"

RESPONDENT: ...I mean, that question—You're not about to ask that question before you have sex and be like, "Are you on birth control or not?"

RESPONDENT: That blows the moment.

An important minority of students reported that they stopped using birth control when their relationships ended. In fact, more than one-third of students who ended their relationships (47 percent of Latino students, 35 percent of white students, and 31 percent of black students) reported that they stopped using contraception when their relationship ended. These students might be at particular risk of unplanned pregnancy, especially if they unexpectedly have sex after their relationship has ended and they are no longer protected from an unplanned pregnancy.

Partner characteristics also seem to influence contraceptive use. Important characteristics include the partners' age, the perceived future potential of that partnership, and whether the partner is a student. Larger age differences might contribute to some type of power imbalance or "experience imbalance" when it comes to issues of sex and contraception. Many students who dated older partners reported that they often trusted the information that partner gave them about contraception and were perhaps more likely to use less effective methods (or no method of contraception) because the partner assured them it would be all right. In addition, as the following quote illustrates, some respondents reported that their contraceptive behavior differed depending on whether or not they wanted to avoid a pregnancy with that particular partner.

19-year-old Female

INTERVIEWER: Have you and your current boyfriend ever talked about having kids together?

RESPONDENT: He wants more kids, but I've seen him with his daughter and he is rarely with her

and the mother takes care of her. He only sees her once in a while so, in my mind, I am not having kids with him 'cause having kids with him does not mean he is going to stay... He wanted to have unprotected sex and he was like if you have my kid, I'll be happy. I was like NO.

INTERVIEWER: [But] that time that you said you had sex with your previous boyfriend, you decided not to use anything that time?

RESPONDENT: I really, really thought I was going to be with him. I thought that this was going to be my husband, my baby's father, the one I was going to be with. So we did have unprotected sex, not always, but sometimes. I trusted him, so I knew he was going to stay.

INTERVIEWER: So at that time it was ok with you?

RESPONDENT: Yea, with that person because I believed that he was going to be there forever.

In this particular qualitative study, whether the partner was an active student or not seemed to play an important role in an individual's decisions about contraception. Many students reported that they dated individuals who were not currently enrolled in school and that their partners often had different goals for the future. Sometimes these differing goals made contraceptive use within the relationship more challenging. Students reported that having a partner with similar goals for the future and who is in a similar situation often made contraceptive use and avoiding an unplanned pregnancy easier. Other, nationally representative research indicates that men and women often disagree on whether a pregnancy was planned or not, which might be especially true in cases where the partners' goals differ.

Nationally representative data from the National Survey of Family Growth (NSFG) indicate that most older teens do not think discussing such issues as whether or not to use a condom with a new partner would be embarrassing. In fact, more than half of women (56 percent) and three-quarters of men (74 percent) report that there is "no chance" that it would be embarrassing to discuss using a condom with a new

partner [25]. An additional 20 percent of women and 17 percent of men say that there is only a little chance that it would be embarrassing to discuss using a condom. The vast majority of older teens (94 percent of women and 86 percent of men) also agree that a new partner would appreciate it if the male wore a condom. However, data from the qualitative study indicate that actually having these discussions is more complicated. While many students in the qualitative study reported talking with their partners about birth control, STIs, and having children one day, many of the conversations were very brief and often were not revisited as the relationship developed. One common reason for not discussing birth control was that students assumed their partner was using something.

19-year-old Male

INTERVIEWER: [S]o when you were with past sexual partners... you didn't talk about birth control, you were saying, but how did you—how did it end up that you would be using something?

RESPONDENT: Like, it was just always like expected. Like, it's just always like, "Yeah, we're going to have sex, we're going to use condoms." Like, that's how it's always been.

Students also reported that they didn't worry about birth control because they felt a sort of invincibility, that getting pregnant unexpectedly or contracting an STI would not happen to them.

Female Focus Group

RESPONDENT: We all get this complex like, oh that's not going to happen to me. Like the stuff you see happen around you and to other people, you always be like, "oh, that's not going to be." I never thought I was going to be pregnant in high school, [but] I didn't take the necessary steps to prevent it.

Other reasons for not discussing and potentially not using birth control include being in the heat of the moment and not wanting to "ruin the mood" by bringing up birth control, being under the influence

of alcohol, and not being comfortable discussing birth control.

19 year-old Female

RESPONDENT: Because when you are drinking, you [aren't] thinking straight. You are honestly not. Because I know that, not with [my current partner], but before him, I got to the point where I did have unprotected sex with him because at that time I wasn't really paying attention. Thank God I didn't get pregnant. So drinking changes your mind.

The Pull of Parenthood

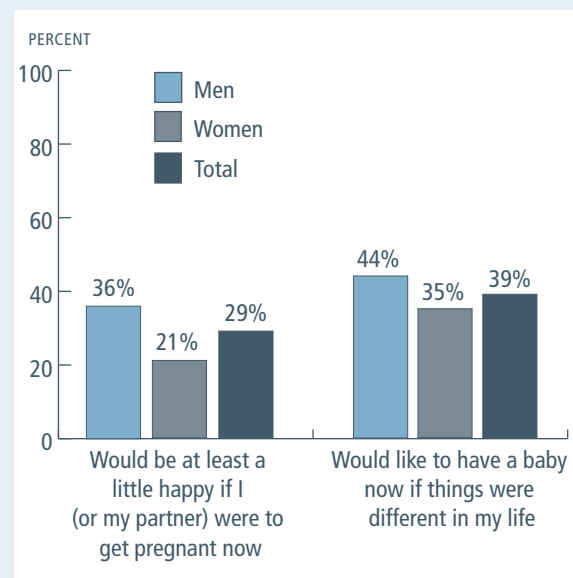
Closely tied to older teens' romantic relationships are expectations to have a family at some point in the future. Most unmarried older teens would like to become parents, and some strongly feel the pull of parenthood even now. In fact, nearly one-third of unmarried 18–19 year-olds report that they would be at least a little happy right now if they or their partner were to get pregnant and nearly four in ten report that they would like to have a baby now if things in their life were different [9](Chart 11). While it's clear that the majority of older teens are not actively seeking pregnancy, and many would be upset if they became pregnant, it is also true that some older teens would eagerly embrace parenthood even if it wasn't something that they had planned.

18 year-old Female

RESPONDENT: We—it's like, we're not really planning. I guess it just happens, but we know, like, if I was to get pregnant, things would be okay. So it's not like, we're like, "Oh my God, [what did we do,]" we do think about it. We'll be like, "What if [we got pregnant]?" And we'll talk about it after, but like we're not mad about [not having used anything].

It is interesting to note that unmarried older teen men are much more likely to say that they would be pleased if they found out their partner were pregnant and that they would like to have a baby if things were different compared to unmarried older teen women.

Chart 11. Unmarried 18–19 Year-Olds Who Somewhat or Strongly Agree with the Statements, 2009



Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

What it All Means

The circumstances of older teens lives are quite varied which has important implications for any efforts to reach this group. Many are still in school and living with their parents, others are living with friends, and a few are living with a partner. Relationships, particularly romantic relationships, play an important role in the lives of older teens, and can have an important impact on their sexual and contraceptive behavior. Those interested in working with this age group or developing policies that might impact this age group should keep these life circumstances in mind when developing programs, outreach materials, and messages about pregnancy prevention. This variety is a challenge, but also offers many different opportunities to reach and engage older teens, through parents, peers, educational institutions, clinics, and other groups working with older teens. The following section explores the sexual and contraceptive behavior of older teens along with important attitudes and beliefs that might guide this behavior.

Section 3. Sexual and Contraceptive Behavior, Knowledge, and Attitudes

KEY FACTS

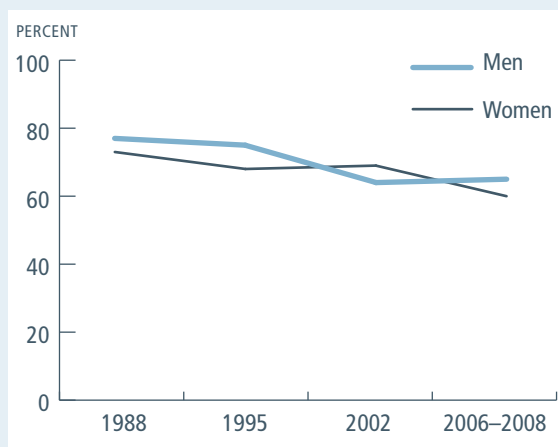
- Most older teens have had sex, and nearly half have had sex in the past three months.
- Most teens use some form of birth control, but many do not use it very well.
- Older teens are aware of a wide variety of birth control options, but misinformation and misperceptions about these options are widespread.
- Many older teens have concerns about the side effects of various methods of contraception. They also tend to underestimate the potential benefits of contraception, including its effectiveness for preventing pregnancy.

Sexual Experience

Most teens age 18–19 have had sex (specific estimates range from approximately 60 percent to 75 percent depending on the data source). By comparison, approximately three in ten younger teens report having had sex. In general, older teen boys are slightly more likely than older teen girls to report having had sex (although this difference is not statistically significant). Data from the NSFG suggest the proportion of never-married older teens—both boys and girls—who have had sex has decreased slightly from 1988 to 2006–2008 [25] (Chart 12).

A large proportion of older teens have also had sex in the past several months. As Chart 13 illustrates, more than one-third have had sex in the past month

Chart 12. Percent of Never-Married 18–19 Year-Olds Who Have Ever Had Sex, by Gender 1988–2008



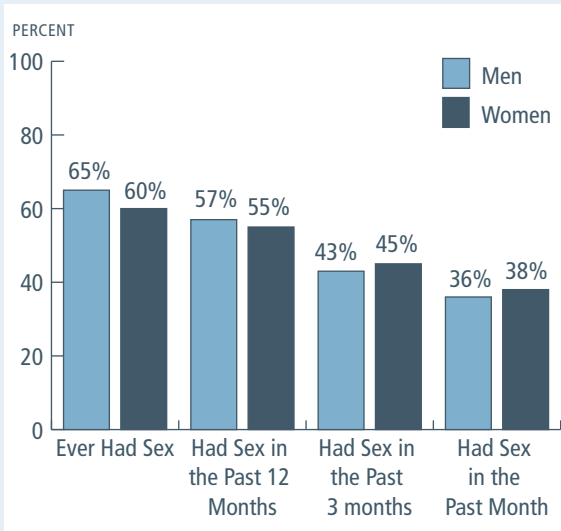
Source: Abma, J.C., Martinez, G.M., Copen, C.E. (2010). Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, National Survey of Family Growth 2006–2008. *Vital Health Statistics*, 23(30).

suggesting that a sizeable minority of older teens are having sex frequently which might put them at risk for pregnancy and STIs if they are not using a method of birth control consistently.

More than half of older teens have had zero or one sexual partner in their lifetime, and approximately one in five have had two or three sexual partners in their lifetime (Chart 14). However, nearly one-third of older teen boys and 21 percent of older teen girls have had 4 or more sexual partners in their lifetime which increases their risk of pregnancy and STIs [26].

While the majority of teens have sex before they turn 18, about one-quarter delay sex until after they turn

Chart 13. Sexual Behavior of Teens Age 18–19 by Gender, 2006–2008

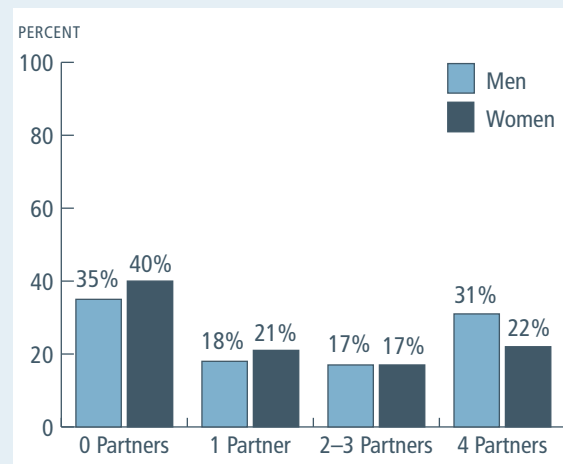


Source: Abma, J.C., Martinez, G.M., Copen, C.E. (2010). Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, National Survey of Family Growth 2006–2008. *Vital Health Statistics*, 23(30).

18 or 19. Teen girls who delay having sex until they are 18–19 are much *less* likely than their peers who had sex at a younger age to regret having sex for the first time. Among those teen girls who waited until they were 18–19 to have sex, about one-third reported mixed emotions about their first sexual experience (“part of me wanted it to happen at the time and part of me didn’t”), and more than half reported that they “really wanted it to happen at the time”[25]. Comparatively, fully half of teen girls who first had sex at age 15–17 had mixed feelings about the experience and 42 percent reported that they really wanted it to happen. Less than one-third of teen girls who had sex at age 14 or younger reported that they really wanted it to happen at the time and 53 percent had mixed feelings (nearly one in five report that they didn’t want it to happen at the time). A similar proportion of teen boys report mixed emotions about having had sex (about one-third) and really wanting it to happen at the time (over six in ten) regardless of age of first sex.

Understanding the reasons why some teens choose to delay sex provides insight into ways that practitio-

Chart 14. Number of Sexual Partners in Lifetime For Never-Married Teens Age 18–19 by Gender, 2006–2008



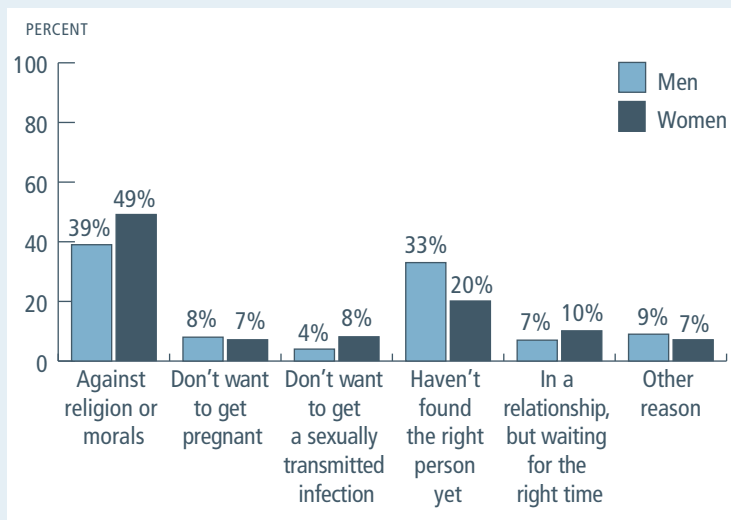
Source: Abma, J.C., Martinez, G.M., Copen, C.E. (2010). Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, National Survey of Family Growth 2006–2008. *Vital Health Statistics*, 23(30).

ners and others might encourage teens to delay their first sexual experience until they are ready. One key reason teens give for waiting to have sex is that it is against their religion or morals to have sex [25](Chart 15). Another prevalent reason, particularly for older teen boys, is that they haven’t found the “right person” yet. Less than one in ten older teens who have not yet had sex report that they are waiting to have sex in order to avoid pregnancy and a similar proportion report that are waiting to have sex in order to avoid getting an STI.

Contraceptive Use

Similar to women overall, nearly all sexually experienced older teen women have used some method of contraception (99 percent) [27]. Data from the NSFG show that nearly eight in ten older teen women report using a method of contraception the first time they had sex (79 percent) and slightly more than eight in ten (83 percent) report using a method the last time they had sex. Birth control pills and/or condoms are the most commonly used methods among

Chart 15. Main Reason for Never Having Had Sex Among 18–19 Year-Olds by Gender, 2006–2008



Source: Abma, J.C., Martinez, G.M., Copen, C.E. (2010). Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, National Survey of Family Growth 2006–2008. *Vital Health Statistics*, 23(30).

older teen women. More than eight in ten older teen men (85 percent) report using a method of contraception the first time they had sex, and more than nine in ten (93 percent) report using a method of contraception the last time they had sex. The vast majority of older teen men report that they used a condom (81 percent used a condom the first time they had sex, and 75 percent used a condom the last time they had sex).

Although many older teens report that they have used contraception, and many report that they used it the first time they had sex, many are not using contraception consistently. According to the NSCRK, among unmarried older teens who are currently in a sexual relationship, only four in ten are well protected from an unplanned pregnancy—that is, they are using an effective method^c of contraception every time they have sex or as directed. Fully one-quarter use a method inconsistently, and nearly one-quarter report that they

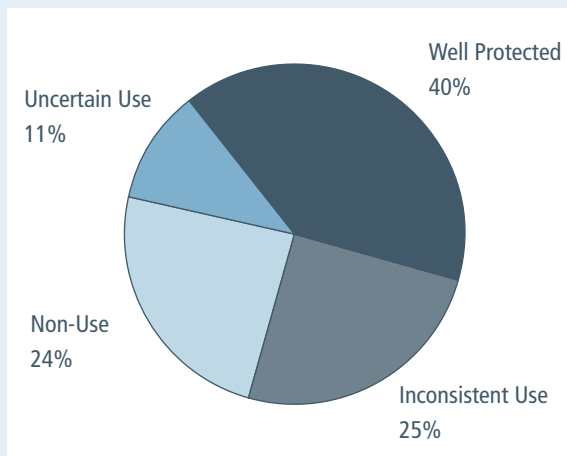
currently use no method at all (Chart 16). The most common methods used are condoms and the pill.

Many older teens admit that there is a good chance they will have unprotected sex in the next few months even though the vast majority say they do not want to get pregnant or cause a pregnancy. More specifically, one in five unmarried 18–19 year-olds report that it is either quite or extremely likely that they will have unprotected sex in the next three months. Even among those unmarried 18-19 year-olds who report that it is very important to avoid pregnancy right now, 19 percent report that it is either quite or extremely likely that they will have unprotected sex in the next three months.

In short, many older teens are having sex, and while the majority use some form of contraception some of the time, few are consistently protecting themselves from pregnancy. Not surprisingly, more than one-

^c Effective methods include: Sterilization, IUD, implant, birth control pill, Depo-Provera, and condoms. Note that consistency of use was not asked for vaginal ring or birth control patch users which are not included in this category (<3% of respondents age 18–19 currently either the vaginal ring or the birth control patch).

Chart 16. Protection Status of Unmarried Teens Age 18–19 in a Current Sexual Relationship, 2009



Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy.

third of sexually experienced older teen girls have taken a pregnancy test in the past 12 months (36 percent), according to data from the NSFG. This suggests that many girls in this age group have experienced at least a “pregnancy scare” and might be at particular risk for an unplanned pregnancy.

19-year-old Female

RESPONDENT: I always told him that I’d never have sex with him if we didn’t use a condom. But one day, we didn’t have one and after that, I just didn’t like it anymore...I knew it was a chance of me getting pregnant, but I didn’t think it was that big of chance...I guess I wasn’t paying attention.

Knowledge and Attitudes about Fertility and Contraception

As previously mentioned, 81 percent of unmarried older teens report that it is very important to avoid pregnancy at this point in their lives, and nearly eight in ten *strongly agree* that pregnancy is some-

thing that should be planned. Clearly preventing an unplanned pregnancy is important for this group of young people. Other data indicate, however, that there is a rather large gap between intentions and behavior—fewer than half in a current sexual relationship are consistently using an effective method of contraception. The question is, why?

Data from the NSCRK provide additional insight into the knowledge, attitudes, and behavior of young adults, including those age 18–19. The results from this survey suggest several potential areas for further consideration when thinking about the disconnect between older teens’ stated intentions and behavior. Data from the qualitative survey of community college students also provide contextual information about older teens’ knowledge and attitudes about unintended pregnancy and contraception.

Sources of Information

While most older teens report that they have had some type of formal sex education (78 percent), more than one in five have not received any formal sex education (22 percent). Among those who have had sex education, most received this education at the beginning of high school—the mean age older teens say they last received sex education was 15.1 years. This suggests that there may be a need for ongoing sex education for many. Older teens also report receiving information about both birth control and abstinence (Table 4), but as the data below will illustrate, for many, the education they received about these topics didn’t translate into increased knowledge about fertility and contraception.

81 percent of unmarried older teens report that it is very important to avoid pregnancy at this point in their lives.

Table 4. Sex Education Topic Covered (Among 18–19 Year-Olds Who Received Formal Sex Education)

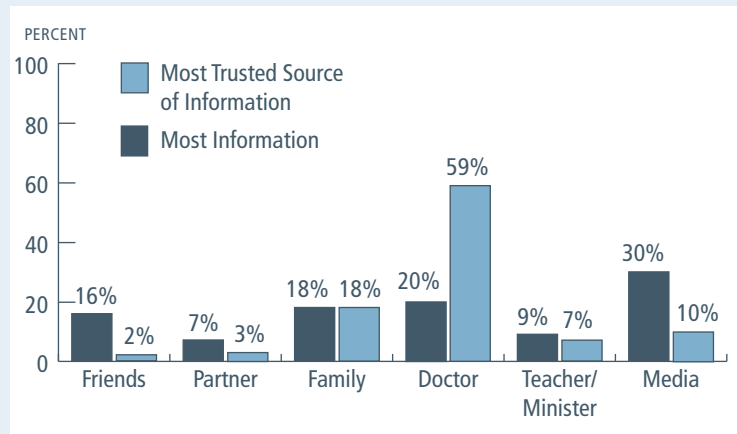
	Men	Women	Total
Importance of Using Birth Control if Sexually Active	79%	79%	79%
Demonstration of How to Use a Condom	57%	54%	55%
The Availability of Many Different Types of Birth Control Methods	65%	79%	71%
How to Say 'No' to Sex	86%	86%	86%
The Importance of Waiting Until Marriage to Have Sex	76%	64%	72%

Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

Unmarried older teens report getting information about birth control or pregnancy prevention from a variety of sources (Chart 17). Often, older teens' most trusted source of information is different from where they get the most information about contraception and pregnancy prevention. More than half (59 percent) report that their doctor is their most trusted source of information, and nearly one in five (18 percent) report that they trust their family (parents, siblings, and other family members) most as a source of information. Despite the fact that more than half of older teens report a doctor as their most trusted source of information, only one in five (20 percent) say that they actually get most of their information from their doctor. A similar proportion report that they get most of their information about birth control or pregnancy prevention from their friends, and fully three in ten older teens report that they get most of their information from a media source (internet, books, TV, or radio). The following quote from an 18-year-old male illustrates the importance of internet and media based information sources.

RESPONDENT: You know, I go to WebMD, and besides that, you know when they show the advertisements on TV, they always manage to mention the side effects....

Chart 17. Sources of Most Information and Source of Most Trusted Information Among Unmarried 18–19 Year-Olds, 2009



Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

Taken together, these data suggest that older teens most *trusted* sources of information (doctors and family members) aren't necessarily where they actually get most of their information about pregnancy prevention and contraception. This might mean that older teens don't have access to enough trusted information about contraception and pregnancy prevention, or that the information they do find is incomplete or incorrect. It may also be the case that despite being a trusted source, the information teens find on the internet or hear from friends and family is incomplete or incorrect. The following quote highlights the fact that misinformation about contraception is easily spread.

18-year-old Female

RESPONDENT: I've heard there's a downside—or downfall if you're using it [the pill] for more than two years, so I do plan to get off of it at some time, and just not have sex as much.... Um, my boyfriend's mother did research, um, online. I don't know what her sources were, but she said that, um, there's a risk of ovarian cancer.

Clearly older teens—and teens and young adults more broadly—need better access to trusted and accurate sources of information about birth control and pregnancy prevention. While health care providers cannot meet this demand alone, new technologies and digital media might allow for new opportunities to disseminate critical information about these topics in a way that older teens can easily access and understand. Combined with ongoing education about sex and relationships, information about contraception, in particular materials about new methods or how to manage concerns about side effects, might improve older teens' abilities to select a method of birth control that is appropriate for them and to use that method consistently.

Familiarity with Various Contraceptive Methods

Most unmarried 18–19 year-olds report that they have at least heard of most birth control methods (Table 5). However, they are less familiar with long-acting reversible methods including IUDs and

implants. Only two-thirds are aware of the IUD and less than half (38 percent) have ever heard of the implant.

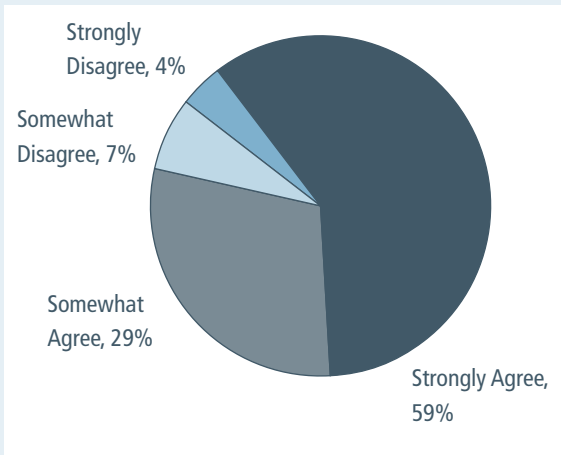
Table 5. Percent of Unmarried Teens Age 18–19 Who Have Heard of Various Contraceptive Methods, 2009

	Men	Women	Total
Condom	99%	99%	99%
Pill	92%	97%	94%
EC	86%	95%	90%
Patch	77%	97%	87%
Ring	78%	91%	84%
Depo-Provera	63%	86%	74%
IUD	62%	78%	69%
Foam	61%	59%	60%
Rhythm/Natural Family Planning	44%	50%	47%
Implant	37%	40%	38%

Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

a significant minority of unmarried older teens say they have limited knowledge of even the most popular methods such as condoms and birth control pills. In fact, 30 percent of older teens who have ever used a condom report that they know little or nothing about the method. In addition, among those older teens who have ever used birth control pills, more than two-thirds (68 percent), report that they know little or nothing about the method. Even so, 59 percent of unmarried older teens *strongly agree* that they have all of the information they need to avoid an unplanned pregnancy (Chart 18). An additional 29 percent somewhat agree that they have all of the information they need to avoid an unplanned pregnancy. Clearly efforts to improve older teens' knowledge about contraception and pregnancy prevention will also need to convince older teens that they have more to learn about these issues in order for them to make truly informed decisions about starting a family.

Chart 18. Unmarried 18–19 Year-Olds’ Level of Agreement with the Statement “I Have All the Information I Need to Avoid an Unplanned Pregnancy,” 2009



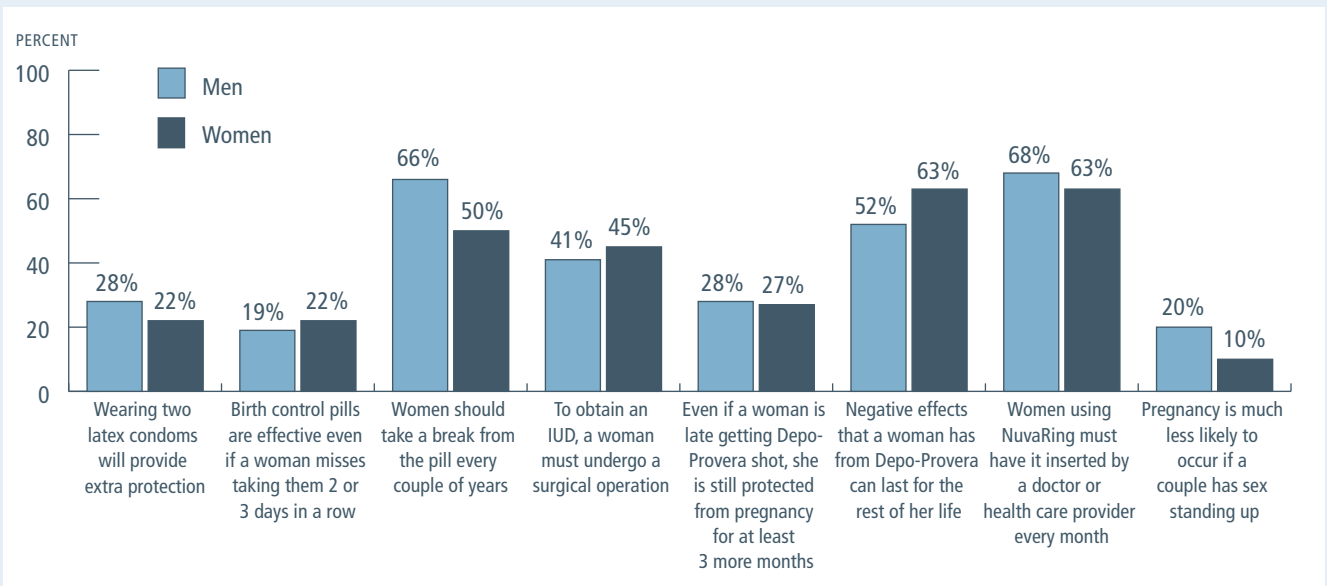
Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

Limited Knowledge

Unfortunately, many unmarried older teens know less than they think they do about various contraceptive methods and seem to harbor myths about many methods. For example—despite no medical evidence to support this belief—more than half of 18–19 year-olds who have used the pill believe that it is necessary for women to “take a break” from the pill every few years, and 15 percent report that birth control pills are effective even if a woman misses taking them 2 to 3 days in a row. Only 21 percent of older teens who have ever used the pill believe that using birth control pills can reduce a woman’s chance of getting certain kinds of cancer, which is actually a potential benefit of the pill [28]. Myths and misinformation are not limited to the birth control pill, they extend to other methods such as condoms, Depo-Provera, the IUD, and the NuvaRing to name a few (Chart 19). These include:

- Among unmarried older teens who have used condoms, four in ten (41 percent) believe it is okay to use petroleum jelly as a lubricant for latex

Chart 19. Proportion of Unmarried Men and Women Age 18–19 Who Incorrectly Report that the Following False Statements are True, 2009



Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

condoms despite the fact that using petroleum jelly as a lubricant actually increases the chance that the condom might break.

- More than half of older teens (58 percent) mistakenly believe that the negative consequences of Depo-Provera can last for the rest of a woman's life.
- Nearly two-thirds of older teens (65 percent) incorrectly believe that women using the Nuva-Ring must have it inserted by a health care provider each month.

Questions About Fertility

In addition to having limited information about various contraceptive methods, unmarried older teens seem to have limited knowledge about fertility in general. While almost all unmarried older teens are aware that a woman is more fertile during certain days of her monthly cycle, less than one-third (28 percent) are able to correctly identify the window of increased fertility. Also, one in five unmarried 18–19 year-olds report that the chance of getting pregnant after one single act of intercourse is almost certain, suggesting that they might overestimate their chances of getting pregnant (the likelihood of getting pregnant from one act of intercourse is actually between 3 percent and 5 percent on average [29]). While this might encourage more consistent contraceptive use, it may also be the case that older teens who have unprotected sex and don't get pregnant incorrectly believe that their fertility is somehow compromised.

Perhaps this partially explains why so many unmarried older teens have concerns about infertility. In fact, 16 percent of all older teens report that it is quite or extremely likely that they are infertile, and fully 1 in 5 older teen girls believe that their likelihood of infertility is high. However, data from the NSFG suggest that only 8.4 percent of women age 15–29 have impaired fecundity (a measure similar to infertility but which is defined as the inability to conceive or carry a baby to term) suggesting that older teens tend to overestimate their likelihood of infertility. It is important to note as well that the vast majority of older teens are not basing their assumptions of fertility on information they received from a

doctor—only 23 percent who believe that it is quite or extremely likely that they are infertile report that the information is based on what a doctor told them. Approximately 14 percent believe they are infertile because a family member has experienced problems conceiving, 28 percent report that they believe they are infertile because they have had unprotected sex and have not gotten pregnant, and 34 percent report some other reason for their belief.

Results from in-depth interviews with community college students provide further support to the notion that older teens and young adults are not very well informed about contraception and fertility more broadly. In the qualitative study approximately one in seven female respondents felt as though their fertility was compromised. While this is a relatively small proportion, the quote from an 18-year-old below describes how these perceptions of fertility might influence contraceptive use.

INTERVIEWER: But you're sometimes not using anything. So tell me a little bit about that, because I'm—I'm a little confused, because you're saying, like, even if you don't have a condom around, you'll use withdrawal, which you think is only 15 percent effective.

RESPONDENT: I—like, I guess 'cause—I don't know. Well, like, when I've been to the doctor, he said that right now I'm not—I don't have a lot of fertility. I'm not very fertile. I guess it's that, and—I don't know, like, we just really don't think. I have talked about it with him, I was like, "Well, what—" Like, I don't want to right now, but if it was to happen, I guess it would be okay. But I would rather for it not to. But I don't—I guess it just happens.

Concerns About Side Effects

In addition to having limited knowledge about various methods of birth control, including popular methods such as condoms and birth control pills, unmarried older teens have great concerns about side effects related to birth control use. For example, fully 39 percent of unmarried older teen women report that it is either quite likely or extremely likely that using birth control pills or other hormonal methods

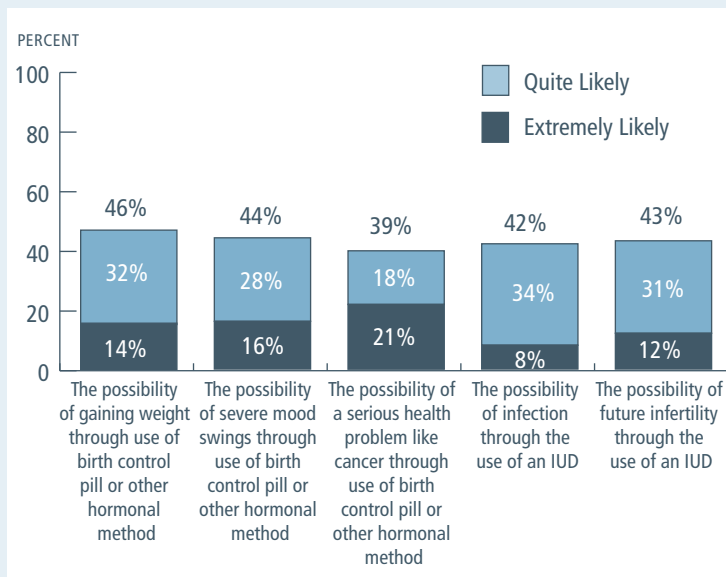
for a long time will lead to a serious health problem like cancer (Chart 20). However, to date, clinical trials have found that developing serious health problems as a result of using the pill is rare, and the likelihood of this occurring is low [28, 30].^d Some studies have even found that birth control pills in particular are protective against certain types of cancer, namely endometrial and ovarian cancer [28].

Similarly, more than four in ten (42 percent) unmarried older teen women report that it is either extremely likely or quite likely that the IUD will cause an

infection. Clinical research suggests that the risk of infection is much lower than older teen women perceive. For example, randomized control trials determined that less than 1 percent of women developed Pelvic Inflammatory Disease (PID) or endometriosis in the first two years after IUD insertion, and these rates of infection are even lower in additional years after insertion [31, 32].

While it is not unreasonable to be concerned about risks associated with various contraceptive methods and want to reduce or avoid these risks, these data

Chart 20. Unmarried Women Age 18–19 Who Believe the Side Effects are Either Quite or Extremely Likely, 2009



Fully half of unmarried older teens strongly or somewhat agree with the statement “It doesn’t matter whether you use birth control or not; when it’s your time to get pregnant, it will happen.”

Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

^d For example, according to a recent meta-analysis by the Mayo Clinic of 39 clinical studies, 13 percent of all women in the general population (including those who did and did not use the pill) will develop breast cancer. Among them, this percentage was about one-fifth higher for women who have used oral contraceptives as compared to those who had not, roughly suggesting *an additional two to three percent chance of developing breast cancer as the result of being on the pill*. The pill has also been associated with an increased risk of heart attack and stroke, but again, the actual risk is orders-of-magnitude-lower than the notion of “highly likely,” with about 1.5 deaths per year in 100,000 non-smoking women under age 45 due to pill use. While not trivial, these numbers are far lower than suggested by many young adults’ perceptions that side effects are highly likely. Put into context, the risk of death from driving a car for a year is more than 10 times higher than risks associated with pill use (approximately 17 per 100,000 men and women who die each year due to driving).

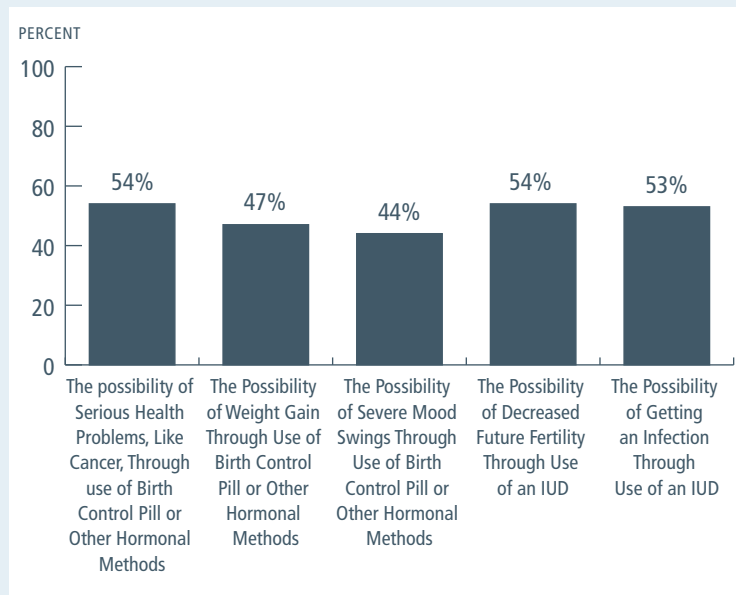
suggest that unmarried older teens greatly overestimate the likelihood of serious side effects, and these misperceptions decrease the chances that they might use some of these methods of birth control, thus putting them at greater risk of an unplanned pregnancy.

Older teens' concerns about side effects from using contraception has a direct impact on whether they will use particular methods (Chart 21). For example, more than half of unmarried 18–19 year-old women (54 percent) report that it is at least somewhat likely that using birth control pills or other hormonal methods for a long time will lead to a serious health problem like cancer *and* this reduces their chances of using these methods. Similarly over half of 18–19 year-old teen women (53 percent) report that it is at least somewhat likely that using the IUD will cause infection and this reduces their chances of using that method. Concerns about other side effects such as weight gain and severe mood swings also decrease unmarried older teens' likelihood of using hormonal methods.

While there are certainly other contraceptive methods that older teens could use instead of hormonal methods or an IUD (such as condoms), barrier methods such as condoms require the user to use them each and every time they have sex. Hormonal methods such as the birth control pill and the patch require consistent use, but not in the moment of sexual intercourse. Methods such as the IUD require even less vigilance on the part of the user and once inserted provide protection for up to 10 years (depending on the type of IUD). Thus, teens' fears about the side effects are leading many of them to avoid using effective methods of contraception and can increase their risk of pregnancy.

Concerns about side effects were also raised during in-depth interviews with community college students. In fact, 89 percent of 18–19 year-olds interviewed reported some concern about side effects, and more than half said that this would limit their use of the method. As the following quotes illustrates, concern

Chart 21. Unmarried Women Age 18–19 Who Believe the Following Side Effects are Likely and This Makes Them Less Likely to Use that Method, 2009



Source: National Survey of Reproductive and Contraceptive Knowledge, 2009.
Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

about side effects may limit older teens' choice of effective contraceptive methods and partners' support for using particular methods.

18-year-old Female

INTERVIEWER: Earlier, you had mentioned there was some concerns about the side effects of the shot... is your decision to use mostly condoms at this point—is that—does the side effects of other birth control methods play a part in your decision to use what you're using right now?

RESPONDENT: Um, kind of, but mostly because of the shot, and he [my doctor] said like it could like take up to two years for me to be able to get pregnant.... Or if I do, they would have to watch the baby closely so it's mostly because like I don't want to use all this birth control, and then when I do have a baby, something could happen to it because the birth control that I used.

INTERVIEWER: Okay.

RESPONDENT: So I just mostly use condoms.

18-year-old Male

INTERVIEWER: You also said that you were worried about side effects with the birth control pill, didn't you?

RESPONDENT: Yeah. You can have nausea, headache, and all that stuff—that I don't want my girl to go through.

A small proportion of respondents indicated that positive side effects were one of the reasons why they started and continued using their method of contraception. The following remarks from focus group participants are illustrative.

Focus Group Participants

RESPONDENT: It's strange but a lot of people, a lot of girls I know started birth control because they had acne and birth control is a great way to control your acne. I started birth control only

because of that, I was a virgin when I started birth control...

RESPONDENT: That's the same way with me, my grandmother put me on birth control when I was 13 or 14 because I was having serious cramps and my doctor was like oh the birth control will fix it. And I have been on it ever since.

RESPONDENT: I didn't start it for sexual activity, I started it because I had crazy periods. I would have one [period] one month and then it would show up again nine months later.

Fatalistic about Contraception

Unmarried older teens seem to underestimate the benefits of using contraception, including the effectiveness of many methods. In fact, close to half of unmarried older teens (47 percent) mistakenly believe that there is a 50 percent or greater chance of getting pregnant while using the birth control pill (in fact there is a 1 percent failure rate if used perfectly and a 8 percent failure rate with typical use). Despite the fact that the majority of unmarried older teens (82 percent) agree that their friends think that using birth control is important, half strongly or somewhat agree with the statement "It doesn't matter whether you use birth control or not; when it's your time to get pregnant, it will happen" (Chart 22). It is clear that many older teens are fatalistic about using birth control themselves. Their limited trust in the effectiveness of birth control combined with concerns about side effects discussed above certainly reduces the motivation to use birth control, particularly hormonal methods, and might increase their risk of unplanned pregnancy.

Unmarried older teens also tend to underestimate the effectiveness of specific methods. Only about half of unmarried older teens recognize that the IUD is more effective than birth control pills and one in five report that condoms and pills are equally effective at preventing pregnancy despite the fact that birth control pills have a lower failure rate (Table 6). This lack of differentiation between method effectiveness might unintentionally limit older teens' birth control options, or discourage them from using a more effective method.

Table 6. Percent of Women Experiencing an Unintended Pregnancy During the First Year of Typical Use and the First Year of Perfect Use of Contraception [28]

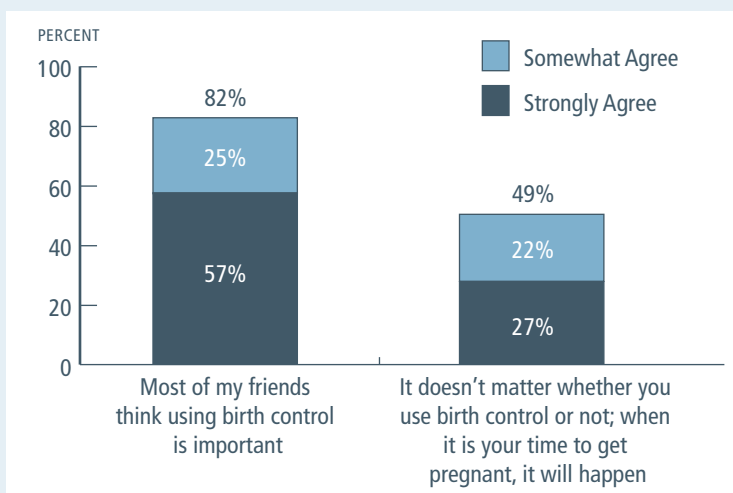
Method	Typical Use	Perfect Use
No Method	85%	85%
Withdrawal	27%	4%
Male Condom	15%	2%
Combined Pill, Patch, Ring	8%	0.3%
Depo-Provera	3%	0.3%
ParaGard (copper-T) IUD	0.8%	0.6%
Mirena (LNG-IUS) IUD	0.1%	0.1%

Source: Hatcher, R., Trussell, J, Stewart, FH, Nelson, AL, Cates, W, Guest F, and Kowal, D, *Contraceptive Technology, Eighteenth Revised Edition*. 2004, New York, NY: Ardent Media.

What it All Means

Taken together, these results suggest that many unmarried older teens are sexually active. The vast majority would like to avoid a pregnancy right now and are using some form of contraception, but their use is many times inconsistent. Despite having received some formal sex education, and living in an age of seemingly unlimited access to information, most harbor misinformation about various contraceptive methods. Older teens also have deep concerns about the side effects of various contraceptive methods, and they are not entirely convinced that contraception is effective at preventing pregnancy. Clearly more work is needed to ensure that older teens have ongoing access to trusted and accurate sources of information about pregnancy planning and contraception. Unfortunately while most older teens trust their health care provider for information, they often turn to other sources instead. Future work might focus on ways to better align older teens' trusted and most used sources of information, perhaps through more innovative use of current technologies. Other efforts might focus on increasing older teens' motivation to use effective methods of contraception and helping this population align their stated goals with their behavior. While access to information alone will not be enough to improve contraceptive use, it seems to be an important step in the process.

Chart 22. Unmarried Men and Women Age 18–19 Who Agree With the Following Statements, 2009



Source: National Survey of Reproductive and Contraceptive Knowledge, 2009. Special tabulations, The National Campaign to Prevent Teen and Unplanned Pregnancy

Section 4. Working With Older Teens and Young Adults

The data presented above suggest that preventing a pregnancy at this point in their lives is very important to older teens. Polling data suggest that most older teens and young adults are interested in delaying pregnancy until later because they are not ready for the financial costs or the responsibility of raising a child, and they believe a child would interfere with their educational and/or career goals [33]. However, their stated goals and actual behavior don't always match. While many older teens are having sex and using some type of contraception, they are not using it consistently. Inconsistent use might be due to misinformation about the method and fertility more broadly or to concerns about particular methods.

Feelings about pregnancy might be influenced by older teens' peers and romantic partners, or an underlying desire to be a parent. In fact, a sizeable minority of older teens say they would be pleased if they found out today that they or their partner were pregnant—this is particularly true of men. Behavioral and attitudinal data about older teens—taken together with the fact that pregnancies and births to older teens account for the vast majority of all teen pregnancies and births—suggest that it is critical for teen pregnancy prevention strategies to include older teens in teen pregnancy prevention efforts. Therefore, practitioners and others interested in preventing pregnancy among older teens need to understand their lives—who influences their decisions and behaviors, their preconceptions about fertility and contraception, their future aspirations for relationships and family, where they turn to for information on contraception—and develop interventions and strategies that address teen pregnancy prevention among this population.

This section includes information from practitioners who are currently working to reach older teens, along with a description of evaluated programs that have included 18–19 year-olds in the target group. There are also examples of work with community college students and suggestions from students themselves about addressing unplanned pregnancy within the community college context. This section is intended to give those interested in addressing the high rates of unplanned pregnancy among this population ideas and recommendations for how to begin working with this age group. Efforts underway in three states are highlighted as well.

Key Lessons Learned from Interviews With Practitioners:

- 1) Make a compelling case for working with older teens (see the state specific spotlights throughout this section for examples of how this has been done in three states).
 - a. Gather available data that will help describe who they are, where they are, what they need to avoid an unplanned pregnancy, and what is/is not available to help them do so (see #2 below).
 - b. Find out what key groups (health, education, social services, employment, youth services, community colleges, training programs, other) know about the needs of older teens and what they provide in terms of programs, services, and supports. Questions to consider: What services are available for older teens? Where are the gaps in services? Which groups might be best suited to

address these gaps? How can services that are currently being provided address the issue of teen pregnancy prevention among this group?

- c. Carefully consider how to frame discussions about unplanned pregnancy within the state and community context and shape discussions in response to feedback from agencies and organizations. Make sure that the benefits of reducing unplanned pregnancy among this population are clear, and that preventing unplanned pregnancy—pregnancies older teens themselves say they want to avoid—is a direct way to help young people reach their educational, career, economic, and/or relationship goals.
- d. When appropriate, present the perspective of older teens and young adults who have had an unplanned pregnancy to highlight the challenges that they may have experienced as a result. In this way the target group has the opportunity to learn from their peers about the issue and why pregnancy planning might be important in their lives.

2) Gather and present state and/or community level data about 18–19 year-olds. These data are critical for helping people understand why efforts should be focused on this.

- a. Some of these key facts include: the proportion of all teen pregnancies and births that occur to older teens and the proportion of pregnancies to older teens that are unplanned. Data on births are available from NCHS (http://www.cdc.gov/nchs/data_access/Vitalstatsonline.htm), and data on pregnancies might be available from your state, county, or city health department.
- b. Include information on the consequences of teen childbearing, particularly for the children of older teen mothers. Many of the consequences for younger teen mothers remain true for older teen mothers as well. More information is available throughout this report and in National Campaign resources such as *By The Numbers: The Costs and Consequences of Teen Childbearing*; *Playing Catch-up: How Children Born to Teen Mothers Fare*; and *Why it Matters: Teen Preg-*

nancy (www.thenationalcampaign.org). Consider working with your state or local health department for state and/or community specific information about low birth weight, preterm birth, breastfeeding, etc. Some of these data are available through the PRAMS survey (<http://www.cdc.gov/prams/>).

- c. When possible, link the teen birth data to education, social services, and/or workforce data and issues that are of concern to policymakers and state/community leaders, such as dropout prevention and creating a skilled workforce. Try addressing such questions as: How many older teens who give birth have graduated from high school? How many older teen parents go on to college or further training?
- d. Consider gathering and presenting qualitative data from focus groups or in-depth interviews with older teens. These discussions might focus on what teens themselves perceive as the benefit of planning their pregnancies and realizing other goals in their lives before starting a family. These examples will help provide context to the quantitative data, and might help a broader audience connect with this issue. Be sure to highlight those stories that provide an example of something that would have helped or did help young people avoid unplanned pregnancy, such as access to health services.

3) Reach out to partners who have a link to this issue and/or this population and could provide specific teen pregnancy prevention programs or services.

- a. It is important to identify key partners who are connected with this age group and then to determine how the issue of too-early pregnancy and parenthood might impact their program or population. For example, many colleges are interested in improving student retention and graduation rates, but teens who become pregnant unintentionally or have a second child that is unplanned might have a hard time staying in school. Help them identify ways their student outreach and health services can address this issue more effectively.

- b. Consider reaching out to other non-traditional partners who are interested in education and economic opportunities for young people, including parenting teens, such as organizations that provide home visiting for young families, alternate education, and/or job training opportunities. Identify employers in your community that might be particularly connected to older teens, or organizations working on STI/HIV prevention. Also consider reaching out to those programs such as early Health Start that work with parents—including a large number of older teen parents—and their children. These organizations might be particularly interested in helping to space and/or delay subsequent pregnancies. Help partners to realize that their own work can be more successful if they help their students, employees, and/or clients avoid unplanned pregnancy by providing ideas or examples of workforce-related programs that include teen pregnancy prevention as a strategy in their employment training programs.
- 4) Consider policies at the state level and address any policies that might make it challenging to work with this population. Start with a focus on state level policies and work down to the specific community-level policies that might hinder progress on these issue. For example, if you are interested in working with health department clinics to make them more teen friendly, consider what kind of policies might be important to address in order to make any changes to the clinic (i.e. extending office hours, etc.)
- 5) Link this issue to other health issues of interest, particularly those that are of interest to this population such as overall health and well-being, alcohol and tobacco use, STI/HIV prevention, and the increased focus on improving overall fitness and nutrition among young people. Consider incorporating the notion of teen pregnancy prevention as one component of an overall good health practice and strategy.
- 6) Include older teens and young adults in your work. For example, consider setting up an advisory group to solicit feedback from older teens in your community. This will help with message development and outreach efforts to ensure that the message to older teens is framed appropriately.
- 7) Know your community or find others that do. This is particularly important if you are a new organization, or are expanding your focus to include older teens. Addressing teen and unplanned pregnancy among this population will require different framing than messages targeted to younger teens and those still in high school. Older teens are able to access their own health care without parental consent which might not be possible for younger teens. There may be fewer opportunities to work with them in a required classroom or auditorium style setting, so programs might need to put more focus on outreach and recruitment for older teens than for younger teens. It is imperative to understand and know how to approach this issue in a way that is appropriate to your community.
- 8) Consider the quality of care that is available for older teens and young adults. For example, determine which clinics they will be able to visit for support and how these clinics respond to older teens and young adults.
- 9) Strategically identify potential funders that might be interested in supporting efforts to both examine this issue in more detail and address this issue in your state and/or community. Funding support will enable your organization to explore the suggestions above and dedicate time and resources to develop partnerships and create materials, products, and programs to fully address this issue.
- a. Federal funding has been made available for teen pregnancy prevention programs and programs and services for pregnant and parenting teens through the Office of Adolescent Health and the Administration on Children, Youth and Families/ Family and Youth Services Bureau. More specifically, competitive funding for organizations was made available to replicate evidence-based programs (Tier 1) and for innovative research and demonstration programs (Tier 2). Both of these funding announcements included pregnancy prevention among 18–19 year-olds as a target population. More information about these funding announcements is available at <http://www.hhs.gov/ophs/oah/prevention/index.html>.

- b. Mandatory funding is also available to states through the State Personal Responsibility Education Programs (PREP) for education on both abstinence and contraception for teens (through age 19) and pregnant and parenting teens through age 21.
 - c. Funding was also made available to provide support to pregnant and parenting teens and women. Activities supported through this funding include a focus on support for pregnant and parenting student services at institutes of higher education and at high schools and community service centers.
- For-profit entities (i.e., local businesses who employ older youth)
 - Non-profit organizations with missions that align with the causes and consequences associated with unplanned pregnancies
 - Community and education groups focused on dropout prevention
 - Early Head Start and home visiting programs serving young parents
 - Foster care and juvenile justice systems serving older teens

Barriers to Focusing on Older Teens

- Lack of concern about addressing pregnancy prevention among “adults,” and the desire to avoid telling adults what to do.
 - Other competing priorities.
 - Policies that encourage a more narrow focus on teen pregnancy prevention.
 - Lack of a traditional focus on unplanned pregnancy through the institutions that most often reach older teens and young adults (i.e. 2- and 4-year schools, technical training programs, etc.)
 - Lack of access to older youth. Older youth are more mobile and they are less likely than younger youth to be in “one place,” such as a high school or after-school program.
- Temporary Assistance for Needy Families (TANF) programs that serve both adolescent children of parents receiving assistance and teen parents themselves
 - If appropriate, you also might consider clubs and restaurants that older teens frequent

Tips for Working With Partners:

- Clearly identify what you need the partner to do. If you’d like them to begin a program of some type, have a suggested program model prepared, packaged, and ready to use. Consider being able to incorporate partner organizations’ input in the program model should they be interested in offering advice about how it might work best for the young people they serve (note that the extent to which you might adapt a program depends on whether or not it has already been evaluated and found to be effective).
- Have examples or ideas of programs that have potential for your community.
- Do your research ahead of time to better understand who your potential partner is working with, and their goals. Consider how your program/partnership will benefit them.

Potential Partners

- Clinics
- Post-secondary educational institutions (2- and 4- year schools)
- Alternative educational settings and/or GED programs
- Job training programs

SPOTLIGHT ON OKLAHOMA

The Oklahoma Institute for Child Advocacy (OICA) has long stressed the need to focus on reducing teen pregnancy among older teens. OICA has worked to ensure that that 18–19 year-olds, not just younger teens, are included in data that is collected about teen pregnancy and in other activities. As the KIDS COUNT grantee in their state, they worked with the Annie E. Casey Foundation to expand the Teen Birth indicator in the national KIDS COUNT Databook to include those ages 18–19. They have promoted the same at the state level, encouraging state agencies to focus on the full 15–19 age range when addressing teen pregnancy and childbearing. OICA prepares teen birth fact sheets that show the birth numbers/rates by age ranges, separating out the 18–19 data, and they have prepared fact sheets focused specifically on the older teen population using data

from the Youth Assets Study. The study is a research project OICA helped design with the University of Oklahoma Health Sciences Center that explores the relationships between risky behavior, including sexual activity, and key protective factors. OICA also has a “young adult” network of their former high school peer educators as they graduate and move on to post secondary education. These students promote prevention issues on their campus and often get their college groups to help OICA promote the National Day to Prevent Teen Pregnancy. They also serve as connections with professors who use OICA’s materials and prevention information in their course work.

Currently, OICA is working with local health care providers to create more teen-friendly environments at their clinics and increase their outreach to older teens, in combination with evidence-based information about

pregnancy prevention that address the lives and health needs of older teens more effectively. The goal is to provide teens with the information and clinical services they need to avoid too-early pregnancy. Areas of specific focus have included: (1) expanding and/or changing the hours of the clinic to accommodate before and after work and/or school appointments, (2) building partnerships with local high schools and alternative schools to expand health services and prevention programs, and (3) making the services more culturally appropriate for specific populations or neighborhoods.

OICA has also been very involved in efforts to reduce teen pregnancy among youth in foster care. This includes working with key agencies with the goal of ensuring that teens who are aging out of the foster care system have the support they need to make positive, and healthy decisions.

Considering Community Colleges

Another important group to reach out to is students in community colleges. Data suggest that 61% of women who have children after enrolling in community college do not complete their education [34]. Therefore, addressing unplanned pregnancy among this population is particularly important for student retention. Many community college students are either older teens or are in their early twenties, and currently approximately 43 percent of all community college students are 21 or younger.

The National Campaign is working with several community colleges and networks throughout the country to reduce unplanned pregnancy among this population. In addition, The National Campaign commissioned a qualitative interview project of community college students. As part of this project students and faculty were asked to consider what types of outreach strategies might work best for their campus, and how a group such as The National Campaign might work to increase consistent contraceptive use among community college students. The ideas below reflect input from the qualitative research, as well as from our ongoing interactions with community college administrators, faculty, and students [35].

Recommendations and Strategies

- Embed discussions about relationships, sexual decision making, and avoiding unplanned pregnancy in academic courses as well as in orientation, first year experience, and college success classes.
 - Underscore for students, faculty, and administrators the connection between unplanned pregnancy and student retention/completion.
 - Disseminate information about contraceptive methods and how to access contraception in various formats such as websites, brochures, orientation materials, and student events.
 - Consider ways to increase access to contraception—either on campus or through referrals to community providers.
- Ensure that efforts to provide contraception or information about contraception respect students' privacy.
 - Make sure that both men and women feel included in outreach and activities.
 - Offer programs to improve negotiation and communication skills with partners and parents.
 - Offer information that is sensitive to the needs of specific populations (for example, students from diverse cultures, those who are already parents, etc).

Be Strategic About How Information on Pregnancy Prevention is Provided

Community college students typically do not live on campus and do not spend a lot of time on campus other than to take classes. They are often juggling school, work, and sometimes family responsibilities as well. In addition, most community colleges have limited resources to deal with the non-academic lives of their students. As a result, the most effective way to reach students with information about pregnancy prevention is likely to be through courses and activities they are already enrolled in rather than add-on activities. For example, several colleges are embedding discussions about unplanned pregnancy in a range of academic classes and both students and faculty are welcoming these opportunities to address an important topic that has not been much discussed in the past.

The issue of improving student completion is a top priority for community colleges, so helping students (and administrators) understand how unplanned pregnancy can affect their ability to achieve educational goals is a compelling framework for discussing this issue. The National Council on Student Development recently completed a curriculum called *Making Smart Choices to Improve Success in College and Life* that can be included in student orientation, first year experience, and college success courses. The goal is to deepen students' recognition of how unplanned pregnancy can derail their educational success and future goals, and to help them understand and reflect on the factors that influence their decisions and behavior about sex, relationships, and pregnancy as they relate to achieving educational goals and

college success. This material will also provide links to contraceptive information to enhance students' knowledge of the full range of birth control options. The following quote clearly articulates how students might connect pregnancy planning with their goals for the future:

RESPONDENT: At least personally, I always take these things into consideration; like if you were going to think about your life, what you do today and your actions, like if you were to not prevent pregnancy and were to get pregnant, you might not be able to do other things, like transfer colleges or pursue things. My goal is to get married and then have kids later, and that all kind of ties into each other, I guess.

Community college students interviewed through qualitative research underscored the importance of finding ways to deliver information that was meaningful for their lives and schedules. They recognized that more information about various contraceptive methods might be helpful, but they were very reluctant to go through "sex ed" again. As the following quotes illustrate, many students had unfavorable memories about their high school sex education classes, and they were not eager to repeat those experiences.

Female Focus Group

RESPONDENT: When I think of "sex ed" I think of those disgusting pictures that they showed us that scared me to death. [laughs]

RESPONDENT: I feel like high school sex education pretty much is made to scare the students from having sex.

There also seemed to be some sentiment that sex education was for younger teens. In addition to a general dislike of previous sex education classes, many students did not want to pay credits to take another sex education class, and would resent paying those credits if the class were mandatory for graduation.

However, many students said that if information about pregnancy and sex were presented in the right way, students would be interested. One student sug-

gested that naming and setting up the class in the right way will help to draw students in:

Female Focus Group Respondent

RESPONDENT: There's discussions like every Tuesday or Wednesday, that my manager Melissa does [with students], and the last one was, "Mini Skirts and Skinny Jeans" because guys are into wearing skinny jeans now and girls with the mini skirts, and we were having a discussion about sex.... Sex and how men view women, you know, with the mini skirt and everything, so I guess that was included in the discussion.... And we didn't come straight out and say sex is going to be a part of it, we called it "Mini Skirts and Skinny Jeans discussion" and it was pretty packed.

Students suggested that using media outlets and technology resources might be a good way to get information to students about birth control, relationships, and any services available on campus and in the community. Using radio or television was appealing to many students. Some also suggested using comedy as a means of sharing the information.

Male Focus Group

INTERVIEWER: So thinking about the radio station, what would, um—whether it's a show or the format, what would it have to [do]... to get community college students to engage in discussions about birth control?

RESPONDENT: It got to be funny. Just like a radio station, you know what I'm saying?

RESPONDENT: Somebody's going to call you... and they just like, "Yeah, ask a question." Any random question, no problems.... 'Cause most people, if you ain't partying during the week-night, and you bored, you in the house, you turn on the radio, you listen to that joint, call in, do whatever... Every day be a different topic you can talk about.

RESPONDENT: They got to be energetic, flat-out, like...there can't be no limit to what they can do

SPOTLIGHT ON SOUTH CAROLINA

The South Carolina Campaign to Prevent Teen Pregnancy currently has an effort underway to increase older teens' access to and use of clinical services. The project is specifically focused on older teens because two-thirds of all teen pregnancies in the state occur to older teens. The project was preceded by more than a year of research which included collecting and analyzing existing data from the state health department as well as

original data collection from 2- and 4-year post secondary institutions across the state. For more information about the project and its results, read *Population Left Behind* (<http://www.teenpregnancysc.org/pdf/PopulationLeftBehind2009.pdf>)

The research indicated that there was a clear need to focus on this population (18–19 year-olds), and that one promising area for intervention might be to connect teens to clinical services. The South Carolina

Campaign is committed to increasing access to sexual health services and to increase the quality of these services for older youth. The project has focused on older teens attending 2-year colleges throughout the state because these colleges, in general, do not have any on-campus clinical services. The project has been ongoing for almost a year and is currently working with eight colleges and six clinics (6 colleges are 2-year schools and 2 colleges are 4-year schools).

or say on that radio. Like, they got a limit, but at the same time, they can't be like, "Yeah, you can't do this, you can't say that, you can't say that." Like, it can't be no restrictions, like, they gotta be flat-out, 'cause nowadays in the world, you gotta be flat-out [honest].

INTERVIEWER: Would it be helpful to also have some times that, um, maybe somebody from the health department to come and talk about—

RESPONDENT: Don't try to act all professional.

RESPONDENT: Yeah, I don't like that.

RESPONDENT: And don't be with it all for like an hour, go in there talk for 15 minutes, and then switch to a vicious song.

Students also suggested using written media such as posters and flyers in campus student centers. There was an overall feeling that new marketing campaigns were needed and could be effective in raising aware-

ness about using birth control consistently and how to deal with relationship pressures.

One campus already publishes a newsletter for distribution in bathroom stalls—this would be a good way to include information about birth control and other sex-related information. Students recommended that other campuses might have similar newsletter type media that could work well for providing information.

Students were hesitant to endorse using email or texting. They were seen as intrusive (especially texting) and unnecessary.

Increasing Access to Contraception

Most community colleges do not have student health centers, and even those that do often don't have the capacity to provide a full range of contraceptive methods. There seems to be mixed feelings and experience about whether it is worth expanding access to health services on campus, not to mention that it may not be feasible due to financial, scheduling, and/

or staffing constraints. Some students interviewed agreed that having a campus health clinic that provided reproductive health services would certainly increase access to birth control. One student who fully supported this idea stated: *“If I had a million dollars, I would build a campus clinic... and consider that students don’t live on campus so the hours of operation should be at different times.”*

However, other students expressed privacy concerns, and were less enthusiastic about a clinic on campus. Some even went so far as to say that they would not want to be seen entering a clinic because others would know that they are going to get birth control. An 18-year-old female expresses this sentiment:

RESPONDENT: ...the clinic program...needs to be aware that students are embarrassed about birth control and don’t want to be seen trying to access birth control or get information about birth control.”

The following from another female student reiterates this concept:

RESPONDENT: I don’t want nobody to see me going here. It doesn’t matter if you are going to speak to somebody or if you are going to get a test, because from the outside of that door, nobody else knows. But you still always wondering somebody might judge me for this.

An alternative solution is for community colleges to forge partnerships with community health providers and pregnancy prevention experts to ensure that students know where they can go to get affordable contraception. For example, Montgomery College in Maryland has invited the nearby Teen and Young Adult Health Connection clinic to attend orientation and campus health fairs to make sure students and staff know they are available to provide information and services.

Addressing Men

It is also important for community colleges and other programs to consider how to engage young men. Interviews with young men attending community college suggested that many felt that there were not

many resources available for them. The following statements from a focus group discussion sum up these feeling:

RESPONDENT: There isn’t a lot of stuff for men here. I mean, if a girl gets pregnant, they have... therapy and all that kind of stuff.

And I know people hand out condoms and stuff, but, you know, if like a guy, like, is dealing with the backlash of getting a girl pregnant, I mean, he is [going through something] pretty fierce, too. I don’t think there’s a lot of stuff for men. People just focus on the female’s worries and stuff, which is understandable. I mean they’re the ones that are pregnant. But, I mean, guys’ [worries are] fierce too. And I think if they were met more, then they’d probably be less afraid of what’s coming.

RESPONDENT: I took the initiative to actually look up on the Internet that, you know, these things that—that I may not have known about, or that, you know, I had heard about and wasn’t exactly clear on. And I feel like I really had to go take a lot of initiative to find out about these things that really, in the long run, should be essential to, you know, anyone who’s sexual—sexually active. Um, and so I feel like, you know, I was—I was lucky enough to take that initiative and inform myself, but not everyone’s going to be able to—gonna want to or be able to take that step, and that’s why I feel like these things should be, you know, taught to us instead of, you know, us having to go out and seek that information ourselves.

While the responsibilities of an unplanned pregnancy and becoming a parent often fall most directly on young women, an unplanned pregnancy can also make it difficult for male students to finish school. Many male students have to drop out of college to earn enough money to support a child. It is also worth noting that more community colleges are beginning to focus in particular on the retention of minority male students. The special clubs, activities, and staff dedicated to such initiatives offer good opportunities to address topics such as promoting healthy relationships and avoiding unplanned pregnancy.

Programs for Older Teens

The vast majority of evidence-based teen pregnancy prevention programs target middle school or early (9th-10th grade) high school students. However, there have been some programs targeting individuals age 18 and older. Many of the programs targeting 18- to 19-year-olds and beyond are HIV/AIDS prevention programs offered through clinical settings. The following section provides information about programs that have been developed and found to be effective with older teens. Programs with more modest evidence of success are also noted. In addition, we present some lessons learned from other programs that have successfully changed the behavior of older teens and young adults. Also, while not presented below, programs targeting pregnant and parenting teens often work with 18- to 19-year-old teen parents, and might be helpful to consider if you are interested in preventing subsequent teen pregnancies. For information about programs for pregnant and parenting teens please refer to *Another Chance: Preventing Additional Births to Teen Mothers* and *Science and Success: Programs that Work to Prevent Subsequent Pregnancies Among Adolescent Mothers*.

Evidence-Based Programs: Identifying and Including Programs

The programs listed below were gathered from a review of three major sources and a scan of relevant literature. The specific sources were:

- The 2009 Compendium of Evidence-Based HIV Prevention Interventions developed through the HIV/AIDS Prevention Research Synthesis Project [36];
- *What Works for Older Youth During the Transition to Adulthood: Lessons from Experimental Evaluations of Programs and Interventions* Research Brief from Child Trends, Inc. [37]; and
- The Impact of Programs to Increase Contraceptive Use Among Adult Women: A Review of Experimental and Quasi-Experimental Studies, research article [38].

The programs described briefly below have been carefully evaluated and have met several criteria.

Specifically, each of these program evaluations must include at least the following characteristics:

- Been completed and published in 1980 or later,
- Been conducted in the United States or Canada,
- Included older teens (age 18–19) in the target age group,
- Included baseline and follow-up data (for at least 3 months),
- Measured impact on behavior,
- Included at least 75 people in both the treatment and the control groups,
- Used sound statistical analyses, and
- Used an experimental or quasi-experimental evaluation design.

Advance Provision of Emergency Contraception

Two studies have focused specifically on whether or not the advanced provision of emergency contraception (EC) would increase use of the method among young women ages 14–24 and 15–24. The intervention in both studies consisted of giving young women who visited family planning clinics several packets of EC to take home. The first study compared women who received three free packets of EC to a group who received instructions on how to obtain EC from participating pharmacies and clinics, and another group who received instructions to return to the clinic for EC if needed. The intervention was evaluated using an experimental design, and behavior was measured 6-months after baseline. The evaluation determined that young women who received EC in advance were more likely to report using EC in the past 6 months compared to those who were given instructions to return to the clinic. However, they were also less likely to report using condoms in the past 6 months (47 percent versus 54 percent) compared to their peers who were told to return to the clinic.

The second study used an experimental design and women were randomly assigned to either receive two packets of EC and free refills, or instructions to return to the clinic for EC at the regular price. The young women were followed for 12 months and those who received the EC in advance were more likely to use it than their peers who received instructions on how to get the EC. There were no other differences between the two groups in terms of contraceptive use, frequency of sex, and incidence of pregnancy and STIs.

Female Condom Skills Training

The Female Condom Skills Training Intervention (FEM-IT) is a four-session intervention based on the Social Learning Theory targeting women who attend family planning clinics. The overall goal of the intervention is to increase the use of female condoms and increase the number of sexual acts that are protected. All four sessions take place at the clinic. The first 2 sessions, lasting approximately 2 hours each, are individual

SPOTLIGHT ON TEXAS

Healthy Futures of Texas is a non-profit organization dedicated to reducing teen and unplanned pregnancy in San Antonio and Texas. In order to focus on this issue more specifically among older teens and young adults ages 18–29, the organization formed the Healthy Futures Alliance. The goals of the Alliance are to raise awareness of the issue of teen and unplanned pregnancy and to develop tools and strategies for reaching older teens and young adults with important messages about pregnancy planning. The Alliance raises awareness of the issue broadly through various press conferences and other media outreach. They also developed a campaign directly targeted to teens and young adults, to encourage them to

think about this issue, and take steps to prevent and unplanned pregnancy.

After extensive focus group discussions with young people in the community, the Alliance developed the “R U Ready to be a Parent” campaign targeting both young men and women. The effort seeks to highlight the importance of planning and preparation for a pregnancy. The campaign also connects young people to family planning services in the community. The Alliance has developed materials that can be distributed by various community partners to the young people they serve (for an example of these materials visit <http://www.healthyfuturestx.org/>). The materials ask the question “R U ready to be a parent?” and include a listing of local

family planning clinics where the young people can learn more about preventing an unplanned pregnancy. The Alliance’s Council of Young Adults provided feedback on the resources as well to ensure that they were appropriate for the older teens and young adults in the community. The Alliance is currently working to disseminate these resources throughout the community.

In addition to these activities, the Alliance has developed a legislative agenda focused key policy issues to help reduce teen and unplanned pregnancy throughout the state of Texas. For more information about Healthy Futures’ activities, and if you have any questions or comments, please email info@healthyfuturestx.org.

counseling sessions with a trained health educator. The third session is a group session with 6 to 10 women and 2 facilitators, lasting approximately 2.5 hours. The final session is an individual session and lasts 30 minutes. The sessions included demonstration and practice using male and female condoms, discussions of personal barriers to female condom use, and effective communication skills for negotiating female condom use with a male partner.

The intervention was evaluated using an experimental design with follow-up surveys 3 and 6 months after baseline. Participants were age 18 to 39—the majority were between ages 18 and 24—and they were not planning to get pregnant in the next 6 months. At the six month follow-up, women in the intervention group were significantly more likely to report using any type of condom (male or female) than women in the control group. At both the 3 month and 6 month follow-up women in the intervention group were significantly more likely to report using the female condom at least once compared to women in the control group.

More information about the intervention and the evaluation results are available at: <http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/femit.htm>

HORIZONS

HORIZONS is a clinic-based small group intervention culturally tailored to female, African-American adolescents ages 15 to 21. The intervention, which was developed based on the Social Cognitive Theory and the Theory of Gender and Power, includes a combination of group sessions and individual follow-up phone calls. The intervention is designed to reduce STIs, increase condom use, increase communication with partners about safer sex and STIs, and increase male partners accessing clinical STI services. It consists of 2, four-hour group sessions on consecutive Saturdays and 4 follow-up phone calls (15 minutes approximately) every 2.5 months. The group sessions are facilitated by trained African-American health educators and use various strategies: discussion, exercises, games, practice, role plays and printed material. Participants are also given vouchers to access STI services.

The intervention was evaluated using an experimental design. Behavior were measured 6 and 12 months after the completion of the group sessions. The women in the intervention group were significantly more likely to report using condoms, and using condoms consistently compared to the women in the control group (at both the 6 and 12 month follow-up). There were also significantly fewer new Chlamydial infections among the women in the intervention group compared to those in the control group at both the 6 and 12 month follow-up.

More information is available at:

<http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/horizons.htm>

<http://www.thenationalcampaign.org/resources/viewprogram.aspx?id=13>

Focus on the Future

Focus on the Future is an intervention targeting young, heterosexual African-American men newly diagnosed with an STI. The men are recruited from an STI clinic and are between the ages of 18 and 29. The intervention consists of a brief 45–50 minute counseling session led by a lay health advisor. The lay health advisors are recruited from the area around the clinic, and are hired based on their ability to comfortably talk about sensitive issues such as sexuality and STIs, and to establish rapport with other young men. The lay health advisors attend intensive training on specific STI prevention messages. The intervention, which was based on the information, motivation, and behavioral skills model, was designed to promote men's quality, correctness, and consistency of condom use. The intervention seeks to increase young men's knowledge and skills with respect to condom use, and encourages them to personally respond to the HIV/AIDS epidemic.

The intervention was evaluated using an experimental design with follow-up 3 months and 6 months after baseline. Young men in the intervention group were significantly less likely to acquire a subsequent STI within the 6 month follow-up interval compared to young men in the control group (50 percent vs.

32 percent). Young men in the intervention group also reported significantly fewer sexual partners, and fewer acts of unprotected sex compared to the control group. Young men in the intervention group were approximately 2 times more likely to report using condoms the last time they had sex compared to peers in the control group.

More information is available at:

<http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/focus-future.htm>

Project the Future is Ours

Project the Future is Ours is a small group, clinic-based intervention informed by the AIDS Risk Reduction Model and Social Learning Theory. The intervention consists of 8, 2-hour group sessions followed by a booster session approximately 7 months after the final group session. The intervention is focused on strengthening communication skills, particularly those necessary to negotiate safer sex, and is led by two female facilitators.

The intervention was evaluated using an experimental design with follow-up 1, 6, and 12 months post-intervention. Participants were all young women (the mean age was 22), and the majority were African-American. Twelve months after the intervention (and approximately 5 months after the booster session), women who participated in the eight-session intervention reported fewer unprotected sexual occasions and more condom protected occasions compared to those in the control group.

More information is available at:

<http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/FIO.htm>

Project SAFE

Project SAFE is a clinic-based intervention for African-American and Mexican-American adolescents age 14–24. The intervention, which is based on several behavioral theories including the Health Belief Model, self-efficacy theory, decision-making models, and diffusion theory, consists of three small group sessions

lasting 3–4 hours. Participants are recruited during their visit to an STI clinic. The overall goal of the intervention is to encourage participants to recognize their risk for STIs, commit to reducing that risk, and seek solutions to reduce that risk. The intervention is delivered to groups of either Mexican-American or African-American women by a trained female facilitator of the same race/ethnicity as the participants. Activities include discussions, games, videos, behavior modeling, and role play.

The intervention was evaluated using an experimental design with follow-up 6 months and 12 months after baseline. Women were randomized to receive either the intervention or standard counseling. Women who participated in the intervention were significantly less likely to have Chlamydial or gonorrheal infections 6 months after the intervention and 12 months after the intervention compared to women in the control group. They were also less likely to report multiple sexual partners (32.5 percent compared to 43.9 percent), and unprotected sex (70.3 percent reported 5 or more acts of unprotected sex compared to 79.8 percent of control group women).

More information is available at:

<http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/SAFE.htm>

<http://www.thenationalcampaign.org/resources/viewprogram.aspx?id=73>

RESPECT

RESPECT is a one-on-one counseling intervention conducted in public, inner-city STI clinics and designed for both men and women. The evaluation tested two interventions: (1) an enhanced counseling model that was based on the theory of reasoned action and social cognitive theory and consisted of 4 individual counseling sessions lasting approximately 60 minutes each (20 minutes for the first session); and (2) a brief counseling model based on the CDC's recommended HIV counseling practices and consisted of 2 individual counseling sessions lasting 20 minutes each. Both types of counseling were designed to be interactive and engaging, and were compared to a didactic session that was not interactive. Participants

were aged 14 and older, and many of them were young adults (median age was 25).

The intervention was evaluated using an experimental design, and follow-up was conducted 3, 6, 9, and 12 months after baseline. The brief counseling sessions had greater retention rates than the enhanced counseling sessions, and both had similar outcomes. Participants in both types of counseling were found to be more likely to report “no unprotected vaginal sex” at the 3 month follow-up (46 percent in enhanced, 44 percent in brief, and 38 percent in standard care). This trend was similar, though smaller at the 6 month follow-up (39 percent enhanced and brief vs. 34 percent of didactic messages). Other behavioral outcomes included increases in any use of condoms and condom use at last sex among those in the counseling interventions compared to the control group.

More information is available at:

<http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/RESPECT.htm>

Sisters Saving Sisters

This clinic-based intervention, which is based on components from effective curriculum-based programs that were adapted for use in a clinic setting, is targeted to urban African-American and Latina female adolescents. The intervention consists of 1 small-group (2–10 youth) session lasting approximately 4 hours and is led by a female facilitator. Session activities include: group discussions, video-tapes, games, and experiential exercises. Participants also practice condom skills, handle condoms, practice putting condoms on models, and role play condom use negotiation. The effective skills-based workshop addresses such topics as perceived vulnerability to STIs, elevated risk of inner-city minority women for contracting an STI, beliefs relevant to HIV/STI risk reduction, the importance of condoms, and the belief that condoms interfere with sexual enjoyment.

The intervention was evaluated using an experimental design in which sexually active teens between ages 12 and 19 were recruited from an adolescent health clinic and randomly assigned to receive either a skills-based intervention, an information-based

intervention, or no intervention. The skills-based intervention was found to change behaviors, but there was no impact on behavior from the information-based intervention. More specifically, twelve months after the program, teen girls in the skills-based intervention were less likely to have sex without a condom in the three months before the survey, less likely to report multiple partners in the three months before the survey, and less likely to test positive for an STI.

More information is available at:

<http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/sisters-saving-sisters.htm>

<http://www.thenationalcampaign.org/resources/viewprogram.aspx?id=11>

Other Reproductive Health Interventions that Include Older Teens

The following programs either do not meet the inclusion criteria described above for consideration as an evidence-based program, or they had mixed results with respect to their outcomes. However, these programs are included here to provide practitioners with potential ideas for reaching this age group, and working to reduce unplanned pregnancy among older teens.

Contraceptive Initiation in an Alternate Setting—An STI Clinic

In an effort to improve contraceptive use among young women, an intervention was designed to provide initial family planning services at an STI clinic. The intervention included one-on-one contraceptive counseling, an initial supply of methods (oral contraceptives, Depo-Provera, or diaphragms), a review of the services that reproductive health providers in the same community offer, an appointment at a provider selected by the participant, and a follow-up appointment reminder. Women ranged in age from under 19 to 29, but more than three-quarters were younger than 25.

The intervention was evaluated using an experimental design with follow-up 4, 8, and 12 months after

the initial visit. The control group received routine information about contraception. The evaluation found that four and eight months after receiving the intervention, women were more likely to have received care from the provider they selected, to be using an effective method of contraception, and to be using dual methods (hormonal contraception and condoms) compared to women who did not receive the intervention. There were no differences at 12 months. In addition, the proportion of women who became pregnant did not differ between the control group and intervention group.

FOCUS

FOCUS is a cognitive-behavioral intervention designed to prevent STIs and unintended pregnancy among young women. The intervention consists of four, 2-hour modules with information and skills building activities. In particular, communication skills and condom use skills are emphasized. Participants are young women age 17 and older. The intervention is delivered by two facilitators to groups of 20–25 women.

The intervention was evaluated with a population of female marine recruits using an experimental design. Participants were assigned by platoon to either receive the intervention or be in the control group, and completed follow-up screening and questionnaires one month and one year after the intervention. When the measures were combined, the intervention group was significantly less likely to experience an unintended pregnancy or to acquire an STI when compared to the control group (there was no difference in unintended pregnancy or STI acquisition alone). However, there was no difference in consistency of condom use or number of sexual partners between the two groups.

More information is available at:

<http://www.childtrends.org/Lifecourse/programs/focus2.htm>

<http://www.socio.com/srch/summary/pasha/full/past22.htm>

Varying the Timing of an HIV Prevention Intervention

This intervention focused on HIV-risk reduction among adolescents age 13 to 24. The participants were recruited from an urban social service agency. The intervention, which was based on the principles of cognitive behavioral theory and social learning theory, tested one program offered in two different formats—either seven 1.5 hour sessions or three 3.5 hour sessions. Regardless of the implementation strategy, each session focused on new skills, gave participants opportunities to practice those skills, and had participants set goals to work on before the next session. Each session included a focused review of personal successes for each participant and ended with participants complimenting one another.

The intervention was evaluated using an experimental design. Three months after the intervention, participants in the seven-session intervention reported fewer sexual partners than those participants in the three session intervention or control group. There were no differences between the three groups for unprotected sex or drug use. There were also no differences between the three session intervention group and the control group.

More information is available at:

<http://www.childtrends.org/Lifecourse/programs/varyhiv.htm>

Condom Promotion Videos for College Students

This intervention consisted of two, gender specific 30 minute videos designed to promote condom use among college students. The video for male students featured males discussing condom use and the video for female students featured females discussing condom use. The intervention was evaluated using an experimental design and the control group did not watch a video. A follow-up survey was conducted four months after watching the video. The evaluation determined that students who watched the videos had great intentions to use condoms, and more positive attitudes toward condom use compared to students who did not watch the videos. Students who watched the videos were also more likely to use

condoms with a regular partner than students who did not watch the video, but there was no difference between the two groups in terms of condom use with a casual partner.

More information is available at:

<http://www.childtrends.org/Lifecourse/programs/condom.htm>

Brief Individualized Computer-Delivered Sexual Risk Reduction Intervention [39]

This intervention was targeted to college age students and was developed based on the information, motivation, and behavioral skills model. The intervention was delivered by computer and was tailored to each participant's individual skills and needs. The goals of the intervention were to provide participants with information on HIV and condom use, motivate participants to engage in HIV-preventive measures, and give participants the skills necessary to avoid HIV. The intervention was evaluated using an experimental design and was found to increase knowledge of condoms and condom use, and increase the frequency of having condoms available among the intervention group compared to the control group. The intervention group was also more likely to report using a condom or persuading their partner to use a condom one month after the intervention. Note that the follow-up timeframe was only one month and the sample size for the intervention and control groups was less than 75 each.

Other Types of Programs Targeting Older Teens and Young Adults

The programs below target behavior change among older teens and young adults, but they do not focus on reproductive health-related outcomes. They are included to provide examples of the wide variety of programs that focus on older teens and young adults, along with examples of different types of outreach strategies that might be used to reach this population. Practitioners interested in targeting this age group might consider partnering with these types of programs, or using some of the outreach and intervention strategies (such as computer delivered interventions) that are described below.

Substance Use: Computer Delivered Interventions [40]

A review of computer delivered interventions (CDIs) to deliver alcohol education and counseling determined that these types of interventions can reduce the quantity and frequency of drinking among college students, and that the outcomes are similar to alternative alcohol-related interventions. CDIs are seen as an appealing way to deliver alcohol-related risk reduction messages because they can be accessed by students on their own time and at their own pace, unlike in-person interventions. CDIs also allow the content to be personalized according to the students' characteristics, and there is a potential to engage youth through games and virtual simulations. This review article looked at 43 separate interventions and determined that in general CDIs had a positive impact and the outcomes were similar to other types of alcohol-related interventions. This review suggests that these types of interventions are certainly worthy of further investigation, and perhaps might have relevance for other public health interventions targeting this age group.

BASICS

BASICS is a brief individual preventive intervention designed to reduce drinking and enhance awareness about alcohol-related issues. The intervention uses motivational interview techniques to provide participants with skills to reduce alcohol consumption and knowledge and insight about the consequences of drinking. The program has been evaluated several times; one evaluation occurred on a college campus and targeted students at high-risk for drinking during college. In order to identify high-risk drinkers, students were mailed a questionnaire the summer before their first year of college. High-risk drinkers were those who reported: (1) drinking at least once a month, (2) consuming 5–6 drinks on at least one occasion in the last month, or (3) experiencing at least 3 negative consequences from drinking on 3 to 5 different occasions in the past 3 years. Potential participants were contacted by phone or mail and asked to participate in the intervention. The intervention consisted of one 50-minute session delivered by a graduate clinical psychologist. Participants were

studied 6 months after the intervention and then annually every fall for 4 total years. The intervention was evaluated using an experimental design and was found to decrease binge drinking over 4 years, decrease negative consequences from drinking, and decrease drinking quantity and frequency. The difference between the intervention group and control group was only significant the first year after the intervention.

More information is available at: <http://www.childtrends.org/Lifecourse/programs/BriefAlcohol-ScreeningBASICS.htm>

Healthy-Relationship Education: Love Notes

Love Notes is a relationship education intervention targeting older teens and young adults who are at risk of experiencing an unplanned pregnancy, being involved in a troubled relationship, or are pregnant and/or parenting. It is designed to help young women and men make wise choices about partners, sex, relationships, pregnancy, and more. The intervention focuses on building assets and developing protective factors such as young people's future aspirations for themselves, their relationships, and their children (now or in the future). The curriculum is 15 sessions long and takes approximately 20 hours to teach the full curriculum. It is administered in a group setting of 5 to 20 people depending on the number of facilitators. Facilitator training is available. Topics covered include: knowing myself, forming and maintaining healthy relationships, frameworks for assessing relationships and making decisions, recognizing unhealthy relationships, responding to dangerous relationships, effective communication, conflict management, intimacy, sexual values, pacing relationships, planning for choices, and unplanned pregnancy and relationship turbulence through the eyes of a child.

A pilot evaluation of the Love Notes program is currently underway (year one has been completed and year two is in progress) in partnership with Youth Build. A more rigorous, experimental evaluation is underway in two additional sites. For more information about the Love Notes program go to: http://www.dibbleinstitute.org/?page_id=1728

Employment Training

Job Corps is a program that provides employment assistance. It is targeted to disadvantaged youth age 16 to 24 who are identified through outreach and admissions agencies. These agencies include private non-profit firms, private for-profit firms, state employment agencies, and the Job Corps centers themselves. These agencies provide information about the program to the public through outreach activities (for example, by placing advertisements and making presentations at schools), screen youth to ensure that they meet the eligibility criteria, assign youth to centers (when the regional office delegates this function), and arrange for transportation to centers. Program participants have the option to complete the program through the residential status or the nonresidential status. An experimental evaluation was conducted to determine whether or not the program was effective at improving the employability of disadvantaged youth. Youth in the control group were eligible for Job Corps, but were not given the option to enroll and instead could select another training or education program. The evaluation determined that Job Corps significantly increased the percentage of youth who attended an education or training program, as well as the amount and intensity of their education and training. On average, Job Corps increased participants' time spent in education and training programs by about 1,000 hours. The impact was equally large across all key subgroups of youth defined by their characteristics at baseline. In addition, those youth in Job Corps were more likely to obtain a GED during the 4 year period than youth in the control group (42 percent versus 27 percent). However, the program had no effect on college attendance or completion. Job Corps was found to increase the earnings and likelihood of employment for all participants except 18- and 19-year-old Hispanic youth. The evaluation did not find an impact on the likelihood of having a child or living with and providing support for a child. Participants, however, were significantly more likely to be married than controls. Job Corps also significantly reduced participants' involvement with the criminal justice system.

More information is available at: <http://www.childtrends.org/Lifecourse/programs/JobCorps.htm>

Conclusion

This report is intended to provide key data and information about the importance of including older teens in efforts to reduce teen pregnancy along with suggestions for strategies and programs that might be considered when working with this population. Despite progress made in reducing the teen pregnancy and birth rates in the past two decades, the United States continues to have much higher teen pregnancy and birth rates than other developed countries. Given that pregnancies and births to older teens account for the vast majority of all teen pregnancies and births, it is critical to include a focus on this population and address the full population of teens in our efforts to reduce teen pregnancy in the United States.

References

1. Martin, J.A., Hamilton, B.E., Sutton, P.D., Ventura, S.J., Mathews, T.J., Kirmeyer, S., Osterman, M.K., *Births: Final Data for 2007*. National Vital Statistics Reports, 2010. 58(24).
2. Guttmacher Institute, *U.S. Teenage Pregnancies, Births, and Abortions: National and State Trends and Trends by Race and Ethnicity*. 2010, Guttmacher Institute: New York, NY.
3. Hamilton, B., Martin, J.A., Ventura, S.J., *Births: Preliminary Data for 2008*. National Vital Statistics Reports, 2010. 58(16).
4. Hoffman, S.D., *By the Numbers: The Public Costs of Teen Childbearing*. 2006, The National Campaign to Prevent Teen Pregnancy: Washington, DC.
5. Terry-Human, E., Manlove, J., Moore, K.A., *Playing Catch-Up: How Children Born to Teen Mothers Fare*. 2005, The National Campaign to Prevent Teen Pregnancy: Washington, DC.
6. Perper, K., Peterson, K., & Manlove, J., *Diploma Attachment Among Teen Mothers*. 2010, Child Trends, Inc.: Washington, DC.
7. Ventura, S.J., Abma, J.C., Mosher, W.D., Henshaw, S.K., *Estimated Pregnancy Rates for the United States, 1990–2005: An Update*. National Vital Statistics Reports, 2009. 58(4).
8. Finer, L., Henshaw, S.K., *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*. Perspectives on Sexual and Reproductive Health, 2006. 38(2): p. 90-6.
9. Kaye, K., Suellentrop, K., Sloup, C., *The Fog Zone: How Misperceptions, Magical Thinking and Ambivalence Put Young Adults at Risk for Unplanned Pregnancy*. 2009, The National Campaign to Prevent Teen and Unplanned Pregnancy: Washington, DC.
10. Kaye, K., *Changes in the Teen Birth Rate from 1991 to 2005 and 2005 to 2006: Assessing the Role of Changes in the Teen Population*. 2009, The National Campaign to Prevent Teen and Unplanned Pregnancy: Washington, DC; and other tabulations.
11. Chandra, A., Martinez, G.M., Mosher, W.D., Abma, J.C., & Jones, J., *Fertility, Family Planning, and Reproductive Health of U.S. Women: Data From the 2002 National Survey of Family Growth*. Vital and Health Statistics, 2005. 23(25).
12. Klerman, L., *Another Chance: Preventing Additional Births to Teen Mothers*. 2004, The National Campaign to Prevent Teen Pregnancy: Washington, DC.
13. Polit, D.F., Kahn, J.R., *Early Subsequent Pregnancy Among Economically Disadvantaged Teenage Mothers*. American Journal of Public Health, 1986. 76(2): p. 167–171.
14. Horwitz, S.M., Klerman, L.V., Kuo, H.S., Jekel, J.F., *School-age mothers: Predictors of long-term educational and economic outcomes*. Pediatrics, 1991. 87(6): p. 862-868.
15. Furstenberg, F.F., Jr., Brooks-Gunn, J., Morgan, S.P., *Adolescent Mothers in Later Life*. 1987, Cambridge, England: Cambridge University Press.
16. Centers for Disease Control and Prevention, VitalStats, National Center for Health Statistics, Editor, 2008.
17. Arnett, J.J., *Emerging Adulthood: The Winding Road from the Late Teens Through the Twenties*. 2004, New York, NY: Oxford University Press.
18. Galston, W.A., *The Changing Twenties*. 2007, The National Campaign to Prevent Teen and Unplanned Pregnancy: Washington, DC.
19. Finer, L., *Trends in Premarital Sex in the United States, 1954–2003*. Public Health Reports, 2007. 122: p. 73-78.
20. Albert, B., *With One Voice 2010*. (in press) The National Campaign to Prevent Teen and Unplanned Pregnancy: Washington, DC.
21. Bessett, D., Prager, J., Havard, J., Murphy, D., Agenor, M., Foster, A., *Young Adults, Health Insurance, & Access to Contraception in the Wake of Health Care Reform: Results from Focus Group Discussions in the Commonwealth of Massachusetts*. 2010, Ibis Reproductive Health: Cambridge, MA.

22. Collins, W.A., Welsh, D.P., Furman, W., *Adolescent Romantic Relationships*. Annual Review of Psychology, 2009. 60: p. 631-652.
23. The National Campaign to Prevent Teen and Unplanned Pregnancy, *Data, Charts, Research Report Section G: Stability of Parent Relationships Following an Unplanned Pregnancy and Birth*. 2009, The National Campaign to Prevent Teen and Unplanned Pregnancy: Washington, DC.
24. Bartell, D., Roberts, L., & Wise, P., *Summary of UW Colleges Spring 2009 Survey Conducted by the Wisconsin Relationship Education (WiRE) Project*. 2009.
25. Abma, J.C., Martinez, G.M, Copen, C.E., *Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, National Survey of Family Growth 2006–2008*. Vital Health Statistics, 2010. 23(30).
26. Kirby, D., *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. 2007, The National Campaign to Prevent Teen and Unplanned Pregnancy: Washington, DC.
27. Mosher, W., Jones, J., *Use of Contraception in the United States: 1982–2008*. Vital Health Statistics, 2010. 23(29).
28. Hatcher, R., Trussell, J, Stewart, FH, Nelson, AL, Cates, W, Guest F, and Kowal, D *Contraceptive Technology, Eighteenth Revised Edition*. 2004, New York, NY: Ardent Media.
29. Wlicox, A.J., Dunson, D.B., Weinberg, C.R., Trussell, J. and Day Baird, D., *Likelihood of Conception with a Single Act of Intercourse: Providing Benchmark Rates for Assessment of Post-Coital Contraceptives*. Contraception, 2001. 63: p. 211–215.
30. Kahlenborn, C., Modugno, F, Potter, DM, and Severs, WB, *Oral Contraceptive Use as a Risk Factor for Premenopausal Breast Cancer: A Meta-Analysis*. Mayo Clinic Proceedings, 2008. 81(10): p. 1290–1302.
31. Sivin, I., Stern, J., Coutinho, E., et al., *Prolonged intra-uterine contraception: a seven-year randomized study of the levonorgestrel 20 mcg/day (LNg 20) and the Copper T380 Ag IUDS*. Contraception, 1991. 44: p. 473-80.
32. Grimes, D., *Intrauterine device and upper-genital tract infection: A Review*. The Lancet, 2000. 365: p. 1013-1019.
33. *Magical Thinking: Young Adults' Beliefs About Sex, Contraception, and Unplanned Pregnancy: Results from a Public Opinion Survey*. 2008, The National Campaign to Prevent Teen and Unplanned Pregnancy and Self Magazine: Washington, DC.
34. The National Campaign to Prevent Teen and Unplanned Pregnancy, *Briefly: Unplanned Pregnancy and Community Colleges*. 2009, The National Campaign to Prevent Teen and Unplanned Pregnancy: Washington, DC.
35. Jacksteit, M., *Getting Started at Community Colleges: Reducing Unplanned Pregnancy and Strengthening Academic Achievement*. 2009, The National Campaign to Prevent Teen and Unplanned Pregnancy: Washington, DC.
36. Centers for Disease Control and Prevention. 2009 Compendium of Evidence-Based HIV Prevention Interventions, accessed August 2010 from www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions
37. Hadley, A.M., Mbwana, K., Hair, E.C., *What Works for Older Youth During the Transition to Adulthood: Lessons from Experimental Evaluations of Programs and Interventions*, Child Trends Fact Sheet, 2010.
38. Kirby, D., *The Impact of Programs to Increase Contraceptive Use Among Adult Women: A Review of Experimental and Quasi-Experimental Studies*. Perspectives on Sexual and Reproductive Health, 2008. 40(1): 34-41.
39. Kiene S., Barta, W., *A Brief Individualized Computer-Delivered Sexual Risk Reduction Intervention Increases HIV/AIDS Preventive Behavior*. Journal of Adolescent Health, 2006. 39: 404–410.
40. Carey, K.B., Scott-Sheldon, L.A., Elliott, J.C., Bolles, J.R., Carey, M.P., *Addiction*, 2009. 104 (111): p.1807–1819.

Appendix 1: Data Sources

The data presented in this report are from a variety of sources including surveillance data, several population-based surveys, and a qualitative survey. Information about pregnancy and birth outcomes are from the Guttmacher Institute and the National Center for Health Statistics.

Data on sexual and contraceptive behavior, knowledge, and attitudes are from three key surveys:

1. The National Survey of Family Growth (NSFG) is a household-based, nationally representative survey of women and men age 15–44 administered through the National Center for Health Statistics. The survey is conducted on a continuous basis and data will be released approximately every two years. The most recent data available through this survey are from 2006–2008. More information about this survey is available at: <http://www.cdc.gov/nchs/nsfg.htm>
2. The National Survey of Reproductive and Contraceptive Knowledge (NSRCK) is a telephone-based nationally representative survey of unmarried women and men age 18–29 conducted by the Guttmacher Institute in collaboration with The National Campaign. Data which focused on young adults' knowledge, attitudes, and behavior on issues related to contraception and unplanned pregnancy were collected in 2009. More information about the survey, including the survey instrument and results, is available at: <http://www.thenationalcampaign.org/fogzone>
3. A Qualitative Study of Community College Students which consisted of two rounds of in-depth interviews and focus group discussions with unmarried men and women age 18–29 who were attending community college. Over half of the sample were age 18–19. The study was conducted in 2009–2010 by Child Trends, Inc. in collaboration with The National Campaign. The quotes presented throughout this report were from this study.

Older teens account for two-thirds of all teen pregnancies and birth in the United States.

Teen birth and pregnancy rates in the United States remain among the highest of all industrialized countries and it remains the case that three in 10 girls in the United States get pregnant by age 20.

The National Campaign to Prevent Teen and Unplanned Pregnancy

1776 Massachusetts Ave, NW, Suite 200 Washington, DC 20036

TheNationalCampaign.org | blog.TheNC.org | StayTeen.org | SexReally.com

Phone: 202.478.8500 | Fax: 202.478.8588 | Email: campaign@thenc.org