

Teenage Sexual and Reproductive Behavior in Developed Countries

Country Report for The United States

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Table of Contents

Part I. Levels and Trends in Adolescent Sexual and Reproductive Behavior.....5

Introduction.....	5
Adolescent Pregnancy, Birth and Abortion Rates.....	5
Sexually Transmitted Diseases.....	8
Sexual Behavior.....	9
Contraceptive Method Use.....	12
Conclusion.....	14

Part II. Societal Attitudes about Sexuality.....16

Attitudes and Norms about Sexuality and Sexual Behavior.....	16
Indicators of Attitudes from Surveys.....	18
Indicators Inferred from Laws.....	19
Services to Adolescents.....	20
Indicators of Society's Attitudes toward Sex and Contraception Illustrated in the Media.....	21
Young People's Socialization about Sexuality, Sexual Behavior and Sexual Responsibility.....	24
Sexuality Education in the Schools.....	24
Interventions that Illustrate Societal Views about Adolescent Sexuality.....	26

Part III. Reproductive Health Services for Adolescents.....31

Accessibility of Reproductive Health Care to Adolescents.....	31
Contraceptive Method Use and the Availability of Contraceptive Supplies to Youth.....	35
Messages that Encourage Responsible Contraceptive and Disease Preventive Behavior.....	37
Interventions.....	37

Part IV. Public Policy and Programs for Disadvantaged Groups.....40

Introduction.....	40
Prevalence and Distribution of Economically, Socially, or Culturally Disadvantaged Groups.....	40
Systems of Social Welfare to Assist Poor or Disadvantaged Populations.....	44

Interventions that Have Been Implemented to Assist Youth from Disadvantaged Populations.....	48
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References.....52

Appendix A.....57

Tables

Table 1. Birth, abortion and pregnancy rates per 1,000 women aged 15-19, and pregnancy rates per 1,000 sexually active women 15-19, 1972-2000.....	6
Table 2. Pregnancy, birth and abortion rates per 1,000 women aged 15-19 by outcome, age and race and ethnicity, 1997.....	7
Table 3. Annual reported rates of sexually transmitted infections among adolescents, by gender, and among the total population, U.S., 1996.....	9
Table 4. Percentage of 15-19 year olds who ever had intercourse by socioeconomic characteristics and gender, 1995.....	10
Table 5. Percentage of women aged 20-24 in 1995 who had intercourse by age 15, 18 and 20, by socioeconomic characteristics.....	11
Table 6. Percentage distribution of sexually experienced women and men aged 15-19 in 1995 by the contraceptive method used at first sex according to socioeconomic characteristics.....	13
Table 7. Percentage distribution of women and men aged 15-19 in 1995 who had sex in the last three months according to current contraceptive method used by socioeconomic characteristics.....	15
Table 8. Percentage of U.S. women aged 15-19 who received contraceptive or other reproductive health services in the prior year and the distribution of adolescent women by poverty status and race/ethnicity all according to the source of care, NSFG 1995.....	33
Table 9. Percentage distribution of the U.S. population by race and ethnicity, 1980, 1990 and 2000.....	41
Table 10. Percentage distribution of the U.S. population by immigrant and citizenship status, 1980, 1990 and 2000.....	41

Table 11. Percentage distribution of U.S. adults aged 20-49 by federal poverty status and according to race, ethnicity, citizenship status, marital status and family status, 1997.....42

Table 12. Percentage distribution of U.S. adults aged 20-49 by employment status and according to gender, poverty status, race, ethnicity and citizenship status, 1997.....43

Table 13. Percentage distribution of U.S. adults aged 20-49 by health insurance status and according to poverty status, race, ethnicity, citizenship status and family status, 1997.....43

Table 14. Percentage of poor and low-income adults aged 20-49 receiving federal aid by type of aid according to race, ethnicity, citizenship status and family status, 1997.....47

Figures

Figure 1. Birth, abortion and pregnancy rates per 1,000 women aged 15-19 and pregnancy rates per 1,000 sexually active women aged 15-19, 1972-2000.....7

Part I. Levels and Trends in Adolescent Sexual and Reproductive Behavior

Introduction

Teenage childbearing has been high in the United States for a long time. It became a matter of public concern in the 1960s as adult fertility decreased more steeply after the post-war baby boom than did adolescent fertility, as unmarried pregnant women became less likely to marry before the baby was born, as rising emphasis on education and employment changed the roles of many women, and as high teenage birthrates among disadvantaged populations were increasingly linked to high social welfare costs.

In the United States today, young women typically begin sexual intercourse at age 17.4, marry at 25.1, and have their first child at age 26.0.¹ However, many young women do become pregnant and bear children during their teenage years. Nine percent of women aged 15 to 19 years become pregnant each year: 5% give birth, 3% have induced abortions, and 1% have miscarriages or stillbirths,² resulting in nearly 900,000 adolescent pregnancies every year. These pregnancies are overwhelmingly unintended, reflecting substantial gaps in contraceptive use, and difficulties in using reversible contraceptives.³ Moreover, by the time they reach age 20, more than 1 in 5 adolescent females has become a mother.⁴

In recent years, teenage pregnancy, birth and abortion levels have decreased. These declines have occurred among both younger and older adolescents, among all racial and ethnic groups and across all states.⁵ Lower adolescent pregnancy rates are primarily due to more effective contraceptive use among sexually active teenagers (responsible for about 75% of the decline), and to fewer adolescents who are sexually active (about 25%).⁶ Despite these recent trends, however, the United States continues to have one of the highest adolescent pregnancy rates in the developed world.

Concern about teenage childbearing in earlier decades reflected observations that women who begin childbearing in their adolescence are less likely to achieve high levels of education and economic

security, or to maintain stable marriages.⁷ Later research showed that early childbearing is both a result and cause of socioeconomic disadvantage;⁸ that the societal cost of childbearing in the early teens (under age 18 as compared with women aged 20-21) is quite high (a minimum of \$7 billion annually in social service costs and foregone tax revenue); and, that there are long-term negative effects on children born to teenage mothers.⁹

A number of factors related to economic and social disadvantage put youth at risk of engaging in unprotected sex and becoming pregnant or acquiring an STD. Youth at greatest risk are more likely to have attained low levels of education, to come from racial or ethnic minority groups and to live in communities with high poverty rates and high rates of nonmarital births.¹⁰ A greater proportion of young women who are poor become sexually active as adolescents, do not use a contraceptive method at first intercourse and give birth by age 20. In addition, disadvantaged youth who are sexually active are more likely to have multiple partners, have negative attitudes towards condoms and other forms of contraception, and have lower self-efficacy in obtaining and using contraceptives effectively.¹¹

Adolescent Pregnancy, Birth and Abortion Levels Trends Over Time

Over the past three decades, the teenage pregnancy rate^a climbed steadily from the early 1970s to the early 1980s, was fairly stable until the late 1980s, increased until 1990, then decreased by 21% between 1990 and 1997 (Table 1, Figure 1). Adolescent birthrates and abortion rates also fell during the 1990s: the abortion rate fell 27% (from 38 per 1,000 women aged 15 to 19 in 1991 to 28 per 1,000 in 1997), whereas the birthrate fell 16% (from 62 to 52 per 1,000 over the same time period, and to its lowest

^a Pregnancy rates throughout this report exclude miscarriages and are calculated as the sum of births and induced abortions.

recorded rate, 49 per 1,000, in 2000).¹²

In order to understand adolescent pregnancy trends in the United States, it is important to consider the impact of changes in adolescent sexual activity levels. In fact, the rising and high overall teenage pregnancy rates in the 1970s and 1980s were due, in part, to increasing proportions of adolescents who were sexually experienced, that is, at risk for becoming pregnant: the percentage of teenagers who had ever had premarital intercourse rose from 32% in 1971 to 38% in 1976 and 43% in 1979; 47% of all teenagers in 1982 and 53% in 1988 had ever had sexual intercourse.¹³ Even as the numbers and percentages of young women at risk for unintended pregnancy because they were sexually active rose from the early 1970s to the late 1980s, the pregnancy rate among those who were sexually experienced decreased quite steadily, probably reflecting increased and more effective contraceptive use (Table 1, Figure 1).

Thus, in the 1970s, the proportion of teenage women having sex increased dramatically and their use of contraceptives rose too; however, the rising exposure to pregnancy risk overwhelmed the benefit of improved contraceptive use, leading to higher pregnancy levels. During the early and mid-1980s, both adolescent birthrates and abortion rates were fairly stable, as was the overall teenage pregnancy rate, covering up actual drops *among sexually experienced teenage women* in pregnancy, birth and abortion rates until the late 1980s.

In the late 1980s, adolescent pregnancy rates increased, even among sexually experienced women, then began a steep drop around 1990. The increase in pregnancy rates coincided with an emphasis on condom use because of the HIV/AIDS epidemic, leading to greater condom use and less pill use among adolescent contraceptors.¹⁴

Between the late 1980s and mid-1990s (the most recent time-period for national sexual activity data), there was a small, though insignificant, decrease in the proportion of young women who were sexually experienced (from 53% to 51%)¹⁵ and a drop in the pregnancy rate among sexually experienced teenage women.¹⁶ These two factors combined to cause a decrease in the overall teenage pregnancy rate, the first sustained decrease in U.S. teenage pregnancy rates since they were first recorded in the early 1970s. Approximately 25% of this decrease between 1988 and 1995 can be attributed to fewer young women starting to have sex, while about 75% was due to lower rates of pregnancy among sexually experienced adolescents. Recent analyses indicate that the decrease in pregnancy rates among sexually experienced adolescent women was not due to less sexual exposure, or to increased overall levels of contraceptive use, or to improved effectiveness of use of specific methods, but, rather, to rising proportions of adolescent women using newly available long-acting and highly effective contraceptive methods.¹⁷

In the 1990s, falling adolescent pregnancy rates resulted in declines in both the adolescent birthrate and the abortion rate as well. In fact, teenage abortion rates dropped more steeply between the late 1980s and mid-1990s than did the teenage birthrate. Although the vast majority of adolescent conceptions are unintended, falling adolescent abortion rates may be due, in part, to a rise in the percentage of adolescent conceptions that were *intended* (from 14% in 1987 to 22% in 1994) and to a decrease in the proportion of unintended teenage pregnancies that were resolved through abortion (from 53% in 1987 to 45% in 1994).¹⁸

Table 1. Birth, abortion and pregnancy* rates per 1,000 women aged 15-19, and pregnancy rates per 1,000 sexually active women 15-19, 1972-2000.

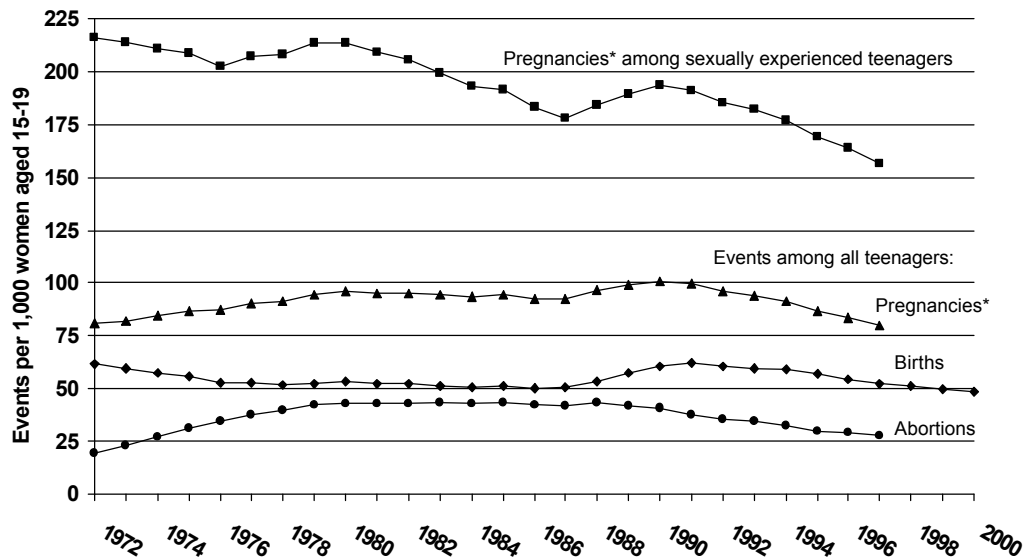
Year	All women 15-19			Sexually active women 15-19
	Birth Rate	Abortion Rate	Pregnancy Rate*	Pregnancy rate*
1972	61.7	19.1	80.8	216.0
1973	59.3	22.8	82.1	213.8
1974	57.5	27.0	84.5	210.8
1975	55.6	31.2	86.8	208.8
1976	52.8	34.3	87.1	202.7
1977	52.8	37.5	90.3	207.3
1978	51.5	39.7	91.2	208.5
1979	52.3	42.4	94.7	213.7
1980	53.2	42.8	96.0	213.6
1981	52.2	42.9	95.1	209.2
1982	52.4	42.7	95.1	205.8
1983	51.4	43.2	94.6	199.6
1984	50.6	42.9	93.5	193.1
1985	51.0	43.5	94.5	191.6
1986	50.2	42.3	92.5	183.3
1987	50.6	41.8	92.4	177.9
1988	53.0	43.5	96.5	184.1
1989	57.3	42.0	99.3	189.3
1990	60.4	40.6	101.0	193.5
1991	62.1	37.6	99.7	191.2
1992	60.7	35.5	96.2	185.4
1993	59.6	34.3	93.9	182.2
1994	58.9	32.2	91.1	177.1
1995	56.8	30.0	86.8	169.4
1996	54.4	29.2	83.6	164.1
1997	52.3	27.5	79.8	156.7
1998	51.1	na	na	na
1999	49.6	na	na	na
2000	48.7	na	na	na

na: data not available

* Pregnancy rate excluding miscarriages

Sources: Births, abortions and pregnancies among all teenagers: Henshaw SK, 2001 (see reference 2) and Ventura SJ et al., 2001 (see reference 5); Pregnancies among sexually active teenagers: updated from AGI, 1994 (see reference 8) and calculated without miscarriages.

Figure 1. Birth, abortion and pregnancy* rates per 1,000 women aged 15-19, and pregnancy rates per 1,000 sexually active women aged 15-19, 1972-2000.



*Pregnancies exclude miscarriages

Sources: See Table 1

Variation Across Groups

- **Age.** Pregnancy rates are higher among older adolescents: 127 per 1,000 women aged 18-19 in 1997 as compared with 50 per 1,000 women aged 15-17 (Table 2). Although some of this difference is due to the fact that older adolescents are more likely to be at risk for pregnancy because they are sexually active, even among those who have had intercourse, pregnancy rates are higher among older teenagers.

Approximately two-thirds (66%) of pregnancies (excluding miscarriages) in adolescent women end in birth, one-third (34%) end in induced abortion. In the United States, this distribution varies little between older and younger adolescents—with 35% and 34% of pregnancies among those aged 15-17 and 18-19, respectively, ending in abortion.

- **Race and ethnicity.** Non-Hispanic white teenagers aged 15-19 have the lowest pregnancy, birth and abortion rates (54, 36 and 18 per 1,000, respectively). Black teenagers consistently have the highest pregnancy and abortion rates (154 and 63 per 1,000, respectively) and Hispanic adolescents have the highest birthrate (97 per 1,000). Black adolescents who are pregnant are most likely to have induced abortions and Hispanic teenagers are most likely to give birth (Table 2).

Table 2. Pregnancy, birth and abortion rates* per 1,000 women aged 15-19 by outcome, age and race and ethnicity, 1997.

Age and outcome	Race and ethnicity			
	Total	White	Black	Hispanic
15-19				
Pregnancies	79.8	54.2	153.5	132.8
Births	52.3	36.0	90.8	97.4
Induced Abortions	27.5	18.2	62.7	35.4
15-17				
Pregnancies	49.5	31.0	103.2	88.2
Births	32.1	19.4	62.6	66.3
Induced Abortions	17.4	11.6	40.6	21.9
18-19				
Pregnancies	126.7	90.0	230.7	200.0
Births	83.6	61.9	134.0	144.3
Induced Abortions	43.1	28.1	96.7	55.7

*Pregnancy rates exclude miscarriages

Sources: Henshaw SK, 2001 (see reference 2) and Ventura SJ et al., 2001 (see reference 5).

Between 1990 and 1997, adolescent pregnancy rates declined 27% among non-Hispanic whites and 21% among black adolescents. Among Hispanics, rates began to decline only after 1994, and decreased 11% between 1994 and 1997. These patterns are consistent for both 15-17-year-olds and 18-19-year-olds.¹⁹ Pregnancy rates for black and Hispanic adolescents are now fairly similar, primarily due to the steep declines among black teenagers.

In addition, there is wide variation in age at first birth among different racial groups. Black (37%) and

Hispanic (33%) women are significantly more likely to have had a birth during adolescence (i.e. before age 20) than whites (17%). On average, Asian, Pacific Islander, Alaskan native and Native Americans were just as likely as whites to report having had a birth by age 20 (18%), although there are differences among these subgroups (see Appendix A, Table A10).

Immigrant status is also related to adolescent childbearing. Foreign-born women are more likely to have an adolescent birth than are U.S.-born women: 29% of young women who are foreign-born have had a birth by age 20, compared with 21% for U.S.-born women. However, U.S.-born women are more likely to have had a birth by ages 15 and 18 than foreign-born women (see Appendix A, Table A10).

- *Economic status.* Adolescent pregnancy and birth is often linked to growing up in conditions of disadvantage. In 1994, 38% of all women aged 15 to 19 lived in families under 200% of the federal poverty level. However, because lower income women are somewhat more highly represented among those who have initiated sexual activity at a young age (42%) and used no method at first intercourse (53%), they are responsible for 73% of all adolescent pregnancies. Teenagers from lower-income families are more likely to give birth if they become pregnant than are those from more advantaged backgrounds. And, lower-income mothers are more likely to be unmarried. Thus, teenagers under 200% of poverty account for 83% of all adolescent births and 85% of nonmarital teenage births.²⁰

Moreover, data on poverty status and age at first birth indicate that 19% of women aged 15–19 and 54% of those aged 20–24 who are below 150% of poverty have had a birth as compared with 2% and 15% respectively for young women at or above 300% of poverty. Young women aged 20–24 who are below 150% of poverty are twice as likely as young women at 150–299% of poverty and 5 times as likely as young women at or above 300% of poverty to have had a birth by age 20 (see Appendix A, Table A10).

- *Marital status.* Although very few adolescents are married, those that do marry young are much more likely to have an adolescent pregnancy. Only 4% of 15-17 year-olds and 14% of 18-19-year-olds are married and many of these marriages were prompted by a teenage pregnancy. Among married women under age 20 in 1994, the pregnancy rate was 454 per 1,000, compared with a pregnancy rate of 97 per 1,000 unmarried women under age 20.²¹

- *Age of partner.* Although most sexually active teenage women are in relationships with men who are roughly their own age (63% have partners who are

within 2 years of their age), some 28% have partners who are 3-5 years older and 9% have partners who are 6 or more years older than they are.

Pregnancy rates are much higher among those young women whose partners are older: among sexually active teenage women, the pregnancy rate is 176 per 1,000 if her partner is no more than 2 years older, 230 if he is 3-5 years older and 451 if he is 6 or more years older.²² This pattern of higher pregnancy rates when the age gap is wider holds for both married and unmarried teenage women, and for those aged 15 to 17 and 18 to 19. As a result of their more continuous sexual activity as compared with teenage men, age patterns of partnerships and the higher pregnancy rates when teenage women have older partners, U.S. women are more than twice as likely to be involved in a pregnancy during their teenage years than are men.²³

- *Geographic differences.* Teenage pregnancy rates in the United States vary widely. In fact, the highest rate in Nevada (121) is nearly 3 times higher than the lowest rate found in North Dakota (42). In general, the highest teenage pregnancy rates are found in the South and Southwest, although they are also high in Hawaii, California, Nevada, Missouri, Illinois, New York, Maryland, and the District of Columbia. States with the lowest teenage pregnancy rates include the Northeastern states of Maine, Vermont, New Hampshire, and Connecticut, as well as Pennsylvania, West Virginia and most of the Midwestern and Mountain states.

Teenage birthrates follow a similar pattern as teenage pregnancy rates with a few exceptions, including New York and Maryland, where pregnancy rates are high, but birthrates are relatively low. Adolescent abortion rates do not follow the same geographic patterns, with high rates scattered across the country and generally found in the most urban states, possibly reflecting in part the limited availability of abortion services in rural areas and small cities.²⁴

Sexually Transmitted Diseases

Levels of Incidence

In the United States, an estimated 15.3 million new cases of sexually transmitted disease (STDs) occur annually. About 25% of all new STD cases are among adolescents aged 15-19. Thus, as many as one in five adolescents (3.8 million) contract an STD each year. However, this is probably an overestimate because some adolescents will contract more than one STD or have multiple cases in a year. There are no estimates of ongoing prevalence of viral STDs among adolescents in the United States, however,

surveys in 1988-1994 found 6% of participants aged 12-19 and 17% of those aged 20-29 tested positive for the herpes virus that is usually sexually transmitted (HSV-2).

Levels of STD infection reported in official statistics provide a limited picture of the overall rates, because of gaps between disease transmission, recognition, treatment and reporting; as well as because not all STDs are reportable infections in all states. However, available reported information does provide valuable detail regarding which infections are more common among adolescents and on how infection rates compare between young men and young women.

Bacterial STDs (chlamydia, gonorrhea and syphilis) disproportionately affect adolescents and are extremely common among sexually experienced teenagers (Table 3). In 1996, reported chlamydia incidence among youth was extremely high with a rate of 1,132 cases per 100,000 adolescents aged 15-19.²⁵ It was even higher among female adolescents with a rate of 2,067 per 100,000 women aged 15-19, over 8 times the rate for adolescent males. The chlamydia rate among the general population was much lower (193 per 100,000). The gonorrhea rate among all adolescents was almost 600 per 100,000; and the rate among female adolescents (758 per 100,000) was much higher than that among male adolescents (395 per 100,000). The annual gonorrhea rate among female and male adolescents was 4 times as great as in the total population (125 per 100,000). Reported incidence of syphilis was low: the rate among female adolescents was about 9 per 100,000 which is still twice as high as among male adolescents and exceeds rates of the general population (4 per 100,000).

The gender difference in STD rates may partly be explained by existing patterns of reproductive health service use, with more women than men seeking reproductive health services where STD screening is provided. Overall, adolescents are at greater risk of

Table 3. Annual reported rates of sexually transmitted infections among adolescents, by gender, and among the total population, U.S., 1996

Infection	Rate (per 100,000)			In total population
	Among 15-19-year-olds			
	Female	Male	Total	
Chlamydia‡	2067.0	245.8	1131.6	192.6
Gonorrhea‡	758.2	394.8	571.8	125.1
Syphilis	8.6	4.3	6.4	4.3

‡Fewer than 70% of diagnosed cases are estimated to be reported for this infection

Source: Panchaud C et al., 2000 (see reference 25).

acquiring an STD than are adults because they are less likely to be married and are more likely to have multiple partners and to have unprotected sex than the older population.

Race and Ethnicity Differentials

STD levels vary widely by race and ethnicity. In 1997, the gonorrhea rate among black adolescents was 24 times greater than among white adolescents. The incidence of syphilis, though at a much lower level, also differs greatly among racial groups with higher rates among black adolescents (23 per 100,000) than whites (fewer than 1 per 100,000) or Hispanics (2 per 100,000).²⁶ Some of these differences by race and ethnicity may be attributed to higher underreporting among whites since minority populations are more likely to use public clinics which have a more complete rate of reporting. Other factors, such as higher proportions of disadvantaged youth who may have limited access to quality medical care and higher levels of early sexual activity and of multiple partners, may help to explain the higher incidence of STDs among minority groups.

Sexual Behavior

Levels and trends

In the mid-1990s, the proportion of all adolescent women aged 15-19 who had ever had intercourse was 51%, slightly lower than the level among adolescent men (55%) (Table 4, see page 10). These proportions represent a slight decrease for adolescent females (53% in 1988, not statistically significant) and for adolescent males (60% in 1988).²⁷

Looking at trends in adolescent sexual activity over a longer period of time, there has been a clear downward shift in the age at first intercourse, with greater proportions of young people initiating sexual activity during adolescence. As reported earlier, the proportions of adolescent women engaging in premarital sexual intercourse rose from 32% in 1971 to 38% in 1976 and 43% in 1979. In the 1980s, the percentage of teenage women who had ever had sexual intercourse was 45% in 1982 and 52% in 1988.²⁸

Similarly, greater proportions of women in more recent cohorts reported being sexually experienced as adolescents compared with older cohorts in 1995. Among 20-24-year-old women, 63% had intercourse by age 18 and 81% had intercourse by age 20. In contrast, 41% of women aged 40-44 reported having had intercourse by age 18 and 69% had intercourse by age 20 (see Appendix A, Table A3).

Socioeconomic Differentials in Sexual Activity

• *Proportion ever sexually active among adolescents.* Poverty status is a strong predictor of early onset of sexual activity among girls. Among adolescent women, low-income teenagers are much more likely than adolescents from higher income families to be sexually experienced. Some 61% of adolescent women who live in families below 150% of the poverty level have ever had intercourse compared with 49% of those in families whose income is 150–299% of poverty and 47% of those at or above 300% of poverty (Table 4). This disparity is not found among adolescent males where there is only a 4–5

percentage point difference between the lower and higher income groups.

On the other hand, levels of sexual activity among adolescent men are more strongly associated with race and ethnicity: In 1995, 80% of black men aged 15–19 reported having had intercourse, compared with 61% of Hispanics and 50% of whites. Among adolescent women a similar pattern can be observed, with more blacks having had intercourse than Hispanics or whites, but the differences are not as great as among adolescent men. As a group, teenagers from Asian, Pacific Islander, Alaskan native or Native American (“other” group) backgrounds are the least likely to have initiated intercourse (24% among adolescent females and 43% among adolescent males).

U.S.-born adolescent males are more likely to have had sexual intercourse than foreign-born adolescent males. This is also the case among female adolescents with 38% of foreign-born females and 52% of U.S.-born females ever having had sex.^{b,29}

The level of sexual activity among adolescents varies by region and metropolitan area of residence. A lower proportion of adolescent women who reside in the West have ever had sex than among those who live in the South, Northeast or Midwest, which may, in part, reflect different racial and ethnic characteristics of regional populations. Moreover, female teenagers residing in a metropolitan area other than a central city are less likely to have had intercourse (47%) than female teenagers living in a central city (56%). This may partially be due to higher levels of poverty and greater concentrations of minority populations in central cities.

Finally, the association of religious affiliation with initiation of intercourse is very pronounced. Among adolescent women, over 71% of those who do not indicate a religious affiliation have ever had intercourse as compared with about 50% among Catholic and Protestant adolescent women (Table 4). A similar trend is apparent among adolescent men, with 67% ever sexually active among those reporting no religious affiliation as compared with 53% among Catholics and 52% among Protestants. The proportion of Protestants and Catholics who have ever had sex is similar among both male and female adolescents. Much, but not all, of the influence of religious affiliation on adolescent sexual activity may reflect the impact of other socioeconomic characteristics.³⁰

Table 4. Percentage of 15-19 year olds who ever had intercourse¹ by socioeconomic characteristics and gender, 1995

Characteristic	Women	Men
Total	51.3	55.2
Age		
15-17	38.5	42.5
18-19	70.8	75.6
Poverty Status/Income³		
0-149% / \$0-20,000	60.9	59.2
150-299% / \$20,001-40,000	49.1	55.2
300+% / >\$40,001	46.8	53.8
Race and Ethnicity		
Hispanic	56.0	61.0
Black, non-Hispanic	60.4	80.4
White, non-Hispanic	50.4	49.9
Other	23.5	43.3
Immigrant Status		
U.S.-born	52.2	56.1
Foreign-born	37.9	48.0
Region		
Northeast	53.9	n/a ²
Midwest	51.6	n/a
South	52.1	n/a
West	47.6	n/a
Metropolitan Status		
MSA-central city	56.2	n/a ²
MSA-other	47.4	n/a
Not MSA	51.8	n/a
Religious Affiliation		
No religion	71.6	66.8
Protestant	48.6	53.3
Catholic	49.8	51.8
Other	30.0	53.6

¹ Among women, ever had intercourse after menarche.

² NSAM does not provide data on metropolitan area and region.

³ Women: based on poverty status; men: based on total family income in past year.

Source: AGI, 2001, special tabulations from the NSFG, Cycle V and the NSAM, 1995.

^b In 1997, 10% of the U.S. population was foreign-born. The proportion of foreign-born population from Europe has dropped substantially. Most of the foreign-born in the mid-1990s were from Latin America and Asia (Cuba, the Dominican Republic, El Salvador, Mexico, China, India, the Philippines and Vietnam).

• *Timing of initiating intercourse.* Lower-income youth are slightly more likely to initiate intercourse at earlier ages than middle or higher-income youth, but these differences are not large. Among girls, 16% of those living in families below 150% of poverty had initiated intercourse by age 15 compared with 11% of girls from families at or above 300% of poverty; by age 18 the corresponding percentages are 65% and 61%, respectively (Table 5).

The association between initiation of intercourse and race and ethnicity is much stronger: early sexual activity is more common among blacks than among Hispanics and whites. Twenty-two percent of young black women had initiated sexual activity by age 15, compared with 12% of Hispanic girls and 13% of non-Hispanic white girls. By age 18, the corresponding percentages are 75% for blacks, 49% for Hispan-

ics and 65% for non-Hispanic whites. Asians, Pacific Islanders, Alaskan native and Native Americans, as a group, are least likely to begin sexual activity in their adolescence, although this may vary among these subgroups. In addition, at all ages, more U.S.-born women had initiated sexual activity as compared with foreign-born young women.

Educational attainment is highly associated with the timing of initiation of sexual intercourse. Indeed, 34% of girls who did not complete high school had had intercourse before age 15, compared with 17% of those who did complete high school. There is an equally marked difference between young women who completed high school and those who went on to pursue a college education: only 9% of young women who have some college education had intercourse before age 15. This disparity can also be found when looking at the percentages initiating first intercourse by ages 18 and 20, suggesting that educational participation, goals/motivation and performance have an impact on age of initiation of intercourse and/or that age at first sex has an impact on educational attainment.

The likelihood of being ever sexually active is much higher among those who are employed only or are neither in school nor employed as compared with those in school or in school and employed. Among 20–24-year-old women, 83% of those currently employed (and not in school) and 92% of those not employed or in school had had sexual intercourse by age 20, compared with approximately 70% of those in school only or in school and working (see Table 4).

Finally, region, metropolitan status, and religious affiliation are not strongly related to the timing of first intercourse as measured by the proportion sexually active by age 20, although there are some differences by religion in the percentages initiating sex by age 15.

Number of Partners

Having had 2 or more sexual partners over a relatively short period of time puts many young men and women at increased risk for STDs.³¹ Overall, more recent cohorts of women are more likely than older cohorts to have had 2 or more sexual partners in the past year. Considering only women who have ever been sexually active, adolescents aged 15–19 are most likely to report having had 2 or more partners in the past year (see Appendix A, Table A5), followed by women aged 20–24 and 25–29. Gender differences are minimal among 15–19-year-olds, with similar proportions of women and men reporting 2 or more partners in the past year.

Table 5. Percentage of women aged 20-24 in 1995 who had intercourse by ages 15, 18 and 20, by socioeconomic characteristics

Characteristic	Intercourse by Age 15	Intercourse by Age 18	Intercourse by Age 20
Total	14.1	63.1	80.6
Poverty Status			
0-149%	16.3	64.6	83.5
150-299%	15.6	63.9	78.5
300+%	10.5	60.8	80.4
Race and Ethnicity			
Hispanic	11.7	49.1	74.2
Black, non-Hispanic	21.5	74.8	89.2
White, non-Hispanic	12.8	64.6	81.1
Other	15.6	44.3	66.0
Immigrant Status			
U.S.-born	14.6	64.8	81.7
Foreign-born	9.4	46.4	70.1
Educational Attainment			
High school incomplete	33.7	83.5	95.2
High school	17.3	71.5	88.9
College incomplete	9	55.4	74.3
College 4+	2.6	45.7	65.3
School/Work Status			
Employed & in school	8.1	47.4	70.8
In school only	8.7	52.0	70.3
Employed only	15.2	66.5	82.6
Neither	20.9	77.6	92.2
Region			
Northeast	13.4	60.6	79.0
Midwest	14.2	67.7	85.0
South	13.8	65.6	81.0
West	14.9	55.0	75.3
Metropolitan Status			
MSA-central city	13.2	61.5	80.6
MSA-other	15.0	63.2	78.4
Not MSA	13.6	65.2	85.3
Religious Affiliation			
No religion	18.0	66.6	83.8
Protestant	15.3	65.1	82.5
Catholic	10.1	58.6	78.0
Other	11.6	55.7	67.8

Source: AGI, 2001, special tabulations of the NSFG, Cycle V.

Current Levels of Sexual Activity and Frequency of Intercourse

About 40% of all female adolescents were sexually active in the 3 months prior to being interviewed in 1995. A higher proportion of older adolescents (59%) are sexually active as compared with younger adolescents (28%). The frequency of sexual activity among those sexually active in the past 3 months is lower among adolescent females than among women in their 20's. Among currently sexually active 15–19-year-olds, 41% have intercourse 1–3 times a week as compared with 52% for the 20–24-year-olds and 56% for the 25–29-year-olds (see Appendix A, Table A6).

The data available for adolescent males are defined differently—overall, 29% of all young men aged 15–19 were sexually active in the 4 weeks prior to interview, a much shorter time period than the 3 month period reported for young women.

Contraceptive Method Use

Levels and Trends in Contraceptive Use at First Intercourse

At first intercourse, three-quarters of adolescent women in 1995 reported using a contraceptive method. A majority used condoms (63%), followed by the pill (8%) and other methods (4%). However, one-quarter used no method (Table 6). A similar pattern is found among male adolescents.

Contraceptive use at first intercourse has increased considerably over the past 3 decades. Among sexually experienced women interviewed in 1995, 49% of those whose first intercourse occurred prior to 1980 used a method compared with 61% of those initiating first intercourse in 1980–84, 65% in 1985–89 and 77% in 1990–1994.³² Much of the increase in contraceptive use is due to greater use of the condom; driven, in part, by educational efforts aimed at preventing HIV and other STDs.³³ In fact, over the past 25 years, condom use at first intercourse has tripled. Before 1980, 18% of women reported using the condom at first intercourse as compared with 25% of those initiating intercourse in 1980–84, 36% in 1985–89 and 54% in 1990–94.³⁴ While condom use has risen substantially, pill use at first intercourse has decreased slightly. Although use of any contraceptive method at first intercourse increased from 48% in 1982 to 75% in 1995, that still leaves approximately 1 out of every 4 teenagers not using a method at first intercourse in 1995.

Contraceptive use at first intercourse has increased among all racial and ethnic groups. Among Hispanics, contraceptive use at first intercourse doubled over the last 30 years: in the early 1970s 26% (of Hispanic sexually experienced 15–44-year-

old women who first had intercourse as adolescents in the 1970s) reported having used a method at first intercourse as compared with 42% who began intercourse in the mid-1980s and 54% in the early 1990s.³⁵ And, the proportion of blacks that reported using a method at first intercourse nearly doubled from 38% in the 1970s to 74% in the 1990s.³⁶ Increases in contraceptive use at first intercourse were also observed among whites, from 55% in the early 1970s to 84% in the early 1990s.³⁷ This increase may help to explain the declining pregnancy rate among all race and ethnic groups and especially among black teenagers.

Socioeconomic Differences in Contraceptive Method Use at First Intercourse

Various factors are associated with whether or not a teenager will use a contraceptive method at first intercourse (Table 6). Contraceptive use at first intercourse is higher among higher income groups: 78% of adolescent females in families living above 150% of poverty reported method use at first intercourse compared with 69% of those adolescent females in families below 150% of poverty. Similarly, among adolescent males, 79% of those with a total family income above \$40,000, 75% with a family income between \$20,001 and \$40,000 and 66% with a family income below \$20,000 used a contraceptive method at first intercourse.

Contraceptive use and method choice at first intercourse also vary among race and ethnic groups. The percentage of young women using any method at first intercourse is highest among white teenagers (81%), high among Asians, Pacific Islanders, Alaskan natives and Native Americans (77%), moderate among black adolescents (68%) and lowest among Hispanics (57%). Condom use among blacks and Hispanics is similar (49%), but much lower than among whites (70%). However, a higher proportion of blacks use oral contraceptives (14%) than whites (8%) or Hispanics (2%). Asians, Pacific Islanders, Alaskan natives and Native Americans are 5 to 9 times more likely to use other types of methods (27%) than do adolescents in any other racial or ethnic group.

Contraceptive method use at first intercourse also varies by immigrant status.^c Foreign-born adolescent males and females are almost twice as likely as U.S. born adolescents to have not used a method at first intercourse (44% among adolescent females and 42% among adolescent males, compared with about 24% for both adolescent females and males).

^c The number of women in the sample of foreign-born is small (under 35); estimates would have large sampling errors.

Table 6. Percentage distribution of sexually experienced women and men aged 15-19 in 1995 by the contraceptive method used at first sex according to socio-economic characteristics

Characteristic	Women				Men			
	Method used at first sex				Method used at first sex			
	Pill	Male Condom	Other Method	No Method	Pill	Male Condom	Other Method	No Method
Total	8.0	62.8	4.5	24.7	9.6	60.9	3.8	25.7
Union Status								
Married	12.7	51.5	3.4	32.4	4.0	32.0	12.0	52.0
Cohabiting	13.1	49.2	1.3	36.5	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Formerly married	0.0	12.6	0.0	87.4	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Never married	7.2	65.9	4.9	22.0	9.8	61.7	3.6	24.9
Poverty Status/Income*								
0-149% / \$0-20,000	7.4	57.2	4.6	30.8	11.7	53.4	1.0	34.0
149%-300% / \$20,001-40	8.3	63.9	5.7	22.0	12.5	59.6	2.8	25.1
300+% / \$40,001+	8.3	66.6	2.9	22.1	5.8	67.8	5.9	20.5
Race and Ethnicity								
Hispanic	2.1	48.8	5.9	43.2	8.9	50.0	4.0	37.1
Black, non-Hispanic	13.9	48.8	5.4	31.8	11.7	50.0	3.1	35.1
White, non-Hispanic	7.9	70.1	3.0	18.9	9.8	66.9	3.6	19.8
Other	0.0	49.7	27.1	23.3	0.0	58.8	11.8	29.4
Immigrant Status								
U.S.-born	8.2	63.3	4.7	23.8	10.2	62.3	3.3	24.1
Foreign-born	3.9	51.9	0.0	44.2	3.7	45.7	8.6	42.0
School/Work Status								
Employed & in school	6.7	70.6	5.1	17.6	9.9	66.7	5.0	18.4
In school only	7.4	65.0	3.6	23.9	9.1	63.4	1.8	25.9
Employed only	6.7	60.1	5.2	27.9	11.4	51.8	6.0	30.7
Neither	13.7	45.0	4.3	37.0	7.9	51.5	5.0	35.6
Region								
Northeast	4.7	68.5	4.0	22.7	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Midwest	9.3	65.6	3.0	22.2	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
South	9.2	63.2	2.2	25.4	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
West	7.9	53.6	10.2	28.3	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Metropolitan Status								
MSA-central city	8.3	54.9	4.4	32.4	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
MSA-other	6.4	69.0	4.8	19.8	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Not MSA	10.4	64.1	3.9	21.6	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Religious Affiliation								
No religion	6.4	64.5	3.2	25.9	13.7	54.0	1.9	30.4
Protestant	10.0	62.2	5.0	22.8	10.0	63.7	4.0	22.3
Catholic	5.8	64.1	3.8	26.4	6.8	60.0	3.9	29.3
Other	4.4	49.5	9.4	36.7	3.3	56.7	3.3	36.7

*Women: based on poverty status; men: based on total family income in past year.

n/a: NSAM does not provide data on region or area of residence.

Other methods include: sterilization, IUD, implant, injectible, diaphragm, cap, female condom, foam, jelly, cream, suppository, sponge, withdrawal and periodic abstinence

Source: AGI, 2001, tabulations from the NSFG, Cycle V and the NSAM, 1995.

Other variables related to contraceptive use at first intercourse are area of residence, region and religion. Adolescent females who reside in the central city of a metropolitan area are more likely to have used no method (32%) compared with those who do not (20-22%). Regional differences in the proportion using

no method are smaller, ranging from 28% in the West, 25% in the South and 23% in the Northeast to 22% in the Midwest. Adolescent females who are living in the Northeast region are more likely to use the condom at first intercourse (69%) than adolescents in the West (54%). There is also a difference in

oral contraceptive use, with adolescent females in the Northeast being least likely to use them compared with adolescent females residing in other regions. There is little variation according to religious affiliation, although Protestant adolescents are more likely to use a method than adolescents who reported a Catholic affiliation, other affiliation or no affiliation.

Levels and Trends in Current Contraceptive Method Use

Among sexually active adolescents, the pill is the leading contraceptive method used on an on-going basis. Thirty-five percent of sexually active female teenagers report current use of the pill as their most effective method, compared with 29% who rely on condoms and 10% who use long-acting methods (Table 7). However, since women who use two methods (e.g. the pill and condom) are classified according to the method with a lower failure rate, the total proportion of sexually active females using the condom is somewhat higher than 29%. Forty-two percent of males report current use of the condom and 31% report pill use by their partners. Still, although most currently sexually active teenagers use contraceptives, approximately 22% of female adolescents and 20% of male adolescents report not using any form of contraception. Female teenagers aged 15–17 have higher levels of nonuse (27%) than do older teenagers (18%); among male adolescents there is very little difference in current use between the younger and older adolescents.

Over time, the proportion of teenage contraceptive users who rely on the pill fell from 64% in 1982 to 59% in 1988 to 44% in 1995.³⁸ On the other hand, use of the condom alone or as the most effective method rose from 21% in 1982 to 37% in 1995 among teenagers; increases in condom use occurred in every age group, but were greater among teenagers and women in their 20's.³⁹ Patterns of method choice have changed considerably among adolescents and may reflect a greater concern about HIV and other STDs.

Socioeconomic Differences in Current Contraceptive Method Use

Overall, there are only small differences in levels of current contraceptive use among teenagers from different socioeconomic subgroups. There are, however, some distinct patterns of method choice that vary by poverty status and racial and ethnic group (Table 7). Among more disadvantaged groups, pill use is lower and use of long-acting methods is higher than among more advantaged groups, in part, because these methods are more often chosen by

teenagers who have been pregnant. Condom use is relatively consistent across groups. About 41% of sexually active white adolescent females report current pill use as compared with only 28% of Hispanics and 22% of blacks. Approximately 16% of black and Hispanic adolescent females report current use of long-acting methods, significantly higher than the small percentage (6%) of whites who use those same methods. Among adolescent males, a similar pattern of behavior emerges.

Other factors that are related to current method use are region and religion. Among adolescent females, 71% of those who reside in the West, 76% who reside in the Northeast, and 82% who reside in the South and in the Midwest currently use a method of contraception. In addition, method choice varies by region with a higher proportion of adolescent females living in the Midwest using the pill and a higher proportion of those residing in the West using long-acting methods than in any other region. The proportion using the condom is relatively similar across all regions except for lower use among residents in the West. Differences in patterns of use in the West compared with other regions may be affected by the high proportion of Hispanics living in that area of the United States.

Current contraceptive use varies little by religious affiliation, with somewhat lower levels of use among adolescents who had no religious affiliation. Protestant adolescents are somewhat more likely to use the pill (37% among adolescent females and 32% among adolescent males). Differences in use of other methods are small and do not follow any consistent pattern.

Conclusion

Trends over recent decades in the sexual and reproductive behavior of U.S. youth reveal a decline in the pregnancy rate, an increase in levels of sexual activity and in contraceptive use and a shift in the patterns of method use. In the most recent period with data, there was little change in the level of sexual activity or contraceptive use. However, a move to more effective contraceptive use—primarily long-acting methods—contributed strongly to a decreasing pregnancy rate. Still, about 1 in 5 sexually active teenagers do not use a method of contraception and U.S. pregnancy rates are among the highest in the developed world.

Table 7: Percentage distribution of women and men aged 15-19 in 1995 who had sex in the last three months according to current contraceptive method used by socio-economic characteristics

Characteristic	Women					Men				
	Current method used					Current method used				
	Pill	Male Condom	Long-Acting*	Other**	No Method	Pill	Male Condom	Long-Acting*	Other**	No Method
Total	35.4	28.5	9.2	5.4	21.6	31.3	42.0	3.4	3.6	19.6
Union Status										
Married	36.8	17.7	23.1	6.9	15.5	60.0	5.0	5.0	0.0	30.0
Cohabiting	47.4	18.7	18.5	5.1	10.3	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Formerly married	21.2	0.0	7.6	16.5	54.7	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Never married	34.4	30.8	7.1	5.0	22.7	30.0	43.8	3.2	3.7	19.2
Poverty Status										
0-149%	33.5	30.1	16.9	2.6	16.9	23.8	31.4	5.7	2.0	37.1
149%-300%	34.8	25.2	6.2	8.0	25.9	32.8	46.9	4.5	0.0	15.8
300+%	37.5	30.4	5.5	5.1	21.5	35.6	43.1	0.5	6.4	14.4
Race and Ethnicity										
Hispanic	28.0	25.0	16.2	4.6	26.2	17.8	46.6	4.1	1.4	30.1
Black, non-Hispanic	22.1	32.7	15.9	4.6	24.6	25.2	47.1	6.8	0.8	20.2
White, non-Hispanic	40.7	28.2	6.4	4.7	20.0	11.5	42.3	7.7	0.0	38.5
Other										
Immigrant Status										
U.S.-born	35.7	28.2	9.0	5.2	21.8	32.5	40.2	3.3	4.0	20.1
Foreign-born	27.1	35.2	14.0	7.1	16.6	19.5	63.4	2.4	0.0	14.6
Region										
Northeast	31.6	29.5	7.4	8.0	23.6	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Midwest	42.2	26.9	9.3	3.3	18.4	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
South	34.5	33.4	9.0	4.9	18.2	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
West	33.5	20.5	11.2	5.6	29.1	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Metropolitan Status										
MSA-central city	32.7	26.7	12.0	4.8	23.8	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
MSA-other	34.4	31.6	6.7	4.2	23.1	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Not MSA	40.2	26.0	9.5	7.6	16.7	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Religious Affiliation										
No religion	34.9	26.1	11.5	1.0	26.5	29.9	37.9	1.1	6.9	24.1
Protestant	37.4	26.6	8.8	6.7	20.4	32.4	42.3	3.6	3.3	18.5
Catholic	33.4	32.0	7.9	6.1	20.6	30.2	44.0	2.6	3.5	19.8
Other	14.3	52.3	11.2	0.0	22.2	27.3	27.3	27.3	0.0	18.2

* Long-acting methods include: IUD, implant and injectable

** Other methods include: sterilization, diaphragm, cap, female condom, foam, jelly, cream, suppository, sponge, withdrawal and periodic abstinence

Source: AGI, 2001, tabulations from the NSFG, Cycle V and the NSAM, 1995.

Part II. Societal Attitudes about Sexuality

Attitudes and Norms about Sexuality and Sexual Behavior

Overview of Openness about Sexuality

The United States can be characterized as ambivalent regarding sexuality because there are many contradictory and conflicting dynamics. On the one hand, the United States is a hyper-consumerist society where “sex sells” and, as such, people are bombarded with sexual images on television, magazines, billboards and the Internet.

Despite the pervasiveness of sexual imagery, many individuals are uncomfortable talking about sexuality issues. The majority of parents discuss AIDS and other STDs with their children, but they are often reluctant to talk with their teenagers about more intimate issues such as how to decide whether or not to have sex and when. Fifteen to 20 years ago, sexuality education was controversial because some conservative and religious groups felt this was a topic that only parents should discuss with their children. Sex education is still contentious, but the current debate centers on what should be taught in these classes and to what degree adolescents (and younger children) should be instructed solely to abstain from sex or provided with comprehensive information that not only includes abstinence but also accurate information about contraception and condom use for pregnancy and STD prevention.

Policies also show divergent goals in other areas. For example, federal family planning funds are allocated to clinics under the Title X program in order to make family planning services accessible to all women, particularly those who are poor. This program includes guidelines that ensure adolescents confidential access to contraceptive and other reproductive health care. On the other hand, another federal program provides funding to implement and develop abstinence-outside-of-marriage education programs for children and teenagers.

Nationwide, there is a loosely organized

abstinence movement that encourages teenagers and young adults to abstain from all sexual activity until marriage. This view of sexuality is held by a minority of adults, but it is supported by several conservative groups. These groups, in turn, have secured funding and further political support for abstinence education programs. Other organizations, such as the Sexuality Information and Education Council of the United States (SIECUS), advocate for a more comprehensive approach to sexuality, but have not received the same degree of political support.

Problematic Aspects of Teenage Sexuality

For many people, the fact that teenagers are exposed to and engage in sex without being married is problematic. Hence, abstinence-only interventions focus on decreasing teenage sexual activity.

Many U.S. adults are also concerned about pregnancies that occur to (unmarried) teenagers. In part, this concern is related to the fact that children born to young, unmarried women usually spend at least part of their childhood in poverty. Also, relative to their counterparts who have children when they are older, unmarried teenagers who give birth have higher school dropout rates, are more likely to receive welfare, and less likely to get married or be employed. Notably, concern over teenage pregnancy is motivated by disapproval as much as it is by sympathy. Many people believe out-of-wedlock births to teenagers are a main cause of welfare dependency, and that the provision of welfare benefits encourages unmarried teenagers to have children. The issue of teenage pregnancy also intersects with issues of premarital sex, abstinence education and abortion.

Compared to the 1970s and 1980s, contemporary teenagers start having sex at earlier ages and, in turn, have more sexual partners in their lifetime. This means they have an increased risk of contracting STDs. In the last two decades parents, educators and

policy makers have become particularly concerned with adolescents' exposure to HIV/AIDS. Rates of HIV/AIDS are relatively low among teenagers, but this may be due to the long period between infection and diagnosis.

The viral STD, human papillomavirus (HPV) is very common and some strains are linked to cervical cancer. It is estimated that three out of four adults between the ages of 15–49 have been diagnosed with HPV at some point in their lifetime.⁴⁰ Recent studies report that condoms do not always prevent the transmission of HPV, because they do not cover all areas from which the virus can be contracted.

U.S. teenagers have higher rates of chlamydia and gonorrhea than do sexually active adults.⁴¹ It is worth noting that the higher rates of STDs among teenagers may be due in part to the fact that the non-teenage population to which they are being compared contains many married individuals. Recent survey data show that many teenagers have inaccurate information about their own likelihood of contracting or transmitting STDs.⁴² These findings have not only spurred efforts to educate teenagers (and adults) about STD prevention, but they have also heightened conservative efforts to implement abstinence education among teenagers and to discourage sex outside of marriage.

Other issues considered problematic by many in the United States include sexual coercion, sexual assault, and the use of “date rape drugs” such as Rohypnol. The issue of sexual harassment in schools has also received some attention due to publicized instances where teachers condoned or refused to address male students verbally and physically harassing female students and to a Supreme Court ruling in 1999 that determined that public schools could be sued and forced to pay damages for failing to stop sexual harassment by students.⁴³ Researchers have found that a substantial proportion of females characterize their first sexual experience as forced or unwanted. Nine percent of young women aged 15–24 report that their first sexual intercourse was not voluntary.⁴⁴ Moreover, when young women whose first intercourse was voluntary were asked to rank the wantedness of this event on a scale of 1 to 10 (with ‘1’ signifying the female really didn’t want it to happen), 26% of young women rated their first intercourse at 4 or lower; only 15% indicated that they really wanted it to happen (rank=10).⁴⁵

National Efforts to Change Adolescents Sexual and Reproductive Behavior

In his 1995 State of the Union address, President Clinton urged adults and activists to come up with solutions for ending teenage pregnancy and out-of-

wedlock births. This resulted in the formation of the National Campaign to Prevent Teen Pregnancy, a non-governmental organization comprised of prominent researchers, politicians, and religious figures. The Campaign is a nonprofit, nonpartisan initiative supported almost entirely by private donations whose mission is to “To improve the well-being of children, youth, and families by reducing teenage pregnancy.” The main strategy of the Campaign has been to provide groups, organizations, and communities with information to facilitate the development of programs and interventions that they feel best suit the populations they are trying to reach, not to support specific approaches.

Sexuality education programs implemented by schools and youth-centered groups are the most common way that groups and organizations attempt to change adolescent sexual behavior. The majority of U.S. students receive some form of sexuality education in school, and many teenagers also receive formal instruction about sexuality issues from non-school sources such as health professionals, youth groups, after school programs, and workshops or seminars. During the 1980s and 1990s the focus of most school sexuality education programs was on HIV/AIDS, STDs and pregnancy prevention, including information about birth control. Teachers reported, however, that their most important messages were about responsibility and abstinence.⁴⁶ The presence and influence of a vocal minority promoting a message of sexual abstinence has increased since the mid-1990s. In fact, the percentage of sexuality teachers who reported that their most important message was abstinence rose from 25% in 1988 to 41% in 1999.⁴⁷ At the same time, 40% of secondary school sexuality education teachers do not cover contraception and condoms at all or teach that they are ineffective for prevention of pregnancy and STDs.

Three pieces of federal legislation, all products of the abstinence-outside-of-marriage movement, are intended to directly impact teenage sexual activity. The Adolescent Family Life Act (AFLA), established in 1981 and funded at \$14.2 million in 1997, gives funds to groups and organizations (including schools) to develop and/or implement abstinence programs. The AFLA also provides support services for pregnant and parenting teenagers. The second piece of legislation intended to influence teenagers originated with the 1996 reform of the means-tested welfare system. In an effort to reduce teenage pregnancy rates, Congress allocated \$50 million dollars annually over 5 years, to be matched with 3 dollars in state funds for every 4 dollars in federal funds, for the provision of abstinence-only sexuality

education programs. Finally, an earmark of the Maternal and Child Health Block Grant's SPRANS program provided \$20 million in fiscal year 2001 for abstinence-only education. To qualify for any of these funds, education programs must adhere to a strict eight-point definition of "abstinence education," although the guidelines state that "it is not necessary to place equal emphasis on each element of the definition," so long as the program is not "inconsistent with any aspect of the abstinence definition."⁴⁸

Programs adhere to the definition if they:

- have as their exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
- teach that abstinence from sexual activity outside marriage is the expected standard for all school age children;
- teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
- teach that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
- teach that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
- teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
- teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances;
- teach the importance of attaining self-sufficiency before engaging in sexual activity.

These abstinence-only programs are not directed only at poor adolescents, but at teenagers of all social classes even though the funding originated in the welfare program.

Recent Changes in "Openness" and Concern toward Teenage Sexuality

Many of the same ambivalent and contradictory attitudes that U.S. society exhibited towards sexuality in the late 70s and 80s still exist. At same time, relative to earlier time periods, U.S. society is more open and accepting of variations in sexual orientations and discussions of sexual activities. Popular primetime television shows, some of which are aimed at teenagers, deal with issues such as sexual dysfunction, same-sex attraction, and decisions about whether or not to have sex. Popular magazines contain advertisements for condoms, and former

presidential candidate Bob Dole has publicly acknowledged his experiences with impotence in Viagra advertisements. The revelation that President Clinton engaged in sexual activities with former White House intern Monica Lewinsky created a tremendous public scandal. Although attempts to remove him from office because of it failed, the affair led to more open public discussions of sexuality issues, including questions such as "what is sex?" (e.g., Is it limited to penile-vaginal intercourse?). All of these developments have resulted in public discussions of sexual issues that were taboo only 10 years ago. Of course, these changes have met resistance on a number of fronts. Conservative religious organizations such as Focus on the Family and the Family Research Council urge members to boycott companies that sponsor shows that they deem sexually immoral (usually those dealing with homosexuality) as well as companies that provide domestic partner benefits to same sex couples. And, public disapproval of Clinton's behavior contributed to Republican strength in the 2000 election.

Indicators of Attitudes from Surveys

Attitudes toward Sexuality

Since the early 1970s, U.S. attitudes toward sexual issues have changed, but the amount and direction of that change depends on the specific issue being addressed. Disapproval of premarital sex has declined slightly in the last few decades; in 1972, over one-third of U.S. adults (37%) indicated that sexual relations before marriage were always wrong.^d In 1982, 29% of adults in the United States thought that premarital sex was "always wrong," and in 1996 only 24% held this opinion. Opinions regarding teenage sexual activity have changed little over time. In 1996, 69% of U.S. adults indicated that it was "always wrong" for adolescents between the ages of 14–16 to have sex. Similarly, in 1986, 67% of adults believed that it was "always wrong." On the other hand, contemporary U.S. adults are more disapproving of extramarital sex than they were in previous decades. In 1996, 78% indicated that they thought that extramarital sex was "always wrong" compared with 73% in 1982 and 70% in 1972.^e

Although the majority of U.S. adults disapprove of homosexual sex, tolerance of homosexuality has

^d Information about trends in attitudes toward premarital sex, teenage sex, extramarital sex, and homosexuality come from the General Social Survey (GSS), special tabulations. The GSS has been administered to a nationally representative sample of U.S. adults on an annual or bi-annual basis since 1972.

^e The 1996 GSS figure of 78% corresponds with a recent Gallup poll that asked about the same issue.

increased substantially in the last 15 years. In 1996, 60% of adults indicated that they thought that sexual relations between two adults of the same sex were always wrong. In comparison, in 1982, 75% of U.S. adults indicated that they thought that homosexual activity was always wrong. Disapproval of homosexual sex does not necessarily translate into support for discrimination against homosexuals. In 1996, 77% of U.S. adults indicated that homosexuals should be allowed to teach in colleges and universities, up from 49% in 1972.⁵⁰

Communication about Sex

Among U.S. teenagers, parents are the second most common source of information about pregnancy and birth control, as well as the most trusted⁵¹ (a larger proportion of students receives information about birth control, STDs, and HIV/AIDS at school, making it the most common source of information).

The majority of teenagers has discussed sexual issues with their parents, but there is some variation according to topic and gender. The majority has discussed AIDS and, to a lesser extent, STDs with their parents. According to the 1995 National Survey of Adolescent Males (NSAM), 57% of young men between the ages of 15–18 have ever discussed AIDS with their parents and 43% have ever talked about STDs. A parallel survey of females—the 1995 National Survey of Family Growth (NSFG)—found that 66% of young women between the ages of 15–18 have discussed STDs (including AIDS) with their parents. These figures are similar to those of the 1996 Youth Risk Behavior Survey (YRBS) administered to a sample of (approximately) 6,500 high school students. The YRBS showed that 68% of females and 56% of males had talked about HIV/AIDS with a parent or other adult member.⁵² Birth control methods are a less common topic of parent-child discussions, at least with male children. Sixty-five percent of females aged 15–18 have discussed this issue with a parent (NSFG), but only 43% of males in the same age group have done so (NSAM).

Gender differences showing that parents are more likely to talk about sexual issues with their daughters than with their sons have also appeared in previous studies. This is due, in part, to the fact that parents are most likely to talk about sex with offspring of the same sex, and mothers are more likely to talk with their children about sex than are fathers.⁵³ The end result of these two conditions is that adolescent girls are more likely to discuss sexual issues with a parent than are boys.

When it comes to communicating with their sexual partners, teenagers are more likely to discuss pregnancy prevention than they are to discuss STDs.

According to the NSAM, 66% of males between the ages of 15–19 who have ever had sex indicated that they had talked with their last female partner about birth control before having sex for the first time. A substantially smaller proportion, 43%, had discussed STDs. Unfortunately, the NSFG did not gather comparable information from women.^f

Sexual Pleasure

Most large-scale surveys that provide information about sexual activities do so in the context of fertility and STD research. Hence, few inquire about sexual pleasure. One exception is the 1992 National Health and Social Life Survey (NHSLs), which asked a nationally representative sample of approximately 3,000 U.S. adults aged 18–59 about emotional and physical dimensions of sexual satisfaction. Notably, the NHSLs was originally intended to have a larger sample, but the investigators failed to secure government funding because some Congress members considered survey items regarding sexual pleasure and masturbation to be immoral and inappropriate.⁵⁴ Large-scale surveys asking teenagers about experiences with or expectations of sexual pleasure are politically untenable, so there is little, if any, information about these issues. Indeed, in order to secure federal funding for a recent longitudinal survey of the health-related behaviors of adolescents, the primary investigators decided to forego questioning youths aged 14 and under about contraception and sexual activity and obtained parental consent before asking such questions of older adolescents.

Indicators Inferred from Laws

Sex and Marriage

There are a number of laws intended to safeguard and protect the rights and well-being of minors in the United States. Laws on age of sexual consent, statutory rape and legal age of marriage are three important examples of such legislation.

The legal age of sexual consent ranges from a low of 14 to a high of 18, depending on the state and is 16 in the majority of states. Almost half require that a teenager be older than 16 (usually 18). In two states it is legal for adolescents aged 14 or 15 to have sex, but at least one of these states is considering raising the age of sexual consent.

Eighteen is the legal age of consent for marriage in most states. In a few states, such as Nebraska, an individual must be 19 in order to marry without

^f Presumably figures for females are similar since the NSAM items ask about communication between males and females. However, it is possible that males and females have different recollection patterns or definitions of what constitutes “talking.”

parental permission. It is possible to marry at age 16 in most states if parental consent is obtained. Additionally, some states allow a female under the age of 18 to marry without parental consent under certain circumstances, such as pregnancy.

Loosely defined, statutory rape occurs when an adult has vaginal intercourse with a minor. All 50 states have statutory rape laws, but there is much inter-state variation. For example, in Massachusetts it is unlawful to have intercourse with anyone under the age of 16. In Montana, the same situation is only defined as rape if the perpetrator is three or more years older than the minor. Other states, such as Hawaii, lessen the severity of the offense as the age of the minor increases. Finally, in a number of states the severity of the charge varies according to both the age of the minor and the age difference between the two individuals involved.⁵⁵

Concerned about data showing that a majority of births to women under age 20 are fathered by men aged 20 and older,⁵⁶ legislators who passed the 1996 welfare reform legislation urged states to enforce statutory rape laws and prosecute “predatory” men. (While most statutory rape laws are worded in gender-neutral language, they are typically only enforced when the younger partner is female.) In response, at least 12 states have modified legislation toward this goal—usually by increasing the categories of relationships that qualify as statutory rape and/or implementing harsher penalties.⁵⁷ A few states also reduced or eliminated punishments for cases where age differences are less pronounced, such as those in which both parties are minors. No federal funds were provided to increase enforcement of statutory rape, but several states use their own money to fund public awareness campaigns, training programs for law enforcement officials, and prosecution.⁵⁸ California has probably put the most effort into apprehending men who have sex with minor females, with special statutory rape prosecution units in most counties. Between 1995 and 1999, more than 17,000 cases were referred for prosecution and more than 6,000 resulted in conviction.⁵⁹

Preliminary reports suggest, however, that increased enforcement of statutory rape has not been particularly widespread or effective.⁶⁰ This is due to several conditions, including lack of public support, unclear state guidelines regarding the reporting process and overburdened child welfare agencies.⁶¹ Sexual activity usually occurs behind closed doors and, for the most part, is voluntary, so it is difficult to prove that an adult man is having sex with a young female, at least without her cooperation. Many teenage women are unwilling to “turn in” their

partners—either out of concern for their partner or fear of retribution. Health care professionals, and particularly those in the field of reproductive health, have been encouraged to report situations where younger women are having sex with older men. But these workers may have little knowledge about the age of their patients’ partners and, out of respect for female patients’ privacy, may be reluctant to ask.⁶² Even in California, where efforts have been most vigorous, the primary punishment for most men who are convicted of statutory rape is probation.⁶³

Services to Adolescents

In the United States, individuals under the age of 18 usually must have parental consent before receiving health care. Reproductive health services, however, are often an exception. No state restricts access to birth control based solely on age, but in some states, individual physicians may, at their discretion, deny services to minors. Only 25 states and the District of Columbia guarantee minors the right to consent to contraceptive services on their own, 27 plus the District of Columbia do so for prenatal care and all 50 states plus the District of Columbia specifically give minors the right to consent to testing and treatment for STDs, including HIV.⁶⁴

Policy makers who implemented the federal Title X family planning program tried to insure clients’ privacy because they understood that many adolescents would not seek services if they thought their parents would find out. Federal guidelines mandate that clinics receiving Title X funds cannot (1) impose minimum age requirements, (2) inform parents when their child accesses services, or (3) require parental consent.

Adolescents who obtain reproductive health services through private physicians or non-Title X providers may not be guaranteed confidential care. Some U.S. health care providers express hesitation and discomfort at the idea of providing family planning services to teenagers because they fear parents’ reactions.⁶⁵ Generally, records of mature minors are not shared with the parents, but doctors in some states can inform a parent when her or his child seeks contraceptive care if the physician determines that it is in the best interest of minor to do so.⁶⁶ Other obstacles that may deter minors from obtaining reproductive health services from private providers include high cost, inconvenient hours and the possibility that parents will find out from health insurance records if the minor provides this information to the provider.

Making birth control available to teenagers has always been controversial, and recent (as well as

past) legislatures have attempted to restrict minors' access to reproductive health services. For example, in 1998 Congress defeated amendments that would have required parental notification for minors receiving contraception from Title X clinics. In addition, state legislatures have attempted to implement similar parental notification and/or consent laws for the provision of contraceptive services using state funding. Currently, two states, Texas and Utah, prohibit the use of state funds to provide contraceptive services to minors without parental consent.⁶⁷

Abortion is the most controversial reproductive health issue in the United States and, not surprisingly, there have been many attempts to restrict access for women under the age of 18. Only two states (Connecticut and Maine) plus the District of Columbia affirm a minor's right to consent to an abortion without parental involvement.⁶⁸ In contrast, 31 states have laws in effect that require the involvement of at least one parent in their daughter's abortion decision. All but one of these states (Utah) provide another mechanism for obtaining an abortion if a minor cannot involve her parents—usually this is judicial authorization. A minor may petition a judge to waive the parental consent or notice requirement (depending on that state's requirement) if (1) she is mature and well informed enough to make her own decision or (2) abortion would serve her best interests. There have been documented cases of anti-choice judges refusing to hear such cases and verbally harassing or unlawfully ruling against minors who seek judicial bypass.⁶⁹

A substantial proportion of minors (20–55%) who seek abortions in states with parental involvement laws exercise the judicial bypass option.⁷⁰ Common obstacles encountered by minors residing in states with mandated parental involvement laws are the inability to reach abortion clinics located out of state, court hours that coincide with school hours, overburdened courts, and out-of-town court locations—all factors that can result in longer gestation periods and delayed access to abortion.

Research suggests that, overall, parental involvement laws have little effect on teenage abortion rates. Though the number or rate of teenagers seeking in-state abortions may fall, most minors either consult with their parents, successfully obtain judicial authorization or, when the option is available, seek abortions in bordering states, although at a later gestation and with higher costs than would otherwise be the case.^{71, 72} Perhaps more importantly, the majority of minors who obtain abortions, 61%, voluntarily involve one or both parents,⁷³ and this limits the impact that parental involvement laws have on abortion.

However, little if any research has examined the extent to which the larger population of minors and/or adults is aware of parental involvement laws in their state. Interestingly, a 1992 study based on data gathered from 11 teenage focus groups across the United States found that most of the adolescents thought that abortion was illegal in their state.⁷⁴ Given the amount of inter-state variation regarding parental involvement laws, along with the fact that the laws often change and contested laws may not be in effect, it is probable that many teenagers and adults lack specific or accurate information regarding these issues.

Indicators of Society's Attitudes toward Sex and Contraception Illustrated in the Media *Standards for Advertising Contraceptives and Type of Media*

With the exception of those methods of birth control that require a prescription, there are no current regulations or codes that restrict their advertisement. Nonetheless, the national offices of most major broadcast stations prohibit birth control advertisements. Local affiliate stations can accept them, but many are reluctant to do so⁷⁵ since some religious organizations and politically conservative groups assert that birth control advertisements promote immoral behavior and sex outside of marriage. Since the late 1980s, magazines, particularly those targeted at women, have been more willing than television and radio stations to accept advertisements for condoms and other types of birth control, though many times the ads focus on disease protection and/or other health benefits and downplay pregnancy prevention.

Until 1982, the organization responsible for setting the television industry codes and standards—the National Association of Broadcasters (NAB)—prohibited birth control advertisements.⁷⁶ When this restriction was lifted, individual stations were able to decide for themselves whether or not to accept birth control advertisements. Most continued to refuse. In 1984, the companies marketing the contraceptive sponge and the contraceptive suppository were marginally successful placing advertisement for their products; the commercials appeared on cable television stations, college stations, and a few commercial stations in large cities.

Many of the contraceptives used by women are only available by prescription and until 1997 there were restrictions against advertising prescription drugs directly to consumers. When the FDA loosened these restrictions, the first prescription drug to be advertised in non-medical magazines was the

injectable contraceptive Depo Provera. Since that time, several drug companies have made efforts to increase public awareness of prescription birth control. For example, in 1998 Johnson & Johnson launched an extensive media campaign to promote their popular birth control pill Ortho Tri-Cyclen.⁷⁷ The ads, which appear on television stations in selected cities and in women's magazine, emphasize the fact that the pill helps clear up acne. For the most part, advertising campaigns for female contraception largely have been restricted to selected cable channels, women's magazines, college newspapers, and a few commercial television stations and newspapers.⁷⁸ However, this is beginning to change. Companies that make and market female contraceptives feel that society, and television stations in particular, are becoming more accepting of these types of advertisements.⁷⁹ And, one major network, CBS, is reviewing its policy regarding birth control advertisements.⁸⁰

Formal and informal rules regarding condom advertisements have followed a somewhat different trajectory than those of female birth control. In 1986, Surgeon General C. Everett Koop issued the first government report on AIDS, and several months later he told policy makers that he believed condom advertisements would help limit the spread of AIDS. Although 15 national magazines announced that they would begin accepting condom advertisements, condom companies, many of which had previously tried to place condom advertisements in TV and radio but failed, found that they were still unable to get their advertisements printed during the 1980s and early 1990s. Most television stations did not change their policies and, with the exception of a few stations in large cities, continued to turn down condom commercials. During the second half of the 1990s, restrictions on condom advertisements were relaxed. This may have been due, in part, to the fact that following the Surgeon General's report on AIDS, public health activists increased pressure on television stations to air public service announcements (PSAs) urging condom use to prevent the spread of HIV/AIDS. It took almost a decade, but the three major networks finally agreed to air the PSAs if the message (1) was one of disease prevention and (2) aired during times when children would be unlikely to be watching.⁸¹ In 1994, the national television network Fox announced that it would carry condom advertisements that followed the same guidelines. More recently, a limited number of magazines and television stations (mostly cable, but also some local affiliates) have accepted advertisements that place condom use in the context of sex for pleasure. Notably, these types of ad campaigns have generated

controversy on at least one college campus, and conservative family organizations have publicly criticized the ads as too graphic. Finally, it is important to emphasize that even though advertisements and images of condoms are more common than they were ten years ago, they are far from widespread, and many magazines and TV stations still refuse to carry them.

Coverage of Sex in TV Programming

Since most children spend several hours a day watching television, a number of parents and policy makers are concerned that children are learning inappropriate sexual mores. The same networks that prohibit the advertisement of birth control are willing to air television shows that depict adults, and sometimes teenagers, talking about sex and engaging in sexual behaviors—usually without discussing or appearing to use contraception. And, although explicit sexual intercourse or eroticism is usually not broadcast on network television, cable channels and Internet sites with such content are widely available.

Several studies have documented the type and amount of sexual content in television shows and have also looked at the contexts in which sexual content occurs. A content analysis of "family hour" programming on four major networks (ABC, CBS, Fox and NBC) in 1976, 1986, and 1996^{82,8} measured levels of sexual content, which included both talk about sex and specific sexual behaviors, ranging from physical flirting to depictions of sexual intercourse. Not surprisingly, the proportion of shows containing any sexual content increased steadily over the 20 year period: from 43% in 1976 to 65% in 1986 and 75% in 1996. Shows that included a variety of sexual behaviors also increased—from 26% in 1976 to 61% in 1996. The most common forms of sexual behavior contained in these shows in all time periods were kissing and flirting, which accounted for 84% of all observed sexual behaviors.

The researchers also examined the situational contexts in which sexual talk and sexual behaviors occurred. In 1996, 10% of all situations containing talk about sex or sexual behaviors involved teenage characters; the most common activities were talking about sex, physical flirting and passionate kissing. However, less than one-third (29%) of the situations containing talk about sex or sexual behaviors involving teenagers did so in the context of responsible sexual activity—by, for example, showing couples waiting to have sex or attempting to avoid STDs and unintended pregnancy.

⁸ The family hour is defined as 8-9 p.m., a time when children are likely to be watching.

In another study, researchers conducted a content analysis of the 15 most popular television shows viewed by teenagers aged 12–17.⁸³ They found that talking about sex was as common on shows for teenagers as on regular primetime (67% for both) as were programs in which intercourse was depicted or strongly implied (13% and 12%, respectively). On a positive note, programs popular with teenagers are more likely than other shows to cover issues of sexual risk or responsibility (14% and 5%, respectively).

Nudity in the Media

Broadcast standards prohibit showing full frontal nudity on (non-cable) television, but some adult television shows, such as *NYPD Blue*, have provided partial nudity such as “glimpses” of bare buttocks—both male and female. When the critically acclaimed movie *Schindler’s List* aired on national broadcast television during prime time, it contained scenes of full frontal nudity (of women and men). The network was publicly criticized, but was not fined or reprimanded by the FCC—probably because the nudity presented in this context was not sexual.

Broadcast standards for cable television are more lenient than those for broadcast television. Full frontal nudity of either sex is allowed, but females are depicted in this manner more than males. Purportedly, networks are prohibited from showing an erect male penis or actual penile penetration. Informal evaluations suggest that partial and full nudity of both women and men has increased on television in the last two decades,⁸⁴ but no formal studies have examined the extent of this change.

Images of partially nude adults, usually women, are common in newspapers, teenage magazines, and general interest magazines. However, full frontal nudity is rarely, if ever, depicted in this context.

Discussion of Sex in the Media

During the last few decades, the structure of television has changed. Until the 1980s, there were only three national networks, and they aired almost all of the television shows viewed by adults and children. During the last two decades, cable and satellite television have flourished and several new national television networks have appeared. In addition to increased diversity of programming, there also has been an increase in the number of televisions owned by families. In 1999, 53% of U.S. children had television sets in their bedrooms.⁸⁵ These changes have made it harder for parents to monitor the television shows that their children watch. In response to these concerns, in 1997, the television industry adopted a

mandatory television show rating system. Each show is assigned one (or two) ratings based on its content (e.g., whether it contains violence, mature content, etc.), and the ratings are flashed on the screen at the beginning of the show. Parents can also buy and activate devices called “V-chips” which allow them to block out the signals from certain shows on their television sets based on the ratings system. Since July 1999, electronics companies have had to include V-chip technology in 50% of all newly produced televisions. By January 2000, the remaining 50% of new televisions were also expected to include V-chip technology. Some policy makers and parents have not found the ratings system to be effective and, for example, some of the programs that contain sexual content do not have ratings that indicate the show is for mature audiences. While many parents express positive views about the V-chip potential,⁸⁶ to date, there are no statistics on the extent of its use.

Some organizations concerned with media portrayals of sexuality have developed proactive strategies. Organizations such as Advocates for Youth, the Henry J. Kaiser Family Foundation and The National Campaign to Prevent Teen Pregnancy consult with producers and writers of television programs, encouraging them to include information and story lines about responsible sexual behavior. For example, in 1998 the popular television show, *ER*, showed an emergency room patient using emergency contraception after she was coerced into having unprotected sex.^{87,h}

In response to the increasing amount of violence, sex and profanity on network television, Paxson Communication introduced PAX TV in 1998. The explicit goal of PAX is to provide “programming that is free of senseless violence, free of explicit sex and free of foul language.” PAX’s viewing audience is much smaller than that of broadcast television stations such as NBC, CBS, and ABC, but the network has been more successful than anticipated and is in the process of expanding its programming.

Efforts to monitor or restrict children’s exposure to sexual content in media other than television are more informal. In 1985, the Parent’s Music Resource Center (PMRC) pressured the recording industry to label “offensive” music and provide the printed song lyrics on the jackets so that parents could read the words of the songs their children were listening too. Magazines aimed at young females (aged 10–13) often contain explicit articles about sexuality issues, including birth control, STDs, teenage pregnancy,

^h A national survey of *ER* viewers who watched the episode found that awareness of emergency contraception increased by as much as one-third (see reference # 87).

oral sex, and how to tell when you are mature enough to have sex for the first time. Some parents have protested, and some schools have ended their subscriptions and pulled back issues off the shelf.⁸⁸ However, teenage magazines have not changed their format, and they continue to include sexually explicit information.

Portrayals of homosexuality on television have generated a considerable amount of attention in the last few years. In 1997, the prime time television show *Ellen* elicited criticism and controversy when the main character, played by Ellen Degeneres, realized that she was gay. While other TV shows up to this point had had minor characters that were lesbian or gay, no show had a main character who was gay, much less one who “switched” from being heterosexual to homosexual. Conservative family organizations immediately began campaigns to boycott companies that advertised during the show. Supporters of *Ellen* countered by sending messages of support to these companies. Approximately one year after the “coming out” episode, ABC cancelled *Ellen*. The network stated that low ratings and failure to secure advertising were responsible for the cancellation, but gay and lesbian organizations argued that the network was uncomfortable with the subject matter and unwilling to stand up for gay and lesbian rights. There was probably an element of truth to both explanations. In the fall 1998 season, after the cancellation of *Ellen*, a different network (NBC) introduced the prime time sitcom *Will and Grace*, in which one of the main characters is a gay male. The show was the top-ranked new sitcom of the season and, interestingly, has failed to create much controversy.

Young People’s Socialization about Sexuality, Sexual Behavior and Sexual Responsibility

What Teenagers Say about the Sexuality Information They Receive

Contemporary adults are under the impression that their children acquire most of their information about sex from the media and from their peers.⁸⁹ However, 40% of teenagers aged 12–18 report that they learned “a lot” about pregnancy and birth control from “teachers, school nurses or classes at school;”⁹⁰ slightly fewer, 36%, reported that they learned “a lot” from their parents.⁹⁰ Both of these percentages are higher than the 27% and 23% who had learned “a lot” from friends and TV or movies, respectively. These results are similar to findings from a smaller,

more recent poll,^j which found that teenagers between the ages of 15–17 learn most of the information they receive about STDs in sex education classes at school, followed by parents.⁹¹ Friends were the least likely source of information about this topic. Teenagers not only rely on their parents for information about sex, but when asked who they could trust most to provide complete and reliable information about birth control, teenagers express the highest level of trust (55%) in their parents.⁹²

When asked about problems with the information that they had received about sex, 32% of teenagers said that they wanted more information about how to use birth control; 44% desired more information about where to get birth control and 47% wanted more information about STD and AIDS prevention.⁹³ Conversations with sexuality education teachers and other individuals who work with adolescents suggest that teenagers are also curious about aspects of sexuality such as masturbation, oral sex and anal sex,⁹⁴ but no survey to date has gauged teenager’s interest in or knowledge about these topics.

Sexuality Education in the Schools

National Guidelines or Recommended Curriculum for Public Schools

Since the federal government provides little funding for public education, most educational policies are developed at the local or state level. Sexuality education policies and practices vary from state to state, school district to school district, and even from school to school within the same district. A 1998 survey of school district superintendents found that 69% of school districts had a policy to teach sex education; the remaining 31% left the decision to the individual schools or to the teachers themselves.⁹⁵ Most students, 86%, reside in school districts that have sex education policies. It is worth noting that even when school districts have policies on sex education, there may not be any mechanism to insure that these classes are, in fact, being taught according to policy guidelines.

Focus, Scope and Intensity of Sexuality Education Curriculum

A 1999 survey of public school sexuality education teachers found that sexuality education was taught in 93% of schools during grades 7–12 and 72% of schools during grades 5–6.⁹⁶ Sex education was most likely to be taught in grades 7–10. The most commonly covered topics in grades 7–12 were

ⁱ These findings are based on telephone interviews with 1,510 teenagers. The margin of error is ± 3 percentage points.

^j These findings are based on telephone interviews with 400 adolescents. The margin of error is ± 5 percentage points.

abstinence, STDs and how HIV/AIDS is transmitted (94–95%). In these grades, teachers were less likely to discuss birth control methods (77%), factual information about abortion (63%), how to access birth control (65%) or abortion ethics (52%). Sexual orientation (51%) and instruction on how to use a condom (53%) were the topics least likely to be discussed.

The majority of young males and females indicate that they have received formal sex education. According to data from the 1995 NSAM, very high proportions of young men aged 15–18 reported that they received instruction at school about AIDS (93%), STDs (85%), birth control methods (80%), how to say no to sex (76%), where to obtain birth control (67%), and how to put on a condom (62%). Data from the 1995 NSFG indicate that similar or higher proportions of females in the same age group have received instruction about STDs (including AIDS) (93%), birth control methods (87%) and abstinence or how to say no to sex (93%).^k

Where sexuality or HIV/AIDS education is a required part of the school curriculum, almost all school systems allow parents to remove their children from such classes. However, very few parents exercise this option.⁹⁷

Geographic Variations in Sexuality Education

The southern United States is typically regarded as more conservative and supportive of traditional family arrangements than other parts of the United States. Not surprisingly, then, only 5% of public school districts in the South with sex education policies mandate comprehensive sex education that does not stress abstinence as the one or preferred way for adolescents to avoid pregnancy and STDs while 55% have “abstinence-only” policies; that is, abstinence is taught as the only effective way to avoid pregnancy and STDs. Comparable figures for the entire United States are 14% and 35% respectively.⁹⁸

Content of Sexuality Education

Theoretically, all sex education programs address the issue of abstinence, and it can be presented in one of three ways: as one option in a broad array of choices, as the preferred way for adolescents to avoid

pregnancy and STDs, and, as the only option outside of marriage. Among the 69% of school districts that have an explicit policy regarding sexuality education, only 14% present both abstinence and contraception as options in a broad sexuality education program.⁹⁹ Fifty-one percent of school districts with any policy present abstinence as the preferred option, but allow discussion of contraception as effective in preventing pregnancy and STDs. The remaining 35% of districts with policies mandate that teachers must tell students that abstaining from sex outside of marriage is the only way to avoid pregnancy and STDs.

The 1999 survey of sexuality education teachers found that 23% of teachers of grades 7–12 instruct students that abstinence is the only way to avoid unwanted pregnancy and STDs while 65% teach that it is the preferred alternative.¹⁰⁰ These figures are substantially different from a parallel survey of sexuality education teachers conducted in 1988. At that time, only 2% of teachers reported presenting abstinence as the only alternative for preventing pregnancy and 86% reported presenting it as the best alternative.¹⁰¹ These patterns demonstrate that the abstinence movement is having a substantial impact on sexuality education in public schools.

Although 77% of sexuality education teachers for grades 7–12 reported that information about birth control methods was taught at their school,¹⁰² they reported variation in the way that this information was presented. In some cases, school policy restricts teachers from teaching about birth control methods but does permit them to answer students’ questions. In other schools, teachers are restricted from teaching about birth control methods and from answering questions posed by students. Notably, even when teachers are permitted to cover this topic or answer student questions, some teachers do not.

In abstinence-until-marriage curricula, teachers are instructed only to discuss contraception in the context of contraceptive failure rates. Some programs have even been accused of providing false or distorted information regarding the effectiveness of contraceptives.¹⁰³ Sex education curricula that promote abstinence as the preferred option and/or as one of a number of options typically provide information about different types of contraception, problems with each, contraceptive availability, and how to use each method effectively.

Controversy Over Sex Education

Trend data show that even in 1974, over 75% of adults favored sex education in public schools and over 75% of males and females aged 15–19 have received formal instruction about birth control and STDs since the late 1980s.¹⁰⁴ Nonetheless, the issue

^k Figures are slightly higher for females because (1) the NSFG asked about sex education instruction received in church, youth groups, and other organizations and (2) respondents aged 18 and older were asked if they had received sex education before age 18. Males surveyed for the NSAM were simply asked if they had ever received instruction in each topic while at school.

has always been a controversial one. In the 1970s and early 1980s, the debate centered on whether or not schools should even be permitted to provide sex education. A vocal minority of adults felt that sexuality was a moral issue that children and teenagers should only discuss with their parents. Critics also feared that providing information about birth control in the context of pregnancy prevention and STDs would encourage teenagers to have sex. The debate has shifted with the appearance of HIV/AIDS; most adults recognize that learning about safe sex practices is a matter of life and death. The debate now focuses on the best way to frame this message. A conservative minority argues that sex education should teach students that abstinence until marriage is the only safe and morally acceptable way to avoid pregnancy and HIV/AIDS. They also assert that information about the effectiveness of birth control legitimates sex outside of marriage.

As previously discussed, surveys of sexuality education teachers in 1988 and 1999 indicate that abstinence-only education has increased substantially in the last decade. Moreover, lower proportions of teachers are providing instruction on birth control methods, abortion, and issues of sexual orientation in 1999.¹⁰⁵

Other Sources of Sexuality Information Used by Teenagers

In addition to schools and parents, teenagers learn about sex from a number of sources. Among adolescents aged 12–18, 27% indicated that they had learned “a lot” about pregnancy and birth control from friends, 12% from magazines, and 9% from a doctor or nurse.¹⁰⁶ There have been some attempts to improve all of these information sources. Some schools and youth organizations have implemented peer education programs where selected teenagers receive accurate information about sexuality issues and then learn how to effectively relay that information to their peers. And, many teenage magazines, most of which are aimed at females, incorporate information about a wide range of sexuality issues.

Interventions that Illustrate Societal Views about Adolescent Sexuality

The Abstinence Education Movement

Adults in the United States understand that most adolescents will have sexual intercourse while they are teenagers, though they may not approve of these activities. For this reason, most adults support messages encouraging teenagers to abstain from sexual activity while simultaneously expressing approval of programs that provide teenagers with

information and access to birth control. A minority of individuals believe that all teenagers, and even all unmarried adults, should abstain from sex outside of marriage. They argue that providing teenagers with comprehensive information about birth control methods is equivalent to giving them permission to have intercourse. They also urge educators to emphasize the negative consequences of non-marital sex and the difficulty of avoiding these consequences—including birth control failure rates, the prevalence of STDs, and problems associated with out-of-wedlock births—in the hopes that teenagers will decide that the potential negative outcomes of sex are too great a risk. Abstinence proponents have pursued several strategies to get their ideas into practice.

Motivated by the belief that the federal government funneled too much money into subsidizing reproductive health services and contraceptives (Title X), conservative Senators Orrin Hatch and Jeremiah Denton sponsored and were able to pass the Adolescent Family Life Act (AFLA) in 1981. The primary goal of the program was to establish family-centered programs that promoted chastity and self-discipline. One strategy was to establish a network of centers, similar to that of Title X clinics, that provided abstinence counseling.¹⁰⁷ In order to gain the support of less conservative Senators, the sponsors also included a provision that 66% of AFLA funds be used to provide support services to pregnant and parenting teenagers. Funding for the first year was \$11 million, with annual increases through 1987. Funding was cut in 1988 and again in 1991, but was increased to \$14 million in FY 1997. The first programs to receive AFLA funds were almost exclusively run by far-right and religious groups.¹⁰⁸ Funds were used for abstinence instruction and curriculum development and, for example, the fear-based sex education curriculum Sex Respect. In the early 1990s, the AFLA was fundamentally altered because (1) reproductive rights and civil rights organizations questioned the constitutionality of its funding practices including by going to courts and (2) the Clinton administration favored providing support to organizations that provided comprehensive sex education. Non-religious organizations, and even some Planned Parenthood Affiliates, started receiving funds, and programs were required to provide medically accurate information. Because of these changes, conservatives looked to develop other programs to support abstinence.

In the United States, many people regard out-of-wedlock births, and particularly those to teenagers, as one of the major causes of poverty and welfare dependency. In 1996, Congress undertook the largest welfare reform effort ever, and many of these efforts

targeted young, unmarried women. For example, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 established a new block-grant program, Temporary Assistance to Needy Families (TANF), which restricts states from providing welfare to unmarried mothers under the age of 18 unless they are living with a parent or guardian and attending school.

As part of this reform, Congress also established new funding for abstinence education. Specifically, \$250 million in block grants was allocated to states over a five-year period for the purpose of teaching abstinence-only sex education. Many people worry that the movement to implement abstinence-only education means that adolescents will not receive accurate information about contraception or access to birth control. However, some states have come up with creative ways to use the federal money without discarding existing sexuality education programs.¹⁰⁹ Abstinence-only funds are often used by state public health departments, youth organizations and committees designed specifically for the purpose of securing and spending abstinence-only education grant money. A Boys and Girls Club in Utah has been criticized by abstinence advocates because it used grant money to sponsor an after-school hockey league.¹¹⁰ The organization was able to receive funds because it also included classes on decision-making, self-esteem and refusal skills. In some cases, then, abstinence-only grant money is not being used to eliminate comprehensive sexuality education but, rather, to enhance the abstinence option that has always been part of comprehensive sexuality education curricula.

Another reason critics are concerned about the abstinence-only block grants has to do with the large amounts of money that are involved. In order to receive funds from federal abstinence block grants, states must provide matching funds—\$3 for every \$4 provided by the federal government. This means that at the end of the 5-year period approximately \$437 million dollars will have been spent on abstinence-only programs. Advocates of comprehensive sexuality education assert that this money could be better spent on programs and services that have been shown to decrease teenage sexual activity. (To date, no studies have shown that abstinence-outside-of-marriage education programs delay sexual debut though quality evaluations in this area are fairly new.)

One final development of the abstinence movement is virginity pledges. A recent study found that a considerable proportion of teenagers—16% of females and 10% of males in grades 7–12—had pledged to abstain from sexual intercourse until they were married.¹¹¹ This finding was somewhat

unexpected because there is no national, unified “pledge movement;” rather, there are more than 80 organizations, such as “True Love Waits,” that sponsor pledge ceremonies and public pledges.¹¹² Multivariate analysis also suggests that virginity pledges have a strong negative effect on sexual debut, but that pledged teenagers who do end up having premarital intercourse are substantially less likely to use contraception.¹¹³ To date, no one has undertaken a thorough examination of this facet of the abstinence movement, but it appears that it may embody many of the contradictory dynamics surrounding teenage sexuality.

Plain Talk about Sex

In 1993, the Annie E. Casey Foundation launched Plain Talk, a neighborhood-based program intended to help adults, parents and community leaders develop the skills to communicate with young people and each other about contraception and sex, with the goal of reducing adolescent sexual risk-taking. The 4-year, \$5 million project was implemented in five urban neighborhoods: Mechanicsville in Atlanta, GA; Logan Heights in San Diego, CA; White Center in Seattle, WA; St. Thomas in New Orleans, LA; and Stowe Village in Hartford, CT. These areas were chosen because they contained many low-income households, had high rates of teenage pregnancy and expressed a willingness to do something about the problem.¹¹⁴ Most of the neighborhoods were predominantly Black or Hispanic. Each Plain Talk community was provided with resources and given one year to develop a program and three years to implement it. While the foundation posed few restrictions or guidelines, they did expect all Plain Talk programs to adhere to four principles: (1) Decision-making processes must involve community residents, (2) decisions about change should be based on community consensus, (3) communities should have access to the appropriate information and tools in order to help them make decisions, and (4) adults should come to terms with the fact that some teenagers engage in sexual activity. Most Plain Talk programs addressed “practical” concerns such as providing teenagers with access to reproductive health services and information about sex, and all of the communities made an overt attempt to change the norms and values surrounding issues of teenage sexuality and sexual activity.

At the onset of each program, Plain Talk representatives worked with community residents to develop, administer, and analyze a survey of local residents. The information from the survey was used to establish the Plain Talk agenda in each community. While each program adopted a different strategy, the

ultimate goal was educating adults about sexuality issues. In turn, adults trained in effective communication techniques and provided with appropriate information about sexuality served as mentors, counselors and instructors to community teenagers and other adults.

The Plain Talk agenda that emerged from each community was distinctly different from the others. For example, Plain Talk in Mechanicsville, Atlanta, hosted home health parties that included games and prizes. The parties were popular because they provided residents with information about sex in a fun, informal atmosphere. Mechanicsville Plain Talk also developed a teenage leadership program and the Dunbar Teen Center. The latter provided teenagers access to reproductive health services. The New Orleans and San Diego Plain Talk (Hablando Claro) programs emphasized males' roles in pregnancy and pregnancy prevention. The Circulo de Hombres (Circle of Men) evolved out of Plain Talk in Seattle. The organization provided young males in the community the opportunity to discuss issues of sex and relationships with their peers in a non-threatening environment. One of the key actors of Plain Talk in New Orleans established Black Men United for Change, an "anti-racist organization of African American males working for spiritual peace, Black unity and self-determination through a sense of identity."

The evaluation of this study found that Plain Talk increased neighborhood awareness about issues of teenage sexuality, improved adult/adolescent communication, increased teenagers' access to reproductive health services, expanded neighborhood outreach, and helped residents develop leadership and advocacy skills.¹¹⁵ "Lessons learned" include the following: (1) Changing community attitudes towards teenage sexuality and teenage pregnancy may only be possible in areas where strong community development is already in place; (2) while many public school personnel are sympathetic to the Plain Talk agenda, political pressures prevent them from collaborating with the program; (3) adolescents and adults need basic information about the biological aspects of sex (such as HIV/AIDS) as well as instruction on communication skills; and, (4) it is important for teenagers to have adults other than their parents with whom they can discuss sexuality issues. Similarly, even parents who were deeply involved with Plain Talk felt awkward talking to their own children about sex. The Annie E. Casey Foundation considers the Plain Talk program to be a success. However, they also found that getting communities to talk about teenage sexual activity is not an easy task.

Sex and the Internet

The latter part of the 20th century is frequently referred to as the "Information Age," and one of the most important tools for transmitting and generating this information is the Internet. The World Wide Web has many sites that provide teenagers (and adults) with frank, and sometimes explicit, information about sex and sexuality. Some sites, such as *sexetc.org* and *Drdrew.com*, are devoted almost exclusively to discussing issues of sexuality, sexual health, and relationships. Others, such as *gURL.com*, are more comprehensive, covering a variety of topics, one of which is sex and relationships. A number of web sites that provide sexual information also provide chat rooms and other forums for open and honest discussions about these issues. The Internet is particularly appealing for discussions of this nature because participants are "faceless."

Though there have been no quantitative studies of teenage sexuality web sites, two patterns are evident. First, many of the web sites are aimed at females. For example, when search engines such as Yahoo and Netscape categorize web sites, they typically have a "girls" or "girls only" section, but seldom have a comparable grouping for boys. Many web sites that contain straightforward information and chats about sexual issues are designed specifically for females (*gURL.com*, *smartgirl.com*). Another interesting pattern is that while there are a number of web sites devoted primarily to the topic of virginity and abstinence education, most of these appear to be geared towards adults rather than adolescents. However, most comprehensive teenage sexuality web sites geared toward youth do contain some information about abstinence and virginity.

The anonymity of the Internet also has its dark side. Some pedophiles use chat rooms to initiate online relationships with young boys and girls so that they can lure them into private meetings. No one knows the degree to which the Internet has facilitated these activities, but there have been several news stories reporting the interception of pedophiles engaging in or trying to initiate sexual contact with children they met over the Internet. In response, the FBI has increased the number of agents in the Crimes Against Children program and established an Internet Crimes Against Children Task Force. Among other things, these programs allow agents to pose as young children on the Internet in order to monitor and apprehend pedophiles.¹¹⁶

The most common sex sites on the web, and the ones that have received the most attention are commercial and/or pornographic sites that provide documents, pictures, and videos containing nudity

and images of people engaged in sexual activities. Unlike television and print media, which typically allow for some amount of parental control, web site content is, for the most part, unregulated and can be viewed by anyone with access to a computer. (A credit card is also necessary for access to most pornographic sites.) In response to parental concerns, around the mid-1990s technology firms introduced filtering software. Programs such as Net Nanny and SurfWatch allow parents to restrict access to certain websites from their home computers. In this way, they can deny their children access to websites containing sexually explicit information. There are programs that keep track of visited sites, allowing parents to review the information their children receive, and other programs that contain timing devices. In recent years, some schools, libraries, and other organizations with public access computers have installed filtering software in order to prevent children who use the facilities from viewing inappropriate material. This practice has proved controversial in some locations because filtering software denies adults unlimited access to the information on the Internet, and some individuals contend that filtering devices are an inherent form of censorship. Also, because many filtering programs rely on “keywords” to determine which sites are and are not accessible, they can deny viewers access to innocuous websites.

Some people feel that the problem of minors’ exposure to sex on the Internet is too large to be solved by filtering software alone. In October 1998, the U.S. federal government stepped in. Congress passed the Child Online Protection Act (COPA), making it a crime for for-profit web sites to display sexually graphic images without insuring that the viewers are at least 18 years of age. Under COPA violators stood to face up to 6 months in jail and \$50,000 in fines per violation. While COPA received strong support in Congress, a federal court judge ruled that the bill violated the free speech amendment and was, therefore, unconstitutional.¹ More recently, the Children’s Internet Protection Act (CIPA) requires schools and libraries to install filtering software. Any school that fails to comply with CIPA will be ineligible for federal funds. This law is being challenged on grounds that available filtering software is too imprecise and inappropriately identifies and restricts access to sites that are informative, and not pornographic.

The National Campaign to Prevent Teen Pregnancy

In his 1995 State of the Union address, President Clinton challenged Americans to become involved in the prevention of teenage pregnancy. In response, a number of prominent individuals and organizations from a number of fields—business, media, research, advocacy, and religion—formed the National Campaign the Prevent Teen Pregnancy. Campaign members recognize that teenage pregnancy is a serious problem whose elimination requires more than one solution. The Campaign is a non-partisan organization that includes advisors from both political parties and from conservative, moderate, and progressive organizations. The Campaign relies on funds from private foundations and does not receive any government funding. Unlike many other organizations concerned with teenage pregnancy, the Campaign does not advocate a specific strategy (e.g., abstinence-only or comprehensive sexuality education). Rather, they disseminate information that supports all positions and advocate that each organization adopt the strategy that is best suited for its goals and constituency.

The primary goal of the Campaign is to reduce the teenage pregnancy rate by one-third between 1996 and 2005.^m It seeks to do this by initiating grassroots activities and influencing cultural values. The Campaign does not initiate, develop, or fund programs specifically directed toward the goal of pregnancy prevention. Instead, information organization, coordination, and dissemination are the important services it provides; the Campaign compiles and organizes statistics, and produces pamphlets, fact sheets, videos, and information kits regarding adolescent sexual activity and teenage pregnancy. Information is tailored for a wide array of audiences including community leaders, parents, teenagers, teachers, policy makers, and religious leaders and their communities. The Campaign also provides forums for representatives from pregnancy prevention programs in different states (and even different countries) to meet and exchange information and ideas.

The Campaign is focused on four key areas and has formed a task force to address each area. These include the Task Force on Effective Programs and Research with the goal of identifying “what works” in community programming; the State and Local

¹ In the previous year the Supreme Court struck down a comparable bill—the Communications Decency Act (CDA)—for similar reasons.

^m Pregnancy prevention is seen as the most effective strategy for reducing teenage birthrates, and the issue of abortion is purposely not addressed.

Action Task Force, with the goal of assisting states and communities in implementing and evaluating programs; the Religion and Public Values Task Force, with the goal of helping religious organizations address the issue of teenage pregnancy and communicate with those who share different perspectives; and a Media Task Force, with the goal of encouraging the (entertainment) media to educate people about the issue of teenage pregnancy and encourage sexually responsible behavior. In early 1999, a fifth task force, the Youth Leadership Team, was formed. It is composed of 30 teenagers from around the country that provide the perspective of teenagers themselves on issues pertaining to teenage pregnancy.

Each task force initiates strategies corresponding to its area. The State and Local Action Task Force has visited over 400 communities to gather information on youth programs. They disseminate this information nationwide and provide technical assistance to help communities and organizations mobilize. The Media Task Force has formed successful partnerships with television broadcasters such as MTV, NBC, WB, and BET in order to help them develop programs and public service announcements encouraging responsible teenage sexual behavior. The Task Force on Religion and Public Values organized a series of Structured Community Dialogues in order to bring together community leaders with differing viewpoints so that they can find common ground. The campaign also conducts its own research and policy evaluations. For example, two recent pieces of original research sponsored by the Campaign examine the issue of peer influence on teenage sexual behavior. Based on the findings of both studies, the campaign developed recommendations for parents and organizations that work with adolescents.

Part III. Reproductive Health Services for Adolescents

Accessibility of Reproductive Health Care to Adolescents

Introduction

Youth in the United States obtain reproductive health care services from a mix of providers. These include health department, Planned Parenthood or other community health clinics that usually serve both adolescents and older women; some school-based, school-linked or youth-focused clinics serving mostly teenagers; and private office-based obstetrician/gynecologists, family practice physicians and pediatricians.

In general, there is government support for the provision of accessible reproductive health care to adolescents. Clinics that receive federal family planning funds (funded through the Title X family planning program) are required to provide confidential services to teenagers, usually free or at very low cost. These clinics base their fees on a sliding scale that depends on the client's income and teenagers are required to report only their own income (not their parent's or family's income) and, since this is usually negligible, almost all teenagers visiting these clinics qualify for free or subsidized care. However, government support of, as well as the provision of, confidential reproductive health services to adolescents is not without controversy. In fact, the provision of reproductive health care to adolescents has been one of the key factors underlying attempts to limit federal support for family planning. Over the years, the controversies surrounding federal financing of family planning care have resulted in large program cutbacks (during the early 1980s) and have limited funding increases during other periods. Thus, even with the recent increases in federal family planning funding beginning in 1992, the overall program remains funded at levels below 1980, after inflation is taken into account.¹¹⁷

At both the national and state levels, some policy-makers have attempted to require clinics to notify parents or obtain parental consent when providing certain reproductive health services to minors. At the federal level, attempts to link Title X funds to parental notification have been unsuccessful. In 1997, the U.S. House of Representatives narrowly rejected a parental involvement amendment that would have required clinics receiving Title X funds to notify a parent at least five days prior to providing contraceptive drugs or devices to minors.¹¹⁸ In 1998, a parental notification requirement was passed by the House of Representatives, but not by the Senate, and was therefore never enacted.¹¹⁹ However, state and local authorities have had some successes in implementing such restrictions. Texas and Utah have enacted statutes that prohibit the use of state funds to provide contraceptive services to minors without parental consent. In 2000, the South Carolina House of Representatives approved a state law that would "allow parents to block their children's access to contraceptives at health clinics." But the bill was dropped during committee consideration in the Senate.¹²⁰ Finally, only half of all states have specific laws or policies that protect an adolescent's right to obtain confidential services; in other states, services provided by non-Title X funded sites or private doctors may notify parents and the continuing public attention to this issue is likely to have an impact on adolescents' perception of the confidentiality of services.

Further controversy over the provision of reproductive services and information to teenagers has occurred within communities that have attempted to make condoms available in high schools,¹²¹ and is evident in the public debate that surrounds the teaching of comprehensive sexuality education versus abstinence-only education,¹²² the decline in teaching on birth control in public schools over the past

decade and the lack of broad support for school-based or school-linked clinics and the limits on the services such clinics are allowed to provide.¹²³

Important barriers to youth accessing reproductive and sexual health care services include the uneven nature of service provision throughout all regions of the country, the high cost of medical care in areas where publicly-funded clinics are not available, the fact that confidential care is not guaranteed by all providers (or by all systems of health insurance reimbursement), and the absence of wide-spread, organized efforts to inform youth where they can go to obtain low-cost, confidential care. Moreover, these barriers are often exacerbated among disadvantaged youth—non-English speaking groups, immigrant populations and those who have dropped out of school or become disenfranchised for a variety of familial, personal or socioeconomic reasons that may put them at great risk for poor sexual or reproductive health outcomes.

Financing Health Care Services for Youth

Health care services in the United States are financed through a mixed system of public and private health insurance, public funding of specific community providers for both general care and certain specialized services, and out-of-pocket payment for services by those individuals who either have no insurance, have insurance that does not cover all services or do not wish to use the provider required by the insurance plan and who cannot obtain other publicly-supported care. Care for adolescents is basically financed by all of these same mechanisms. The majority of American young people have private health insurance coverage (usually through their parents). In 1995, 87% of all young women aged 15–19 reported either private or public health insurance coverage—72% had private insurance (65% through their parents) and nearly one in five (19%) reported public health insurance (Medicaid); four percent reported both private and public insurance. Thirteen percent did not have any health insurance coverage at all.¹²⁴ In addition to Medicaid, which provides public health insurance to poor families meeting certain income requirements set by states, in 1997 the U.S. Congress enacted the State Children’s Health Insurance Program (CHIP or SCHIP), designed to provide health insurance coverage to many of the nation’s uninsured children. The program is targeted to children up to age 19 who live in families with incomes below 200% of the federal poverty level (a level that is much higher than that set for many states’ Medicaid programs). Although enrollment in the program was initially much slower than expected,¹²⁵ a recent analysis has

shown that most states have instituted plans that cover a range of reproductive health care services and contraceptive drugs and devices for adolescent enrollees.¹²⁶

Although the majority of youth do have access to private health insurance, many cannot or do not use this coverage for sexual or reproductive health care services. Some private health insurance plans do not cover routine gynecological care or contraceptive services, and among those that do, some do not always provide mechanisms through which a dependent child can obtain care without their parent’s knowledge.¹²⁷ Therefore, young people often must figure out for themselves where to go and how to pay for confidential sexual or reproductive health care. When asked how their most recent visit for contraceptive or other reproductive health services was paid for, more than half of women aged 15–19 in 1995 reported that all or some of their visit was paid for by either private insurance (41%) or public insurance, i.e. Medicaid (18%). One in five (20%) reported that they went to a clinic that either fully or partially subsidized their care and a similar proportion (21%) reported paying the full cost of the visit themselves.¹²⁸

Availability and Sources of Contraceptive Services for Youth

Among the 4.2 million adolescent women (aged 15–19) who reported making a visit for contraceptive or other reproductive health services in 1994, slightly less than half went to clinics (44%) and a little more than half (56%) went to private doctors or health maintenance organizations (HMOs). Most teenagers obtaining any of these services received a combination of contraceptive care and preventive gynecological services (a pap test and/or pelvic exam) with two-thirds (65%) reporting any contraceptive service and three-quarters (78%) reporting some preventive care (Table 8). Significantly, however, more than half of teenagers who made any visit (57%), reported also receiving some kind of STD-related care (STD or HIV testing or treatment or testing/treatment for other gynecological infections) and over one third (38%) reported some kind of pregnancy-related service, primarily a pregnancy test.

- *Family planning clinics.* There are over 7,000 clinics nationwide providing publicly funded family planning services.¹²⁹ These clinics have been set up to provide needed care to individuals who are not able to access care from private sources—typically poor women and teenagers. Among adolescent women obtaining any services, those going to clinics are more likely to be poor and from a minority group

than are teenagers obtaining care from private physicians: Twenty-four percent versus 13% are under 100% of poverty; 25% versus 15% are black and 18% versus 12% are Hispanic (Table 8). In 1997, an estimated 6.6 million women of all ages obtained family planning care from publicly funded family planning clinics; just over one quarter of these were under age 20.¹³⁰ Thus, clinics provide family planning care to more than four out of ten sexually active adolescent women.

Table 8. Percentage of U.S. women aged 15-19 who received contraceptive or other reproductive health services in the prior year and the distribution of adolescent women by poverty status and race/ethnicity all according to the source of care, NSFG 1995.

Service type and characteristic	All Teens	Teens obtaining any reproductive health service by source of care		
		Total	Clinic/other	MD/HMO
Number (in 1,000)	8,923	4,238	1,877	2,360
	100.0	100.0	100.0	100.0
Services received in prior year*				
Any contraceptive service	31.5	65.2	75.4	57.2
Preventive gynecologic service	37.0	77.8	72.3	82.2
Pregnancy related service	17.9	37.7	39.5	36.4
STD related service	27.1	57.1	58.0	56.5
Poverty status				
0-99%	15.6	18.1	24.1	13.4
100-249%	33.8	33.8	34.3	33.5
250+%	50.6	48.1	41.6	53.2
Race/ethnicity				
Non-Hispanic white	66.4	64.4	55.5	71.5
Non-Hispanic black	15.6	19.6	24.9	15.4
Hispanic	12.8	14.5	18.0	11.7
Other	5.2	1.5	1.7	1.4

* Percentages for each type of service do not add to 100 since women may have received multiple types of services.

Source: AGI, 2001, unpublished tabulations of the 1995 National Survey of Family Growth (NSFG).

Clinics providing family planning services are administered by over 3,000 different agencies—representing a variety of agency types: state or local health departments (40%), hospitals (11%), community or migrant health centers (21%), other agencies (16%) and Planned Parenthood Affiliates (13%). Sixty percent of these sites obtain federal funds through the Title X family planning program and are therefore bound by certain guidelines required by this program, including the guarantee of confidential access to reproductive and contraceptive services by adolescents. In one state, Utah, federal Title X funds were withdrawn from the principal grantee—the state health department—when state law conflicted with their ability to abide by this guideline. Instead, the federal funds were allocated to the Planned Parenthood Affiliate in the state to administer Title X funds to non-health department clinic sites. Although the Title X program provides some unification and common guidelines for a wide variety of different

clinics, it is not the principal source of funding for family planning clinics in the United States. Among those sites that obtain any Title X funding, this source accounts for only about one-quarter of total revenues. Other federal grants such as the Maternal and Child Health (MCH) block grant and the Social Services Block grant account for about 12% of revenues, Medicaid for about 14% and state and local grants for about 33%. Only about 16% of clinics' revenues come from patient fees or charges or private insurance reimbursement.¹³¹

Clinics vary widely in the extent to which family planning or contraceptive services are emphasized relative to other medical care. Many are dedicated family planning clinics, serving mostly contraceptive clients and offering a wide range of contraceptive methods. Others provide a range of primary care services, including family planning services.

Some family planning clinics are designed to serve only teenagers and most have specialized services for teenagers. In 1995, three in 10 family planning agencies reported having special clinic times or sites devoted specifically to teenagers.¹³² Moreover, a survey conducted in 1999 among a nationally representative sample of publicly funded family planning agencies, found that nearly 9 in 10 agencies (87%) reported having one or more educational or outreach service targeting teenagers at one or more sites.¹³³ Interestingly, the most common special teenage program reported by family planning agencies was provision of education emphasizing abstinence or postponement of sexual activity (reported by 68% of all agencies).¹³⁴ In addition, over half of all agencies reported programs to teach teenagers communication and negotiation skills (57%) or to provide outreach or education at schools or youth centers in the community (57%), and nearly half of all agencies reported programs to teach parenting skills to pregnant/parenting teenagers (49%) or to encourage teenagers to delay the next birth (46%). Finally, agencies reported programs designed to help parents communicate with their adolescent children (42%) or to provide education and training for the staff at other community

organizations (42%).

- *School-based sites.* In addition to these community-based clinics, there are at least 800 school-based clinics that provide medical services to secondary school students (grades 7–12).¹³⁵ Most of these clinics are operated by some of the same organizations that administer family planning clinics—health departments, community and migrant health centers, hospitals and other organizations. However, not all provide even preventive reproductive health services and most are prohibited from dispensing contraceptives. Fewer than two-thirds of school-based clinics in secondary schools report providing gynecological exams (62%) or birth control counseling (62%) and only 1 in 4 provide prescriptions for oral contraceptives (29%) or dispense condoms (24%). Even fewer—15%—actually dispense oral contraceptives on-site. Prohibitions against dispensing of contraceptives on-site were reported for three-quarters of all school-based clinics. In most cases the prohibition came from the school district (80%); but 21% of school-based clinics are restricted from dispensing contraceptives by state law and 21% by the agency administering the clinic (some sites were restricted by multiple sources). To compensate for their inability to provide more complete reproductive health care, slightly more than half (56%) of school-based clinics report having a referral agreement with family planning clinics in their community. Based on an average annual number of users per site of 600, an estimated number of sites of 825 and fewer than 8% of all visits estimated to be for “other” services, which includes all reproductive health care services, it is likely that fewer than 40,000 adolescents obtain reproductive care directly from school-based clinics—accounting for no more than 1.5% of all young women who obtain such care per year

- *Private physicians.* Although adolescent women are more likely than older women to seek family planning services from clinics rather than private physicians, it is still true that about half of all reproductive health care services obtained by adolescents are provided in the private sector. Little is known about the care provided to adolescents in such settings. However, existing national guidelines from both professional medical associations and governmental health agencies strongly emphasize that comprehensive reproductive health services for teenagers be an integral component of preventive health services for this population. These guidelines are very consistent in recommending that primary care physicians and others treating adolescents include medical care, education and counseling related to sexual and reproductive health, as part of

their routine preventive services. To assist physicians in caring for adolescents, in 1992 the American Medical Association (AMA) developed the “Guidelines for Adolescent Preventive Services (GAPS),” a comprehensive set of recommendations for the organization and content of adolescent preventive health services.¹³⁶ In particular, it provides guidance for regular screening of adolescents with regard to sexual and contraceptive behavior, as well as risk factors associated with unintended pregnancy and STDs. The American College of Obstetricians and Gynecologists (ACOG) has, more recently, developed similar guidelines called “Primary and preventive health care for female adolescents,” which were released in November 1999.¹³⁷ Finally, the U.S. Department of Health and Human Services released the second edition of their guidelines in 2000, “Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.”¹³⁸

However, the promotion of standards and guidelines by professional and government organizations does not always translate into practice within private health care settings. Several recent studies generally suggest physicians have a long way to go to fully comply with these recommendations.¹³⁹ In one national study, only half of all office visits made by adolescents included counseling or education of any kind,¹⁴⁰ and in only 3% of visits was counseling on STDs or HIV provided. In another study, one or more health-habit counseling services was provided in only 38% of adolescent physician visits.¹⁴¹ A study focusing on managed care settings suggests that screening and education of adolescents was somewhat better among this group of physicians, but still below recommended levels.¹⁴²

Finally, although many teenagers do obtain reproductive health care services from private physicians, those who seek care in these settings face both real and perceived barriers related to confidentiality and many are not provided with screening or education beyond the primary purpose for which they sought care.

STD Services for Youth

Adolescents in the United States obtain services related to sexually transmitted infections from most of the same sources that they use to obtain contraceptive care—family planning, community and youth-based clinics and private physicians. In addition, a number of public health department clinics are available that focus primarily on the provision of STD services.¹⁴³

Abortion Services for Youth

Adolescents in the United States seeking to end an

unintended pregnancy or who must terminate their pregnancies for other medical or non-medical reasons face a number of barriers in obtaining abortion services. First, they face the same difficulties related to access as do women of all ages. Abortion services are available from some 2,000 clinics, hospitals, or private physicians.¹⁴⁴ However, most abortions in the United States (70%) are performed by fewer than 500 specialized free-standing facilities, concentrated in large, metropolitan areas. Abortion providers are available in only 16% of all U.S. counties (out of 3,139 counties nationwide) and only 8% of counties have an abortion provider that performs at least 400 abortions annually. Moreover, even in many of America's cities, women do not have easy access to abortion services—one third of the country's 320 metropolitan areas either have no known abortion provider or have one or more providers that together perform a total of fewer than 50 abortions annually. Thus, many women in the United States, old and young alike, must travel some distance to obtain an abortion. According to providers' estimates, nearly one in four women nationwide (24%) obtaining an abortion traveled 50 miles or more to obtain care (in some states and areas of the country these distances and the percentages of women affected are much greater).¹⁴⁵ For adolescents, finding a distant provider and making travel or hotel arrangements can be especially daunting.

Adolescents also face barriers related to the confidentiality of obtaining abortion services. Some have unwarranted fears that a provider will notify their parents about the abortion. Others live in states that require parental notification or consent before an abortion will be provided to a minor (under age 18 in most states). As discussed in Part II, in 2001, seventeen states required consent of one or both parents before a minor may obtain an abortion and an additional 14 states required parental notification in similar cases.¹⁴⁶ Most of these laws do provide young women with the option of confidentially bypassing this requirement, usually by obtaining authorization for the abortion from a judge in cases where the minor is determined to be capable of giving informed consent or if parental notification would lead to abuse of the minor. However, navigating the legal system in order to obtain a bypass presents a significant barrier to youth and often results in delays in obtaining services. Minors, as well as older women seeking abortion in 16 states, face statutes that require women to wait, typically 24 hours, after receiving state-directed counseling before the procedure is performed.

Minors in the United States also face barriers to abortion services related to the cost of obtaining care.

Federal funding for abortion under Medicaid is banned except in cases of rape or incest or where the mother's life is endangered. In 2001, only 19 states had opted to provide funding for medically necessary abortion services to women on Medicaid using state funds.¹⁴⁷ Thus, most abortion providers require women to cover the full cost of the procedure themselves, either through private insurance or cash payment. Minors attempting to obtain a confidential abortion may not be able to access their insurance without parental knowledge and they, as well as others without insurance, must find other means to obtain the necessary funds. Abortion clinics generally charge less than nonspecialized clinics or MDs' offices, but the typical fees charged for a non-hospital abortion at 10 weeks gestation are close to \$300, and range from \$140 (at some abortion clinics) to \$1,700 (charged by some private physicians).¹⁴⁸

In addition, teenagers may be deterred from seeking or obtaining abortion services because of anti-abortion sentiment that they perceive in their community or among family members or peers. They may be especially wary of seeking services in cases of known or suspected harassment of providers by anti-abortion groups. Adolescents, because of their fear of confidentiality breaches or lack of maturity, may be reluctant to seek services where they may have to face a group of intimidating protesters in order to enter a clinic.

In sum, although the U.S. adolescent abortion rate has declined significantly since 1990, adolescents in the United States have a higher abortion rate than most developed countries and they face a number of barriers in obtaining abortion services. The numbers of abortion providers have declined,¹⁴⁹ the numbers of adolescents affected by parental consent or notification laws have risen,¹⁵⁰ and incidents of abortion provider harassment and picketing rose during the late 1980s and early 1990s¹⁵¹ and continue to be a real barrier in some areas.

Contraceptive Method Use and the Availability of Contraceptive Supplies to Youth

Methods Used

Among the 2.8 million adolescent women using contraceptive methods, based on the 1995 NSFG, most reported using either oral contraceptives (44%) or male condoms (37%) as their primary method. However, a significant, and growing minority reported use of the hormonal injectable (Depo Provera) (10%). Fewer reported use of withdrawal (4%), contraceptive implants (3%), periodic abstinence (3%) or other methods (1%). Among younger teenagers (aged 15–17), the injectable is even more

popular—with 15% using this method, 39% using pills and 38% using condoms. Comparatively, among 18–19-year-old women, only 7% reported use of the injectable, 47% were using pills and 36% condoms.¹⁵² In the United States, the hormonal injectable was approved by the Food and Drug Administration (FDA) for contraceptive use in 1992. The pharmaceutical company's advertisements have promoted this as a new method, emphasizing its benefits over pill use regarding ease of continuation and confidentiality (e.g., no need to remember to take a pill every day, no pill pack lying around for others to find, etc.). Since such benefits are particularly appealing to adolescents, its use among teenagers has grown steadily in the United States. In particular, in the United States, use of the injectable has been high among teenagers who have already had a baby or an unintended pregnancy.¹⁵³

Contraceptive Choice

In the United States, one of the key tenets of contraceptive method provision has been offering each woman a range of method choices, informing her of the risks and benefits of each method and counseling her to choose the method right for her. Although there has been some debate about the possible advantages (and disadvantages) of more directed contraceptive counseling that, for example, might recommend or present only one specific method to the adolescent¹⁵⁴ and some talk among providers indicating that many clients already know what method they want and are not interested in lengthy counseling about other methods, this tenet remains a key component of contraceptive method provision, particularly in Title X clinics that are required to offer or refer women for all available contraceptive methods.

Contraceptive Failure

Overall, about 13% of all women using reversible contraceptive methods will become pregnant during the first year of method use.¹⁵⁵ This varies widely depending on the method actually used, with about 2–4% of women using long-acting methods (IUD, injectable, implant) becoming pregnant during the first year of use, compared with 8% of pill users, 14% of condom users and 23–28% of those depending on periodic abstinence, withdrawal or spermicides. Among sexually active teenagers using no contraceptive method, an estimated 90% become pregnant in a year.¹⁵⁶ A recent analysis of contraceptive failure rates among women in the United States found that contrary to some expectations, younger teenagers (<18) did not experience higher rates of contraceptive failure than did older teenagers (18–19)

and both groups did not differ significantly in their rates of contraceptive failure from women aged 20–24.¹⁵⁷ Only among women aged 25 and older were contraceptive failure rates lower than those of teenagers and of women in their early 20s.

Cost of Methods

Among the 2.4 million teenagers who visit private physicians for contraceptive or other reproductive health services, it is likely that many will have to pay the full cost of contraceptive method supplies themselves. Some may have private health insurance that covers contraceptive supplies and they would be required to pay only a co-payment when filling a prescription from a pharmacy (these co-payments typically vary between \$5 and \$25 per prescription). Typical wholesale costs for common prescription methods are approximately \$30/cycle for oral contraceptives, \$20 each for diaphragm and cervical caps, \$45/injection for the injectable; \$450/system for implants and \$240 each for IUDs.¹⁵⁸ The actual fee that is charged to clients obtaining supplies from a pharmacy or at a private physician's office is likely to be more. And, unless they have Medicaid coverage or private insurance, adolescents will be required to pay for the cost of the visit as well.

Among nearly 2 million U.S. teenagers who reported obtaining contraceptive or other reproductive health care from clinics, most are likely to receive some of their methods free or for a reduced fee.¹⁵⁹ Nearly nine in 10 agencies providing contraceptive services indicate that condoms are provided free of charge at their clinic sites.¹⁶⁰ However, adolescent clinic clients who use the condom are unlikely to obtain all their supplies free. Most likely they will obtain an initial supply free and will later have to purchase additional supplies. Condoms can be purchased from pharmacies, drug stores, grocery stores and in vending machines for about 50 cents each. Some teenagers (most likely, a small fraction) have access to free condoms distributed at clinics, schools and youth centers.

Adolescent clinic clients who chose other prescription methods including oral contraceptives, the injectable, implants or IUDs are likely to obtain their method free or for a reduced fee based on a sliding scale. Those that pay are usually charged about \$10 for a 3-month supply of oral contraceptives.¹⁶¹ In addition, most teenagers that visit Title X funded clinics qualify for free services. Those that do not qualify for free services would typically be charged between \$20 and \$60 depending on their income for an initial family planning visit, in addition to the supply fee.¹⁶²

Messages that Encourage Responsible Contraceptive and Disease Preventive Behavior

In the United States, outreach related to adolescent sexual behavior, similar to other aspects of this issue, varies widely from place to place and is usually driven by local concerns and local constraints. Publicity related to service availability, public education campaigns, links between schools and service providers, and other outreach activities designed to encourage young women and men to act responsibly all exist in the United States, but vary in their intensity and in their ability to actually influence youth. There has never been a coordinated national effort to publicize the availability of contraceptive or reproductive health care services for adolescents (or for the adult population in general). Adolescents, therefore, are usually left to seek out these services for themselves, and must rely upon the widely variable services available in their communities. In some communities, providers targeting young people may be quite vigorous in their outreach efforts—visiting schools and youth centers and using a variety of media activities to inform youth in the community of the services available. In other communities, providers are less active in their outreach, either because they do not have the resources for these activities, because they do not have community support for outreach efforts in schools or other public places frequented by youth or because they are already at capacity.

Public education campaigns designed to encourage responsible adolescent sexual behavior have been used periodically in the United States, but primarily at the local level. For example, city or state health departments or providers such as Planned Parenthood Affiliates have designed and implemented such campaigns, including public service announcements on television and radio, ads in magazines and newspapers, and billboards on buses or subways. Other public education campaigns in the United States have focused on abstinence as the only choice for responsible adolescents. Because federal funding is available for programs and education that promote abstinence through the Adolescent Family Life Act (AFLA) and through TANF block grants to states (Title V), many states and local communities have initiated abstinence-oriented education campaigns (see Part II). These messages often conflict with the message promoting responsible sexual behavior through use of contraceptives and often suggest that messages encouraging contraceptive use are, in fact, promoting irresponsible behavior.

School-based sexuality education is a key means through which teenagers hear messages regarding

appropriate sexual and reproductive behavior and, more and more, the message that is conveyed at U.S. schools is one of abstinence-only. Most of the states reporting about their activities using federal Title V abstinence education funds indicated that some funds were being used for in-school instruction or presentations (38 out of 45 respondents).¹⁶³ And, surveys of sexuality education teachers in public schools reveal that in 1999 fewer teachers were providing information about specific contraceptive methods and where students can go to obtain methods compared with the percentages of teachers who did so in 1988 (see discussion of sexuality education in Part II).¹⁶⁴

The National Campaign to Prevent Teen Pregnancy (also described in Part II) has implemented a public education campaign that focuses on teenage pregnancy prevention. In designing this campaign, they brought together a variety of individuals, including adolescents, to help craft the messages to be used. However, in contrast to messages commonly used in Europe that present positive images of adolescents as a way to encourage responsible behavior, a series of posters developed by the campaign present teenagers in a very negative manner and focus on the negative consequences of sex. In this campaign, unflattering pictures of teenagers who have had unprotected sex or have become pregnant are shown with a single negative word in bold red ink as a caption for their situation—“CHEAP,” “DIRTY,” “NOBODY,” “REJECT,” “USELESS,” and “PRICK;” further information and a supportive message is included in very small print.

Interventions

In the United States, a variety of interventions have been implemented that attempt to reduce the level of unplanned adolescent pregnancy and childbearing. In the previous chapter, we looked at interventions that illustrated societal views about adolescent sexuality. Here we review some of the interventions that illustrate attempts to improve adolescent use of contraceptives and services related to contraceptive and reproductive health services. A recent review of research findings on programs to reduce adolescent pregnancy provides additional information about these interventions and others.¹⁶⁵

Programs to Provide Reproductive Health Care or to Improve Access to Condoms or other Contraceptives

- *School-based or school-linked health clinics.* Although at least 800 school-based or school-linked clinics are located in middle and high schools (grades 7–12) across the United States, most of these do not

provide comprehensive reproductive health care services or dispense contraceptives. Six scientifically rigorous evaluations have been conducted among some of those sites that at least provide comprehensive reproductive health services—with or without actually dispensing contraceptives—to assess the impact of school-based or school-linked clinics on adolescent sexual and reproductive behavior. A summary of the findings of these evaluations concludes that although it is clear that the school programs did not increase sexual behavior among teenagers in the schools with clinics, the impacts on contraceptive use and pregnancy or birthrates were mixed.¹⁶⁶ Several of the studies found that contraceptive use was not different between the schools with clinics and comparison schools without clinics. In one study, use of oral contraceptives was higher in the study school, but use of condoms was not; and, in another study, use of contraceptives was actually higher in the comparison school than in the study school. Findings related to birth or pregnancy rates in the communities where school-based clinics were located were also mixed. It is not clear whether or not some of these results were due to methodological problems with the studies or whether teenagers' use of school clinics simply substituted for their use of other community facilities to obtain contraceptive services and supplies and therefore did not lead to overall behavioral change. There was some evidence that the clinics that had a strong educational component, emphasizing both abstinence and use of oral contraceptives, did have a positive impact on contraceptive use.¹⁶⁷

Initiatives with Multiple Components

In the United States, it has long been recognized that it may take multiple, complementary efforts to change the behavior of youth. Several multi-component interventions have been implemented across the country. Many of these are community wide, while others focus on providing a specific group of youth with multiple types of services and resource. One of these, the Plain Talk program, was described in Part II. Several others, that have been rigorously evaluated, are described in the recent review by Doug Kirby.¹⁶⁸

- *A multi-component, community-wide intervention.* One of the most intensive of these was a program in a small, rural community in South Carolina. This program provided community leaders with education and training in sexuality education, integrated sexuality education into all grades at school, trained peer counselors, encouraged local media and organizations to highlight the pregnancy prevention message, and, most importantly, provided a link between the

school nurse and the local family planning clinic.¹⁶⁹ Evaluations of the program found that initially, for the first several years of the program, the pregnancy rates for 14–17-year-olds in the community significantly declined. However, in subsequent years, after some of the components were stopped, the pregnancy rates returned to their pre-program levels. In particular, the school nurse resigned, condom distribution stopped, referrals to family planning clinics declined and community involvement waned.¹⁷⁰ These findings suggest that in order for community-wide programs to have a sustained impact, the commitment to continue the program and its intensity must be maintained.

- *A multi-component program with both sexuality and youth development components.* One of the most successful evaluated programs addresses both sexual and non-sexual antecedents to adolescent pregnancy. The Children's Aid Society-Carrera Program is a long-term, intensive program that recruits youth when they are 13–15 years old. Youth participate in special events, education programs and entrepreneurial activities. The program uses a holistic approach that includes (1) family life and sex education; (2) an educational component, including tutoring and college assistance; (3) work-related activities; (4) self-expression through the arts; and (5) individual sports. The program has been rigorously evaluated, using multiple sites, random assignment, a large sample size and follow-up over 3 years. The evaluation revealed that the program had a significant positive impact, especially on the girls in the program: after three years, the program significantly delayed the onset of sexual intercourse among girls, increased their use of condoms as a dual method along with other methods, reduced pregnancy rates and reduced birthrates.¹⁷¹

Although these findings are quite striking, it is still not entirely clear what aspects of the program contributed to its success over other multi-component programs that have not resulted in similar positive impacts. Undoubtedly, part of its success is likely due to the fact that it is an extremely intensive program, requiring a significant commitment of time and money to implement. During the school year, the program operates every day, with additional activities scheduled over the summer. Program staff develop a strong bond with participants and these bonds may be important to the ultimate results. Since this program has been implemented in areas that were relatively disadvantaged and had high levels of teenage pregnancy and childbearing, it offers encouragement that youth in disadvantaged circumstances can be positively impacted by such a program; and that the pattern of teenage childbearing can be broken, if

adults are willing to provide the time and resources necessary so that youth obtain the education, information, services and support that they need during adolescence and as they become adults.

Part IV. Public Policy and Programs for Disadvantaged Groups

Introduction

In the United States, social and economic disadvantage is strongly associated with teenage childbearing. However, the relationship is not a straightforward one. On the one hand, there is evidence that early childbearing leads to economic disadvantage. Research has found that unmarried adolescents who give birth are more likely to spend at least several years in poverty, to collect welfare and to have lower wages than their counterparts who postpone or forego childbearing.¹⁷² They are also less likely to complete high school (or college) or to get married. These potentially negative outcomes are one reason why out-of-wedlock births to teenagers are considered a social problem.

But the relationship also works in the other direction. Women who grow up in disadvantaged environments are more likely to become pregnant and to give birth during adolescence. Although only 38% of all young women aged 15–19 are poor or low-income, among all adolescents who become pregnant, 73% are poor or low-income; and, of those giving birth outside of marriage, 85% come from poor or low-income families.¹⁷³ One explanation for these patterns is that young women with limited employment and educational prospects have little to lose by having children at a young age. Alternately, some argue that these young women grow up in an environment where early, single parenthood is the norm, making teenage childbearing acceptable. Finally, researchers have found that some poor, minority women who give birth during their adolescent years actually have better birth outcomes, and potentially better employment outcomes, than women who give birth at age 20 or later.¹⁷⁴ These women often have extended family and kinship networks of people who help them raise their children, and it has been argued that this resource is most practical when used during the adolescent years because women often are expected to care for elderly kin in later adulthood. In this context, social and economic disadvantage can make

adolescent childbearing a rational choice for some young, poor, minority women.

The relationship between disadvantage and adolescent childbearing is clearly complicated, and is better understood when placed within the larger context of inequality in the United States. This chapter begins with a brief overview of the ways that economic, social and cultural disadvantage can be measured. We then discuss some of the social welfare programs designed to address these problems, and conclude with a summary of specific interventions designed to assist disadvantaged youth.

Prevalence and Distribution of Economically, Socially, or Culturally Disadvantaged Groups

The United States is a diverse society and, as such, inequality and disadvantage manifest themselves in a variety of ways. Some characteristics associated with disadvantage include gender, race and ethnicity, immigrant status, economic well-being, employment status and being a single parent. It is also worth noting that many individuals, for example, poor women of color confront inequality in a variety of forms since they occupy several (potentially) disadvantaged positions.

Race and Ethnicity

Non-Hispanic whites comprise the majority of the U.S. population, but this proportion has been decreasing steadily over the last few decades: from 80% in 1980 to 76% in 1990 and 70% in 2000.^{n,175} Blacks comprise the largest racial minority, making up 13% of the U.S. population in 2000 (Table 9). However, other minority race and ethnic groups have increased significantly over the last two decades. Asians and others (including American Indian, Alaskan Native, Native Hawaiian or other Pacific Islander) have

ⁿ The proportion of non-Hispanic whites is expected to decline even more in the next 50 years, making up only 53% of the population in 2050.

tripled from 2% in 1980 to 6% in 2000; while Hispanics have grown from 6% in 1980 to 12% in 2000. The rise in U.S. Hispanics is due both to higher birthrates among Hispanics (compared with non-Hispanic whites) and to an influx of immigrants from Central and South America and the Caribbean.

Table 9. Percentage distribution of the U.S. population by race and ethnicity, 1980, 1990 and 2000

Year	Total		Non-Hispanic			Hispanic
	In 1,000	%	White	Black	Asian/other*	
1980	226,546	100.0	79.9	11.5	2.2	6.4
1990	248,791	100.0	75.7	11.8	3.5	9.0
2000**	281,422	101.3	70.4	12.6	6.2	12.1

*Other races include American Indian/Alaskan Native, Native Hawaiian and Other Pacific Islander

** In 2000, multiple race categories could be indicated. Therefore, these percentages represent the maximum proportion possible, including all residents reporting each race.

Source: For 1980 and 1990: U.S. Bureau of the Census, *Statistical Abstract of the United States, 2001*, Table no. 15, page 17. For 2000, U.S. Bureau of the Census, *Census 2000*, obtained from www.census.gov; internet release date: April 2, 2001.

Immigrants and Citizens

Even though America is a “country of immigrants,” the overwhelming majority of residents are native-born (Table 10). The proportion of immigrants has increased in the last 20 years, from 6% in 1980 to 11% in 2000. The proportion of U.S. residents who are not citizens, in particular, has increased—from 3% in 1980 to 7% in 2000. Distinguishing between immigrants who are naturalized citizens and those who are not is important for several reasons. First, naturalization confers social welfare benefits, voting privileges and the removal of employment restrictions. More informally, naturalization also represents some degree of assimilation into U.S. society. Though not shown in Table 10, Hispanics comprise the majority of both immigrants (54%) and non-citizens (63%), although the majority (63%) of Hispanics has been born in the United States.

Table 10. Percentage distribution of the U.S. population by immigrant and citizenship status, 1980, 1990 and 2000

Year	Total		Foreign Born		
	In 1,000	%	Native born citizen	Naturalized citizen	Not a citizen
1980	226,546	100.0	93.8	3.1	3.1
1990	248,710	100.0	92.1	3.2	4.7
2000	273,643	100.1	88.9	4.5	6.7

Source: U.S. Bureau of the Census, Current Population Survey, March 2000, Ethnic and Hispanic Statistics Branch, Population Division, internet release date: January 3, 2001; and tables for 1980 and 1990 found at <http://census.gov/population/www/documentation/twps0029/tab01.html> and <http://www.census.gov/population/www/documentation/twps0029/tab11.html>

Economic Well-Being

Perhaps the most straightforward indicator of disadvantage in the United States is economic well-being. The most widely used measure of economic disadvantage in the United States is the poverty line.^o In 1997, 11% of U.S. adults aged 20-49 were considered poor because their income was under 100% of the poverty line (Table 11, see page 42)^p and an additional 8% were “borderline poor” because their income was between 100–150% of the poverty level.

The incidence of poverty and borderline poverty varies according to a number of characteristics. White adults are less likely to be poor than are those from other race or ethnic groups. Only one in ten white adults are poor compared with one in five black or Hispanic adults.

While immigrants have a harder time achieving economic success than non-immigrants, the more important distinction may be citizenship status. The proportion poor among adults born outside the United States is not much higher than that for their native-born counterparts if they are naturalized citizens. However, non-citizens are twice as likely to be poor as are citizens, and more than one-half of non-citizens have incomes below 200% of the poverty level.

Married couples have a distinct economic advantage: only 6% are poor, and the majority (79%) has incomes above 200% of the poverty level. On the other hand, approximately one in five unmarried adults are poor (21% of those who are widowed, 20% of those who are divorced or separated and 17% of those who have never married). Moreover, regardless of whether or not married couples have children, low proportions are poor. Single women with children are the most likely to live in poverty (37%) and over one-half of single mothers are poor or border-line poor. Single women without children and single men are less likely to be poor than those with children, but are still more likely to be poor than those who are married.

Although we cannot examine single fathers separately due to small sample size, it is worth noting that in the last three decades, there has been an

^o This standard was originally developed by the Social Security Administration in 1963. Analysts who devised the poverty standard determined that the average family spent one-third of its income on food. Using this logic, they calculated the amount of income needed to purchase the least expensive, nutritionally adequate diet, making adjustments for family size. This amount was multiplied by three. The poverty line is adjusted for inflation each year, but the criteria upon which it is based have not been revised since its implementation. Many consider the original criteria outdated and advocate for a new poverty measure.

^p The measure of poverty does not include federal or state income assistance funds received by families or individuals.

Table 11. Percentage distribution of U.S. adults aged 20-49 by federal poverty status and according to race, ethnicity, citizenship status, marital status and family status, 1997

Characteristic	Total		Poverty status			
	In 1,000	%	<100%	100-149%	150-199%	200%+
TOTAL	119,306	100.0	11.2	8.1	8.7	72.0
Race						
White	97,782	100.0	9.6	7.5	8.3	74.6
Black	15,399	100.0	20.6	12.0	11.5	55.9
American Indian	1,064	99.9	21.4	12.9	10.7	54.9
Asian	5,062	99.9	11.3	5.8	7.6	75.2
Ethnicity						
Non-Hispanic	150,104	99.9	9.8	7.0	7.9	75.2
Hispanic	14,202	99.9	21.5	15.8	14.3	48.3
Citizenship Status						
Native born citizen	103,457	100.0	10.0	7.3	8.2	74.5
Foreign born						
Naturalized citizen	5,027	100.0	11.2	8.2	9.9	70.7
Not a citizen	10,822	100.0	22.6	15.4	13.2	48.8
Marital Status						
Married	67,242	99.9	6.0	6.6	7.9	79.4
Widowed	898	100.0	20.7	14.8	12.6	51.9
Divorced/separated	15,457	100.0	20.2	10.6	9.8	59.4
Never married	35,710	100.1	16.8	9.6	9.5	64.2
Family Status						
Married adult	67,242	99.9	6.0	6.6	7.9	79.4
w/ children	47,573	100.0	7.1	7.8	9.2	75.9
w/out children	19,669	100.0	3.5	3.8	4.9	87.8
Unmarried female	25,076	100.1	24.2	11.4	9.8	54.7
w/ children	10,076	99.9	36.6	14.4	11.1	37.9
w/out children	15,000	99.9	15.8	9.3	8.9	66.0
Unmarried male	26,988	99.9	12.0	8.6	9.5	69.8

Source: AGI, 2001, special tabulations of the 1998 CPS.

increase in the number of single fathers raising children.¹⁷⁶ It is estimated that unmarried men head 5% of all families containing children, and that this group comprises 18% of all single-parent families.¹⁷⁷ Research suggests that children in families headed by unmarried males are better off than children in female-headed families, but that they are economically less advantaged than children living with two parents.¹⁷⁸

Employment

Wages are the major source of income for the majority of individuals in the United States, so variations in employment status provide insights into economic well-being. A majority of adults (61%) aged 20-49 were employed full-time in 1997, and an additional 16% were employed part-time (Table 12). Rates of full-time employment were highest among men (72%). In comparison, while 71% of women were employed at all, only 50% were employed full-time and 21% worked part-time hours. Women's higher rates of part-time employment are primarily a product of (1) their desire to combine employment and family responsibilities and (2) their inability to find full-time employment that accommodates their

family responsibilities. Twenty-six percent of women were not in the labor force, either because they were ill, disabled, had family responsibilities or chose not to work. Considering only those in the labor force, approximately 5% of both men and women were unemployed.

Economic well-being and employment status are intimately intertwined, and in 1997 the majority of poor persons were not employed—either because they were unemployed (9.5%) or because they were not looking for work, often because they were ill or disabled, attending school, or had family and child care responsibilities (46%).^{q,179}

The relationship between employment and poverty is not direct or causal: close to one-half of poor people (44%) were employed in 1997 but they did not earn enough to pull them out of poverty. Individuals whose incomes were within 100-199% of the poverty line had higher rates of employment than poor persons, but still had lower than average full-time employment rates and higher unemployment rates.

Among the different racial and ethnic groups there is little variation regarding full-time and part-time employment, but black adults had higher unemployment rates. Finally, naturalized citizens have higher rates of full-time employment and lower rates of unemployment than both native born adults and non-citizens. The higher rate of unemployment among non-citizens may partly reflect restricted access to jobs and employment in unstable job markets or occupations. That this group has a higher rate of non-employment may also reflect undocumented employment or work in a family business, which was not reported as formal employment.

Health Care Coverage

Unlike many industrialized countries, coverage for

^q Research focusing on income and work in poor communities has found that many poor adults who are not formerly employed do engage in undocumented employment activities or sporadic "odd jobs" in exchange for money. Examples of informal jobs include childcare, hair dressing, housecleaning, manual labor, and prostitution. This means it is possible that larger proportions of poor people are employed than official statistics indicate.

Table 12. Percentage distribution of U.S. adults aged 20-49 by employment status and according to gender, poverty status, race, ethnicity and citizenship status, 1997

Characteristic	Total		Employed full-time	Employed part-time	Unemployed	Not in labor force
	In 1,000	%				
Total	119,306	100.1	60.8	16.3	4.1	18.9
Gender						
Female	60,460	99.9	49.6	20.8	3.6	25.9
Male	58,846	100.0	72.2	11.6	4.5	11.7
Poverty Status						
<100%	13,347	100.0	26.5	17.9	9.5	46.1
100-199%	20,006	100.0	50.5	18.4	6.5	24.6
200%+	85,953	99.9	68.5	15.5	2.6	13.3
Race						
White	97,782	100.0	61.5	16.8	3.5	18.2
Black	15,399	100.0	57.0	13.6	7.7	21.7
Other	6,126	100.0	58.5	15.1	3.8	22.6
Ethnicity						
Non-Hispanic	105,104	100.0	61.3	16.6	3.9	18.2
Hispanic	14,202	100.0	56.5	14.2	5.2	24.1
Citizenship status						
Native born citizen	103,457	99.9	61.0	16.7	4.0	18.2
Foreign born						
Naturalized citizen	5,027	100.0	66.1	12.3	2.9	18.7
Not a citizen	10,822	100.0	55.5	14.0	4.9	25.6

Source: AGI, 2001, special tabulations of the 1998 CPS.

Table 13. Percentage distribution of U.S. adults aged 20-49 by health insurance status and according to poverty status, race, ethnicity, citizenship status and family status, 1997

Characteristic	Total		No health insurance	Any health insurance		
	In 1,000	%		Total	Private	Govt.-sponsored
Total	119,306	100.0	21.1	78.9	72.7	7.7
Poverty Status						
< 100%	13,347	100.0	45.1	54.9	22.7	34.5
100-199%	20,006	100.0	38.7	61.3	51.7	12.2
200% +	85,953	100.0	13.3	86.7	85.3	2.5
Race						
White	97,782	100.0	19.9	80.1	74.9	6.6
Black	15,399	100.0	26.5	73.5	60.4	15.5
Other	6,126	100.0	26.5	73.5	68.4	6.2
Ethnicity						
Non-Hispanic	105,104	100.0	18.4	81.6	75.9	7.3
Hispanic	14,202	100.0	41.4	58.6	48.8	11.0
Citizenship Status						
Native born citizen	103,457	100.0	18.3	81.7	75.5	7.8
Foreign born						
Naturalized citizen	5,027	100.0	24.8	75.2	70.8	5.2
Not a citizen	10,822	100.0	46.8	53.2	46.6	7.8
Marital Status						
Married	67,242	100.0	14.4	85.6	82.9	4.0
Widowed	898	100.0	31.7	68.3	54.3	16.9
Divorced/separated	15,457	100.0	26.6	73.4	61.4	13.8
Never married	35,710	100.0	31.2	68.8	58.8	11.8
Family Status						
Married adult	67,242	100.0	14.4	85.6	82.9	4.0
w/children	47,573	100.0	13.6	86.4	83.3	4.4
w/out children	19,669	100.0	16.2	83.8	81.8	3.1
Unmarried female	25,076	100.0	24.9	75.1	59.5	17.8
w/children	10,076	100.0	24.4	75.6	49.2	29.6
w/out children	15,000	100.0	25.3	74.7	66.5	9.9
Unmarried male	26,988	100.0	34.4	65.6	59.5	7.4

Note: "Any coverage" does not add up to "private" and "govt-sponsored" as individuals may be covered by both.

Source: AGI, 2001, special tabulations of the 1998 CPS.

health care in the United States is not universal. Generally speaking, for people under the age of 65, financial coverage for health care in the United States is restricted to (1) individuals who have private health insurance, usually subsidized or provided by an employer and (2) poor or near-poor individuals who are eligible for federal/state sponsored health insurance (called Medicaid).[†] Although the majority of adults age 20–49 (79%) have coverage for health care, one in five Americans has no coverage (Table 13, see page 43). Most Americans are covered through private insurance (73%) and 8% have government sponsored insurance (a small proportion had dual coverage). Among poor adults, nearly half (45%) have no health care coverage and those that do are more likely to be covered by government-funded programs than by private insurance plans. At the same time, government insurance programs do not guarantee health care coverage for all persons with low incomes: only one third of poor adults were covered under these plans in 1997.

There are variations in insurance coverage according to race, with non-whites being more likely to lack coverage. The rate of coverage among Hispanics is substantially lower than non-Hispanic groups. This is, in part, due to the fact that just over one-half of Hispanic adults (53%, not shown) were not born in the United States, and therefore have more limited access to both private and government-sponsored health insurance. Similarly, almost one-half of non-citizens (47%)—the majority of whom are Hispanic—are without health insurance coverage, and a very low proportion are covered by government health insurance.

Eighty-six percent of married adults have health insurance, with coverage levels slightly higher among those with children present. The overwhelming majority of married adults are covered by private plans, a product of their high levels of employment and income. Less than 5% have government-sponsored insurance. Unmarried women with no children are least likely to have health insurance of any sort. Sixty-seven percent in this group have private insurance and 10% have government-sponsored health insurance. Finally, 24% of single women with children do not have health insurance. Almost one-third (30%) of unmarried women with children obtain coverage through government medical programs, a reflection of their low income and high levels of employment in jobs that do not offer health coverage.

[†] Individuals in the military, along with their family, have access to government-sponsored health care. Individuals aged 65 and older have access to an additional health insurance program, Medicare.

Systems of Social Welfare to Assist Poor or Disadvantaged Populations

Relative to most other Western, industrialized countries, the U.S. welfare system has many limitations. Few benefits are universal and social assistance programs are stigmatized. Nonetheless, there are a range of programs intended to meet the most pressing needs of the poor. The most used programs include income assistance, such as Temporary Aid to Needy Families (TANF), food stamps, housing assistance and health insurance (Medicaid). Other forms of means-tested assistance include a cash benefit available to the elderly poor, blind and disabled (SSI), an Earned Income Tax Credit program (EITC), energy assistance, free and reduced-price school lunches, educational assistance and, most recently, the Children’s Health Insurance Program (CHIP).

Eligibility requirements for benefits vary from program to program, and, in some cases, from state to state and even within states. Further complicating the discussion of the U.S. welfare system is recent legislation that “reformed” many aspects of the system, giving state governments more administrative control. For example, the food stamp program is fully funded by the federal government; thus, there is little state-by-state variation. Until 1997, families and individuals with incomes under 185% of the poverty line were eligible for food stamp benefits.¹⁸⁰ The welfare reform legislation of 1996 lowered that limit to 130%. Programs such as TANF and SSI provide cash assistance. They are funded by both the federal and state governments, and they use only broad federal poverty guidelines to determine maximum eligibility limits.¹⁸¹ Individual states then set their own eligibility cutoffs, within the federal guidelines, taking into account earnings and income as well as savings, assets and property.

Cash Assistance and Food Stamps

Programs that provide a cash benefit are probably the most controversial and criticized element of the U.S. social welfare system. As such, they have always had a number of restrictions and these increased under recent reforms. For example, starting in 1997, a person can only receive TANF benefits for two consecutive years and for a maximum of five years over the course of a lifetime. Previously there were no time limits. Work requirements under TANF are quite stringent, and all able-bodied adults are expected to seek employment. Under the prior welfare program, Aid to Families with Dependent Children (AFDC), employment was encouraged, but most states did not require it. All states exempt recipients with very young children from employ-

ment requirements, though the age of the youngest child required for exemption varies from state to state—from a low of under 90 days in Oregon to a maximum of under age 4 in Texas.

Motivated by the belief that providing higher welfare benefits for additional children encourages welfare dependent women to have more children, 23 states imposed family caps in 1997.¹⁸² This means that women in these states who become pregnant while receiving TANF benefits will not receive a higher benefit when the child is born. Similarly, in an effort to curb adolescent birthrates, Congress mandated that unmarried minors with children must (1) live with a parent or responsible adult and (2) attend school or vocational training in order to receive benefits. Prior to 1997, welfare payments in most states were only available to single-parent families, but many legislators felt that this discouraged women from getting married. One of the stipulations of welfare reform was that eligibility be extended to married couple families. Preliminary data suggest that this development has not yet greatly altered the composition of welfare recipients. In 1998, 16% of adult recipients were married and living together.¹⁸³ This figure is not much higher than that for 1993, when 13% of mothers receiving AFDC were living with their spouse.¹⁸⁴

The benefits provided under TANF (and SSI) vary from state to state. In 1997, a single mother with two children in Mississippi could receive a maximum TANF benefit of \$120 a month; a similar family in Alaska, which has a higher cost of living, could receive a maximum benefit of \$1,025. Many critics feared that welfare reform would result in substantially lower cash benefits for poor families, but the Department of Health and Human Services (1998) reports that the majority of states have maintained the same benefit levels for TANF as they did for AFDC. What most states have done is change their income criteria so that recipients are encouraged to work; recipients can keep a larger proportion of their assistance benefit now than before while they make the transition from welfare to employment. Additionally, many states have relaxed property rules and, for example, having a car no longer counts against a (potential) recipient's eligibility or benefit amount.

With a few exceptions (e.g., SSI), means-tested welfare programs are intended for families with young children. Indeed, "able-bodied" adults are usually only eligible for TANF if there is a young child in the household. The most widely used program is food stamps. In most states, the eligibility criteria for this benefit are more generous than for programs that provide cash benefits and, unlike the

most commonly used cash assistance program (TANF), receipt of food stamps does not usually have time limits. However, starting in 1997 non-disabled adults between the ages of 18 and 50 with no dependent children are restricted to 3 months of benefits over a 3-year period, unless they are working or participating in a work program at least 20 hours a week.¹⁸⁵

SSI was developed in the early 1970s to provide cash assistance to low-income elderly, blind and disabled individuals. In the last 20 years the number of children receiving SSI benefits increased tenfold—to 955,000 in 1996—and children now comprise 13% of the total SSI population.¹⁸⁶ Because SSI is partially funded by state governments, income-eligibility criteria vary from state to state. An individual is not eligible to receive both TANF and SSI, but a family with a disabled child can combine both benefits.^{s,187} Since children (and caretakers) with health problems such as mental retardation often require more medical treatment, in-home monitoring, and financial resources than non-disabled children, SSI benefits are an important source of income for these families. While most means-tested welfare programs are intended to assist families with children, recent changes to SSI sought to reduce benefits to this group. Prior to 1996, children with asthma and attention deficit disorder were eligible for SSI benefits. A number of legislators did not think these medical problems warranted extra income assistance and, under the new welfare reform legislation passed in 1996, developed more stringent disability criteria. This had the effect of ending SSI benefits to children (and adults) with all but the most extreme mental and physical disorders.

Public Health Insurance

Because of the high cost of medical care in the United States, Medicaid, a program that provides health insurance for the economically disadvantaged, is an important component of the U.S. social welfare system. The federal government reimburses states for part of the cost for covering health care for poor recipients. Medicaid benefits are particularly valuable to poor and near-poor women of childbearing age because they cover contraception, pre- and post-natal care, and insure that infants and children have access to health care. Starting in the late 1980s, coverage was extended nationally to pregnant women within 133% of the poverty line and up to 185% in some states.¹⁸⁸ In fact, Medicaid is the largest source of

^s Generally, these families will forego the extra TANF income provided by the disabled dependent (claiming the benefit for a two-member family instead of a three-member one) and accept the full SSI benefit.

federal funding for family planning services. Prior to welfare reform, families and individuals that received AFDC were automatically enrolled in Medicaid, though they typically lost these benefits soon after the adult head became employed. Under welfare reform, legislators sought to “uncouple” the two programs in order to (1) provide Medicaid coverage to a broader population and (2) remove the employment disincentive that many believed was embedded in AFDC. Medicaid coverage now extends to former TANF recipients for one to two years after they have obtained a job, and qualifying for welfare receipt is not a prerequisite for Medicaid eligibility. Although many states have implemented outreach programs to inform non-TANF (and TANF) families that this benefit is available to them, the number of Medicaid recipients has declined in the last few years while the proportion of uninsured individuals has increased.¹⁸⁹

As another way of extending medical coverage to economically disadvantaged families, the 1997 Congress designated funds for the new Children’s Health Insurance Program (CHIP). This program provides health insurance for children (usually through age 18, thereby covering younger adolescents) in low-income and working families whose incomes are too high to allow them access to Medicaid benefits but too low to purchase private insurance. All fifty states plus the District of Columbia have developed a CHIP program.¹⁹⁰ Income eligibility criteria are determined by each state and range from 150–200% of the poverty line. While benefits vary from state to state, most include regular checkups, immunizations, doctor visits, and prescription drugs. CHIP has the potential to impact the reproductive health of the adolescents who are enrolled. In 21 states plus DC, CHIP is an expanded form of Medicaid which means that access to family planning services is mandated. In the remaining 29 states, CHIP is a state designated program (sometimes in conjunction with Medicaid). Although it is not required, all but one state appears to provide coverage of family planning services to adolescents under age 18; sixteen specify that this is to include prescription contraceptives.¹⁹¹ Only Georgia prohibits contraception coverage under CHIP.

Housing

Housing assistance for the economically disadvantaged takes several forms. Public housing developments constructed by the U.S. Department of Housing and Urban Development (HUD) provide low-cost housing for several thousand low-income families. Since the 1970s, HUD has also provided

housing vouchers and certificates (Section 8). Under this program, tenants pay 30% of their monthly income for rent in private housing, and the Section 8 vouchers pay the remaining amount. Housing assistance is a federal program, so eligibility guidelines and benefits do not vary much from state to state. In order to qualify for housing assistance, a family must have an income that is less than 80% of the area median income.¹⁹² Housing assistance has always been in short supply, and most families are put on a waiting list for one or more years. Housing programs were overlooked during the 1997 welfare reform, but in 1998 Congress passed the Quality Housing and Work Responsibility Act. The act reserves a portion of the housing assistance budget for families whose incomes are lower than 30% of the area median, but a larger proportion is reserved for families whose incomes are between 50–80% of the median than was previously the case. This strategy is intended to facilitate mixed-income housing as opposed to having areas of concentrated poverty.

The Special Case of Immigrants

Immigrants’ access to welfare benefits was purposely reduced by recent welfare reform. Disregarding the fact that legal immigrants pay the same taxes as citizens, Congress made members of this group ineligible for most welfare programs—including food stamps, SSI, Medicaid, and TANF—during their first 5 years of residency. This resulted in the removal of benefits for immigrant families who had arrived before the legislation was enacted. In 1998 and 1999, Congress altered reform legislation so that legal immigrants who had arrived in the United States prior to August 1996 were eligible for food stamps, SSI and Medicaid. More recently, legislation was introduced in 1999 that, if passed, would remove the 5-year waiting period and allow qualified legal immigrants to receive food stamps, SSI and Medicaid upon entry into the United States. Notably, a number of states, and particularly those with large numbers of immigrants, did not cut off immigrant benefits to the extent that they could have done; instead, they used their own funds to provide benefits to at least some new and pre-reform immigrants.¹⁹³

The Special Case of Young Mothers

Lowering out-of-wedlock births, with a focus on teenage females, was a major goal of welfare reform. In addition to placing requirements on young women who have children out-of-wedlock and wish to receive a cash benefit—requiring them to live at home and attend school or work—Congress also

Table 14. Percentage of poor and low-income adults aged 20-49 receiving federal aid by type of aid according to race, ethnicity, citizenship status and family status, 1997

Characteristic	Public assistance		Food stamps		SSI		Housing assistance	
	Poor	100-199%	Poor	100-199%	Poor	100-199%	Poor	100-199%
Total	19.8	4.8	39.9	12.6	10.0	6.7	17.0	5.8
Race								
White	17.0	4.0	36.6	10.9	9.2	5.6	13.3	4.4
Black	28.9	9.1	52.3	20.5	12.8	11.0	29.2	11.3
Other	17.8	3.0	30.3	12.0	8.9	9.6	13.1	5.5
Ethnicity								
Non-Hispanic	19.2	5.0	40.1	13.1	11.3	7.2	17.7	5.6
Hispanic	22.1	4.3	39.3	10.8	5.9	5.3	15.1	5.9
Citizenship Status								
Native born citizen	21.1	5.4	43.2	13.6	12.1	7.3	18.8	5.9
Foreign born								
Naturalized citizen	14.0	3.6	27.4	9.5	3.9	8.9	14.6	5.2
Not a citizen	15.9	2.5	29.1	8.8	2.6	3.4	10.4	4.3
Family Status								
Married adult	15.2	3.6	37.4	10.5	8.2	4.5	10.4	3.7
w/children	16.9	3.6	39.7	10.9	7.4	4.2	10.5	3.9
w/out children	7.1	3.7	26.2	9.0	12.2	6.2	10.0	2.8
Unmarried adult	21.9	6.1	41.0	14.7	10.8	9.0	20.0	7.5
w/children	39.9	11.6	61.4	21.6	8.2	7.6	29.3	11.6
w/out children	6.8	3.1	23.9	10.9	13.1	9.7	12.2	5.3

Public assistance includes any cash benefit provided by the federal, state or local government (e.g. TANF).

Food stamps are provided by the federal government to individuals and families meeting certain eligibility criteria.

Supplemental Security Income is available to the blind, the disabled and to poor elderly individuals.

Housing assistance refers to families living in public housing or receive vouchers from the federal government which they can use to pay part of their rent (Section 8).

Source: AGI, 2001, special tabulations of the 1998 CPS.

implemented a system that provides cash bonuses to states that experience a reduction in the proportion of out-of-wedlock births and abortions. The authors of the program, called the “Bonus to Reward Decrease in Illegitimacy Ratio,” hoped that it would encourage states to come up with creative solutions for reducing adolescent pregnancy and abortion. The annual budget for the program is (up to) \$100 million annually, to be split between “winning” states in each year between 1999 and 2002. In 1999, four states plus the District of Columbia received \$20 million each. Welfare reform also provided funds for abstinence education (see Part II), with the goal of encouraging all adolescents to postpone sexual activity until marriage.

In 1995, approximately 6% of AFDC adult recipients, presumably with children, were under the age of 20. This proportion was the same in 1998.¹⁹⁴ These statistics suggest that the focus on adolescent pregnancy (1) is disproportionate to the actual financial burden posed by teenage mothers and (2) has not (yet) resulted in any overall reduction in adolescent mothers on welfare.

Who Uses Means-Tested Welfare?

Table 14 shows the frequency with which four popular social welfare programs were accessed by poor and near-poor adults in 1997, with breakdowns according to some of the characteristics discussed in

the previous section.¹ Many people believe that cash welfare benefits are the main source of income for poor people, but the first column of Table 14 (see page 48) shows that only 20% of poor adults receive public assistance.

Many states require that individuals have incomes at or below the poverty level in order to receive income assistance, but often those with incomes above poverty-level are eligible to receive food stamps. This partially explains why a larger proportion of poor and borderline poor adults received this benefit (40% and 13%, respectively) than received cash assistance.¹⁹⁵ SSI was

received by 10% of poor adults in 1997. Finally, 17% of poor and 6% of near-poor adults lived in public housing developments or received housing vouchers.

Similar to patterns shown in earlier research,¹⁹⁵ poor black adults are more likely than individuals from other race or ethnic groups to receive public assistance, food stamps, SSI or housing assistance. The higher rate of utilization among poor African-Americans relative to poor whites is probably due to several factors including longer periods of poverty, the geographical concentration of black families that are extremely poor, and social networks that facilitate the transmission of information about benefit programs and application processes. Poor Hispanic adults also use public assistance and food stamps at slightly higher rates than do all poor white adults, although their use of SSI and housing benefits is lower than or similar to the rates of poor white adults. Moreover, poor adults who were born in the United States are more likely to receive any form of welfare

¹ Welfare reform legislation passed in 1996 was implemented in 1997 and 1998. These statistics reflect the transition from the old system to the new one.

¹⁹⁵ The item used to compute this statistic measured whether anyone in the household had received food stamps in the previous year. Since it is possible for an individual to reside in a food stamp household without having access to the food purchased with these coupons, this figure overestimates the proportion of individuals using food stamps in 1997.

Table 14. Percentage of poor and low-income adults aged 20-49 receiving federal aid by type of aid according to race, ethnicity, citizenship status and family status, 1997

Characteristic	Public assistance		Food stamps		SSI		Housing assistance	
	Poor	100-199%	Poor	100-199%	Poor	100-199%	Poor	100-199%
Total	19.9	4.9	39.9	12.7	10.0	6.8	17.1	5.7
Race								
White	17.0	4.0	36.6	10.9	9.2	5.6	13.3	4.4
Black	28.9	9.1	52.3	20.5	12.8	11.0	29.2	11.3
Other	17.8	3.0	30.3	12.0	8.9	9.6	13.1	5.5
Ethnicity								
Non-Hispanic	19.2	5.0	40.1	13.1	11.3	7.2	17.7	5.6
Hispanic	22.1	4.3	39.3	10.8	5.9	5.3	15.1	5.9
Citizenship Status								
Native born citizen	21.1	5.4	43.2	13.6	12.1	7.3	18.8	5.9
Foreign born								
Naturalized citizen	14.0	3.6	27.4	9.5	3.9	8.9	14.6	5.2
Not a citizen	15.9	2.5	29.1	8.8	2.6	3.4	10.4	4.3
Family Status								
Married adult	15.2	3.6	37.4	10.5	8.2	4.5	10.4	3.7
w/children	16.9	3.6	39.7	10.9	7.4	4.2	10.5	3.9
w/out children	7.1	3.7	26.2	9.0	12.2	6.2	10.0	2.8
Unmarried adult	21.9	6.1	41.0	14.7	10.8	9.0	20.0	7.5
w/children	39.9	11.6	61.4	21.6	8.2	7.6	29.3	11.6
w/out children	6.8	3.1	23.9	10.9	13.1	9.7	12.2	5.3

Public assistance includes any cash benefit provided by the federal, state or local government (e.g. TANF).

Food stamps are provided by the federal government to individuals and families meeting certain eligibility criteria.

Supplemental Security Income is available to the blind, the disabled and to poor elderly individuals.

Housing assistance refers to families living in public housing or receive vouchers from the federal government which they can use to pay part of their rent (Section 8).

Source: AGI, 2001, special tabulations of the 1998 CPS.

benefit than are foreign-born individuals.

Unmarried adults with children have disproportionately high poverty rates, longer spells of poverty, and are more likely to experience extreme poverty than their married counterparts or others without children. It is not surprising, then, that poor and near-poor single parents are more likely to receive welfare benefits than other married adults or those without children. In 1997, 40% of poor adults with children received public assistance, as did 12% of similar adults with incomes between 100–199% of the poverty line. A majority of poor single parents (61%) received food stamps, and 29% received housing assistance.

The Effects of Welfare Reform

Policy makers and researchers are not yet able to determine the overall effects of welfare reform. This is due to both its recent implementation and the fact that any effects of reforms are impossible to separate from the strong economy that the United States has sustained during the late 1990s.^v Inarguably, the number of individuals and families receiving income assistance (TANF), food stamps, Medicaid benefits, and SSI has decreased in most, if not all, states since 1996.¹⁹⁶ Critics of “big government” contend that these developments alone represent a “success.” Some groups argue that welfare reform is indirectly,

^v It is also worth noting that enrollment in many social assistance programs (and teen birthrates) was declining before welfare reform.

if not directly, responsible for recent declines in adolescent pregnancy rates and birthrates because it provided money for abstinence education and implemented “birth disincentives” for welfare recipients.

There appear to be some positive individual outcomes. One study compared a nationally representative sample of families that went off welfare with a population of low-income mothers who had not received welfare.^{197,w} Former welfare recipients, comprised almost solely of single

mothers, had higher rates of employment than their non-welfare counterparts, though this was probably due to the fact that former recipients were much less likely to have access to a spousal income.¹⁹⁸ Former recipients held the same types of jobs as low-income women, and their wages were similar to, and perhaps a little higher than, those of low-income mothers. On a less positive note, 25% of former recipients were neither employed nor married, and nearly a third of the “first wave” of women affected by welfare reform returned to the rolls within the two year time period of the study.

There is some evidence that individuals who leave the welfare rolls may be worse off than welfare recipients who left in previous years. In some cities, the number of individuals and families using homelessness services has increased, and some attribute this trend to welfare reform.¹⁹⁹ Census data show that the annual income of the poorest 20% of female-headed households declined an average of \$580 between 1995 and 1997.²⁰⁰ More than three-quarters of the income loss was due to declines in receipt of food stamps and cash assistance (AFDC and TANF). Indeed, concern over the declining enrollment in the food stamp program has motivated the Department of Agriculture to implement an outreach program, informing potentially eligible populations that these

^w 94% of former recipients were female and, by default of the study design, 100% of the respondents had children.

benefits are available to them. In sum, then, it is probable that welfare reform has benefited some former recipients, but it has not been the panacea that many thought it would be.

Interventions that Have Been Implemented to Assist Youth from Disadvantaged Populations

Job Corps

Established in 1964, Job Corps is a federally funded program that provides approximately 100,000 disadvantaged youths a year with educational and vocational training as well as job placement services. In 1996, there were 110 Job Corps centers nationwide: 30 were jointly operated by the Department of Agriculture and the Department of Labor, and 80 were run by private contractors. Job Corps counselors recruit participants through advertising and by contacting peer counselors, schools and employers.

To be eligible for Job Corps, young people must be between 16–24 years of age, economically disadvantaged, a high school dropout or in need of additional education, not on probation or parole, free of serious medical and behavioral problems, from a debilitating environment (e.g., the inner-city), and drug-free. The majority of Job Corps students are male (60%), belong to a racial/ethnic minority (70%), and have not completed high school (80%). Relative to the larger population of disadvantaged youth, Job Corps students have lower family incomes.²⁰¹

The basic components of Job Corps are educational and vocational training. Only 20% of Job Corps participants have a high school degree, and, including these graduates, only 40% read at a level that qualifies them for a GED preparation course.²⁰² The Job Corps academic curriculum includes courses in reading, math and writing or thinking skills. Training is provided for jobs in 75 vocational areas, but 80% of training slots are accounted for by 10 trades: clerical, health, carpentry, masonry, maintenance, food service, mechanics, welding, painter and electrician. Job Corps centers consult with local employers to find out anticipated labor needs, and adjust their vocational training accordingly. Instruction is individualized and self-paced. Participants can leave the program at any time and can stay enrolled for up to two years.

One of the distinguishing characteristics of Job Corps is that the majority of students (90%) live in Job Corps dormitories. This allows for the provision of services and programs that are less directly related to educational and vocational training, including health care and social skills training. Health services include routine medical, dental and mental health, a health education program, and, in some cases, access

to ob/gyn services, a pharmacy or an optometrist. Social skills training provides instruction on issues such as getting along with others and accepting criticism. Participants are provided with a modest weekly living allowance and a clothing allowance to allow them to purchase clothes for work.

According to the Department of Labor, about 30% of students drop out within the first 3 months of enrollment, and 40% complete vocational training. Few of the recent reports examining program effectiveness are available to the general public. However, the Urban Institute, which has conducted evaluations of government job training programs, contends that the Job Corps is the only program for youth that has been rigorously evaluated and found to have positive outcomes.²⁰³ However, writers have asserted that Job Corps is not successful since participants do not earn substantially higher wages than non-participants.²⁰⁴

Boys and Girls Clubs of America

The Boys and Girls Clubs of America (BGCA) is a national, non-profit (and non-governmental) youth organization with the primary mission of providing opportunities for personal growth and achievement to disadvantaged youths. BGCA is comprised of 1,850 club facilities that serve 2.6 million boys and girls across the United States. BGCA was established in 1860 and, because of its longevity, is a popular and widely respected organization. The BGCA secures financial support from a number of sources, including federal and local governments, corporations, foundations and private donations.

The type and range of programs adopted by individual Boys and Girls Clubs varies from city to city and even within cities; each facility implements the programs that best suits the needs of area youth. Most facilities (appear to) provide programs in the areas of education, career/employment and health. For example, POWER HOUR is a BGCA program that provides comprehensive homework help and tutoring. The Career Explorers Club serves youths between the ages of 13–15, introducing them to career opportunities through instruction and field trips. The JOB READY! program is geared for older youths (aged 16–18). It teaches effective job-hunting and interview techniques, and helps participants develop the skills to be successful employees. Health programs cover a wide range of the topics, including nutrition, safety and HIV/AIDS prevention. SMART Moves addresses the issues of drug and alcohol use and early sexual activity. The program coaches participants on resistance skills through role-playing and discussion. More recently, some facilities, and

particularly those located in or near public housing developments, have tried to implement comprehensive health programs, providing services as well as information and instruction. While program availability is restricted, BGCA facilities are open daily, after school and on weekends.

Nationwide, youth who participate in BGCA tend to be male (62%), live in inner-city areas (71%), come from minority families (56%), and live in single-parent families (53%). The organization serves youths in all age groups: 18% are aged 7 years or younger, 33% 8–10-years-old, 29% 11–13 years and 20% 14–18-years-old. No one has formally evaluated the extent to which different BGCA programs have successfully achieved their goals.

WIC Special Supplemental Nutrition Program for Women, Infants, and Children

Established in 1974, this federally funded program provides supplemental food, health care referrals, and nutrition education to low-income women who are pregnant, postpartum or breastfeeding and to infants and children up to age 5 who are found to be at nutritional risk. In order for an adult woman to qualify as “low-income” for the WIC program, she must have a family income no more than 185% of the poverty line, though states are allowed to lower this threshold. Nutritional risk includes (1) medically-based risks such as anemia, underweight, maternal age, and history of pregnancy complications and poor pregnancy outcomes, and (2) diet-based risks, such as inadequate dietary patterns. Interestingly, WIC is one program that appears to have been “overlooked” in recent welfare reforms.

WIC benefits are free and are obtained through a number of different organizations and agencies, including county health departments, family planning clinics, hospitals, schools, community centers and public housing sites. WIC services include nutrition education, counseling and screening and referrals to health, welfare and social services. WIC also provides recipients with vouchers that they can use at participating stores to purchase selected food products such as infant formula, eggs, cereal, milk, cheese and beans. It is not directed at youth, per se, but the majority of participants are young. Indeed, over 50% are infants and children. Among adult recipients, 13% are women aged 15–19 and 32% are aged 20–24.

WIC is quite narrow in scope, focusing almost solely on nutrition and related issues among pregnant women and/or their young children. The program does provide information and referrals for drug abuse, but larger reproductive health issues, such as

HIV/AIDS and family planning, are not addressed. The U.S. Department of Agriculture reports that a 1990 study found WIC use was associated with decreased Medicaid costs as well as lower pre-term delivery and higher birth weight.

The Healthy Start Initiative

The Healthy Start Initiative is sponsored by the federal government and funded by the Maternal and Child Health Bureau (part of the U.S. Department of Health and Human Services). Established in 1991, the goal of the program is to use community-based strategies to improve infant health in areas with extremely high rates of infant mortality. Healthy Start initially supported 22 demonstration projects in communities across the United States. Though several communities did not continue Healthy Start after the 6 year “experimental” period, the overall program was successful enough to prompt the implementation of more than 50 additional sites.

The federal government provides funding for Healthy Start, but participants from each community design and implement different strategies based on what they view as most appropriate and likely to succeed in their area. This has resulted in a diverse number of intervention models, including community-based consortia, care coordination/case management, outreach and client recruitment, education and training, and adolescent programs. Access to Healthy Start programs is not restricted to adolescents, but because adolescent pregnancy is associated with low-birth weight and infant mortality, many Healthy Start communities target their services and message to adolescents.

A comprehensive evaluation of Healthy Start is nearing completion, and results are not yet available. Hence, we do not yet know the characteristics of the individuals who participate in the program or the degree to which it has reduced infant mortality. However, the Healthy Start website (www.healthystart.net) reports that the programs have increased the number of women who access early prenatal care, reduced behavioral risk among clients and improved access to and coordination of care.

Teenage Parent Demonstration Programs

Because they were initiated fairly recently, policy makers have not yet had a chance to fully evaluate the effectiveness of changes in welfare programs. However, some insights can be gained from looking at past welfare “experiments.” Prior to 1996, the Department of Health and Human Services initiated several projects that resemble current welfare

programs (and may have, in fact, served as the model for welfare reform in different states): the Teenage Parent Demonstration (TPD) in Illinois and New Jersey (1987–1991), the Learning, Earning and Parenting Program (LEAP) in Ohio (1989–present) and the New Chance Demonstration (NCD) implemented in 10 states (1989–1992). There has been a considerable amount of variation among the different programs. For example, LEAP focuses on educational outcomes and provides financial bonuses for every month of completed schooling. TPD required that (first-time) teenage mothers on welfare spend a minimum of 30 hours per week in education, job training, and/or employment-related activities, and failure to comply resulted in a \$160 a month penalty. NCD was voluntary, targeting first-time adolescent mothers who had not completed high school. In all three programs, the young mothers were offered extra assistance with day care, transportation and case management, and were expected to “earn” their benefits.

The demonstrations were experimental and, at the beginning of each project, policy evaluation teams assigned new welfare enrollees into either the control or experimental group. Evaluators followed the progress of participants in both groups during the program as well as several years after the demonstrations had ended. Early findings from the studies showed that the demonstration programs were most effective at increasing school enrollment levels. Ohio’s LEAP significantly increased GED enrollment, earnings and high school completion rates for teenage mothers in 9th, 10th and 11th grades. The demonstrations also increased mothers’ use of child care centers, and researchers found that maternal employment did not have detrimental effects on child development. Long term results were less promising. Follow-up studies found that the programs did NOT end the cycle of welfare dependency as approximately 70% of participating adolescents were receiving welfare 3–4 years later. While LEAP temporarily increased earnings and enrollment, ultimately participants did not have higher graduation rates and their employment situation after leaving the program was no better than that of the comparison group. In turn, more than three-fourths of participants still lived in households with incomes below poverty level. A stated goal of the demonstrations was to prevent further pregnancies to poor women. With the exception of 3 TPD sites with intensive family planning workshops and small caseloads, the programs had no significant impact on fertility. In fact, many mothers became pregnant with a second child shortly after entering the demonstration programs.

In the last few years, the number of families and individuals on welfare has dropped substantially. Some people attribute this trend, at least in part, to welfare reform. However, the findings of these demonstrations as well as others suggest that, in the long-run, welfare reform efforts are not substantial or intensive enough to improve, alone, the educational and occupational skills of poor women.

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Appendix A

Table A1. Birth, pregnancy and abortion rates per 1,000 women aged 15-19, 15-17, 18-19 and 20-24 for selected years

Table A2. Birth and abortion rates per 1,000 women aged 15-19, 15-17, 18-19 and 20-24 by marital status, 1995

Table A3. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey and gender

Table A4. Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey

Table A5. Percentage distribution according to the number of sexual partners in the past year by respondent's age at the survey and gender

Table A6. Percentage distribution according to the frequency of intercourse in the past three months among currently sexually active by respondent's age at the survey and gender

Table A7. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey and gender

Table A8. Percentage distribution according to current contraceptive method used by age of respondent at the survey and gender among those currently sexually active

Table A9. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey (15-19 and 20-24), gender and socioeconomic variables

Table A10. Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey (15-19 and 20-24) and socioeconomic variables

Table A11. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables among those ever sexually active

Table A12. Percentage distribution according to current contraceptive method used by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables among currently sexually active

Table A13. Percentage distribution according to socioeconomic measures by age and gender

Table A14. Summary table: Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey (15-19 and 20-24), gender and socioeconomic variables

Table A15. Summary table: Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey (15-19 and 20-24) and socioeconomic variables

Table A16. Summary table: Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables among those ever sexually active

Table A17. Summary table: Percentage distribution according to current contraceptive method used by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables among those currently sexually active

Table A1. Birth, pregnancy and abortion rates per 1,000 women aged 15-19, 15-17, 18-19 and 20-24 for selected years

Year and Age Group		All Women				
1980	Birth Rate	Abortion Rate	Pregnancy Rate	Number of births	Number of Abortions	
15-19	53.2	42.8	96.0	552,161	444,780	
15-17	32.7	30.2	62.9	198,222	183,350	
18-19	81.9	60.5	142.4	353,939	261,430	
20-24	114.8	51.4	166.2	1,226,200	549,410	

1985	Birth Rate	Abortion Rate	Pregnancy Rate	Number of births	Number of Abortions
15-19	51.0	43.5	94.5	467,485	399,200
15-17	31.0	30.6	61.6	167,789	165,630
18-19	79.6	62.0	141.6	299,696	233,570
20-24	108.3	52.0	160.3	1,141,320	548,020

1990	Birth Rate	Abortion Rate	Pregnancy Rate	Number of births	Number of Abortions
15-19	60.4	40.6	101.0	521,826	350,970
15-17	37.6	26.6	64.2	183,327	129,820
18-19	90.0	58.8	148.8	338,499	221,150
20-24	116.5	56.7	173.2	1,093,730	532,480

1995	Birth Rate	Abortion Rate	Pregnancy Rate	Number of births	Number of Abortions
15-19	56.8	30.0	86.8	499,873	263,750
15-17	36.0	19.9	55.9	192,508	106,300
18-19	89.1	45.7	134.8	307,365	157,450
20-24	109.8	50.3	160.1	965,547	442,160

Most recent year 1996	Birth Rate	Abortion Rate	Pregnancy Rate	Number of births	Number of Abortions
15-19	54.4	29.2	83.6	491,577	263,890
15-17	33.8	19.0	52.8	185,721	104,240
18-19	86.0	44.9	130.9	305,856	159,650
20-24	110.4	50.7	161.1	945,210	433,910

Source: Henshaw SK, U.S. Teenage pregnancy statistics: with comparative statistics for women aged 20-24, New York: AGI, 2001.

Table A2. Birth and abortion rates per 1,000 women aged 15-19, 15-17, 18-19 and 20-24 by marital status, 1995

Year and Age Group		Currently Married Women		
1995	Birth Rate	Abortion Rate	Number of births	Number of Abortions
15-19	362.4	18.8		
15-17				
18-19				
20-24				

Women Not Currently Married				
1995	Birth Rate	Abortion Rate	Number of births	Number of Abortions
15-19	44.4	30.4	375,738	
15-17	30.5		161,140	
18-19	67.6		214,598	
20-24	70.3		432,003	

Source: Ventura SJ et al., Advance report of final natality statistics, 1995, *Monthly Vital Statistics*, 1997, Vol. 45, No. 11 (Supplement).

Table A3. Percentage distribution according to the age when respondents first had intercourse¹ by respondent's age at the survey and gender
Females

Percent who first had intercourse at age:	Respondent's age at survey					
	15-19	20-24	25-29	30-34	35-39	40-44
<13	2.5	2.0	1.2	0.9	1.0	0.6
13	5.3	4.8	3.7	3.7	3.2	1.3
14	10.6	7.3	6.5	6.2	4.2	3.0
15	12.7	13.9	12.5	11.9	10.6	6.4
16	11.5	19.0	14.4	15.2	16.7	12.7
17	5.0	16.1	16.8	15.5	16.9	16.5
18	2.7	10.0	12.3	13.8	13.1	16.6
19	0.9	7.5	7.6	8.8	9.6	12.3
20		4.3	6.8	6.3	6.1	8.4
21 or older		4.1	13.9	15.0	17.1	20.8
Never had intercourse	48.7	11.0	4.2	2.6	1.4	1.5
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	8,923	8,946	9,794	10,982	11,291	10,015
Number-unweighted (N)	1,396	1,518	1,739	2,149	2,143	1,862

Males

Percent who first had intercourse at age:	Respondent's age at survey					
	15-19	20-24	25-29	30-34	35-39	40-44
<13	4.0					
13	6.8					
14	10.4					
15	12.3					
16	12.1					
17	6.1					
18	3.5					
19	0.1					
20						
21 or older						
Never had intercourse	44.8					
Total Percent	100%					
Adjusted Number (N)	1,727					
Number-unweighted (N)	1,724					

Source(s): NSFG, NSAM
Year of survey: 1995

¹ For women: After menarche

Note: For males, the NSAM adjusted N's shown here have been weighted, but have not been inflated to represent population N's.

Table A4. Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey

Females

Percent whose first birth was at age:	Age at survey					
	15-19	20-24	25-29	30-34	35-39	40-44
<15	0.5	0.9	0.5	0.5	0.4	0.7
15	1.1	1.7	1.3	0.9	1.3	0.8
16	1.2	3.2	1.6	2.8	2.9	2.0
17	3.1	3.3	3.9	3.8	4.6	5.9
18	2.0	5.1	4.9	4.7	5.8	7.0
19	0.4	7.7	5.2	6.5	6.0	7.3
20		5.0	7.1	6.3	5.5	7.2
21 or older		8.7	32.0	47.9	54.0	51.6
Never had a birth	91.6	64.4	43.5	26.7	19.5	17.4
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N)	8,923	8,946	9,794	10,982	11,291	10,015
Number-unweighted (N)	1,396	1,518	1,739	2,149	2,143	1,862

Source(s): NSFG
 Year of survey: 1995

Table A5. Percentage distribution according to the number of sexual partners in the past year by respondent's age at the survey and gender

Females

Number of sexual partners in past year	Respondent's age at survey					
	15-19	20-24	25-29	30-34	35-39	40-44
Never had sex	48.7	11.0	4.2	2.6	1.4	1.5
No partners past year	2.0	4.0	3.9	4.8	7.2	10.3
1 partner	26.3	55.2	71.4	76.9	79.2	79.5
2 partners	10.2	14.2	11.6	8.5	6.8	4.5
3 or more partners	12.7	15.6	8.8	7.2	5.5	4.2
Total Percent	99.9%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	8,904	8,936	9,792	10,979	11,273	9,994
Number-unweighted (N)	1,393	1,516	1,738	2,148	2,141	1,858

Males

Number of sexual partners in past year	Respondent's age at survey					
	15-19	20-24	25-29	30-34	35-39	40-44
Never had sex	44.7					
No partners past year	6.0					
1 partner	24.2					
2 partners	14.4					
3 or more partners	10.6					
Total Percent	100%					
Adjusted Number (N)	1,729					
Number-unweighted (N)	1,729					

Source(s): NSFG, NSAM
 Year of survey: 1995

Table A6. Percentage distribution according to the frequency of intercourse in the past three months among currently sexually active by respondent's age at the survey and gender

Females

Frequency of intercourse in past three months	Respondent's age at survey					
	15-19	20-24	25-29	30-34	35-39	40-44
1 or less/month	22.6	11.8	13.3	14.4	13.4	16.3
2-3 times/month	26.9	24.1	19.8	19.6	24.8	24.8
1/week	16.6	19.4	24.0	22.5	22.5	25.7
2-3 times/week	24.1	32.3	31.7	33.3	30.0	25.3
4 or more times/week	9.5	11.6	10.1	9.2	7.9	5.5
Not ascertained	0.3	0.7	1.0	1.0	1.3	2.4
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	3,542	6,897	8,226	9,679	9,842	8,324
Number-unweighted (N)	579	1,187	1,488	1,908	1,879	1,550

Source(s): NSFG
 Year of survey: 1995

Table A7. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey and gender

Females Percent using each method at first intercourse	Respondent's age at survey							
	15-19			20-24	25-29	30-34	35-39	40-44
	Total	15-17	18-19					
Sterilization	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Oral contraceptives	8.0	6.6	9.2	16.6	20.2	21.2	21.7	22.2
IUD	0.0	0.0	0.0	0.0	0.0	0.1	0.2	0.5
Norplant	0.3	0.0	0.5	0.0	0.1	0.0	0.0	0.0
Depo Provera	0.2	0.2	0.2	0.0	0.0	0.0	0.0	0.0
Male condom	62.8	66.1	60.1	45.4	32.5	20.4	20.6	16.6
Diaphragm/Cap/f.condom	0.1	0.0	0.3	0.3	0.3	0.7	1.2	0.8
Foam/jelly/cream/suppository/sponge	0.1	0.0	0.1	0.6	0.8	1.9	1.1	1.5
Withdrawal	3.8	2.8	4.5	5.7	6.8	8.3	6.6	7.6
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.3	0.8	1.7	1.6	1.9
Other Methods	0.0	0.0	0.0	0.0	0.1	0.3	0.5	0.8
No Method	24.7	24.3	25.1	31.1	38.5	45.5	46.4	48.2
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	4,553	2,023	2,530	7,918	9,359	10,694	11,129	9,851
Number-unweighted (N)	743	324	419	1,364	1,682	2,110	2,123	1,836

Males Percent using each method at first intercourse	Respondent's age at survey							
	15-19			20-24	25-29	30-34	35-39	40-44
	Total	15-17	18-19					
Sterilization	0.3	0.0	0.6					
Oral contraceptives	9.6	10.1	9.3					
IUD	0.0	0.0	0.0					
Norplant	0.2	0.2	0.4					
Depo Provera	0.1	0.2	0.0					
Condoms	60.9	62.5	58.9					
Diaphragm, Cap, f.condom	0.1	0.2	0.0					
Foam/jelly/cream/suppository	0.1	0.2	0.0					
Withdrawal	2.4	1.2	3.5					
Rhythm (periodic abstinence)	0.1	0.0	0.2					
Other Methods	0.4	0.2	0.8					
No Method	25.7	25.1	26.1					
Total Percent	100%	100%	100%					
Adjusted Number (N)	907	427	482					
Number-unweighted (N)	970	537	433					

Source(s): NSFG, NSAM
Year of survey: 1995

Table A8. Percentage distribution according to current contraceptive method used by age of respondent at the survey and gender among those currently sexually active

Females Percent using each method	Respondent's age at survey							
	15-19			20-24	25-29	30-34	35-39	40-44
	Total	15-17	18-19					
Sterilization	0.3	0.7	0.0	3.6	15.9	27.5	36.9	44.1
Oral contraceptives	35.4	29.6	39.2	47.5	36.2	26.5	10.6	5.6
IUD	0.0	0.0	0.0	0.3	0.8	0.9	0.7	1.2
Norplant	1.8	1.6	1.9	3.5	1.9	0.5	0.3	0.1
Depo Provera	7.4	8.8	6.4	4.7	3.5	1.6	1.1	0.3
Condoms	28.5	28.8	28.3	24.3	22.6	17.3	16.1	12.2
Diaphragm/Cap/f.condom	0.0	0.0	0.0	0.7	1.0	2.3	3.1	2.5
Foam/jelly/cream/suppository/sponge	0.7	0.5	0.8	1.5	1.4	1.3	1.2	1.7
Withdrawal	3.4	2.8	3.7	3.3	3.4	2.9	3.0	1.8
Rhythm (periodic abstinence)	1.0	0.0	1.7	1.0	1.8	3.1	2.6	2.8
Other methods	0.0	0.0	0.0	1.1	4.6	10.2	18.4	20.8
No method used	21.6	27.1	17.9	8.6	6.9	5.9	6.0	6.9
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	3,028	1,225	1,803	5,950	6,739	8,125	8,297	7,025
Number-unweighted (N)	496	194	302	1,019	1,230	1,600	1,583	1,306

Males Percent using each method	Respondent's age at survey							
	15-19			20-24	25-29	30-34	35-39	40-44
	Total	15-17	18-19					
Sterilization	0.6	0.0	1.0					
Oral contraceptives	31.3	25.5	35.6					
IUD	0.0	0.0	0.0					
Norplant	2.0	2.5	1.7					
Depo Provera	1.4	0.5	2.1					
Condoms	42.0	49.0	37.4					
Diaphragm/Cap/f.condom	0.0	0.0	0.0					
Foam/jelly/cream/suppository	0.4	1.0	0.0					
Withdrawal	1.8	1.5	1.7					
Rhythm (periodic abstinence)	0.2	0.5	0.0					
Other Methods	0.6	1.0	0.0					
No method used	19.6	18.6	20.4					
Total Percent	100%	100%	100%					
Adjusted Number (N)	495	204	289					
Number-unweighted (N)	558	274	284					

Source(s): NSFG, NSAM
 Year of survey: 1995

TableA9. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey (15-19 and 20-24), gender and socioeconomic variables

Females Percent who first had intercourse at age:	Variable name: Level of Education									
	High School Incomp.		High School		College Incomplete		College 4+			
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>			
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	15-19 N/A	20-24
<13	3.0	6.0	1.7	2.1	0.0	1.2				0.0
13	6.3	12.4	2.8	6.4	1.9	2.4				0.9
14	11.8	15.3	8.5	8.8	4.6	5.4				1.7
15	12.1	17.0	15.2	16.9	12.8	12.1				9.1
16	9.6	22.7	18.7	20.9	14.1	17.3				15.7
17	2.2	10.1	13.9	16.4	12.4	17.0				18.3
18	0.5	7.5	7.7	9.8	11.7	10.3				12.1
19	0.2	4.2	1.0	7.6	6.5	8.6				7.5
20		2.5		2.8		5.4				6.1
21 or older		1.3		2.2		3.3				12.7
Never had intercourse	54.2	0.9	30.4	6.0	36.1	16.9				16.0
Total Percent	100%	100%	100%	100%	100%	100%				100%
Number-weighted (N) in 000's	6,659	1,243	1,482	2,900	783	3,434				1,369
Number-unweighted (N)	1,032	263	246	492	118	560				203

Males Percent who first had intercourse at age:	Variable name: Level of Education							
	High School Incomp.		High School		College Incomplete		College 4+	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<13	4.0		5.0		1.2		0.0	
13	7.5		4.3		3.5		0.0	
14	10.2		11.7		4.7		100.0	
15	11.4		14.2		20.9		0.0	
16	11.1		16.4		14.0		0.0	
17	3.9		14.2		14.0		0.0	
18	1.5		11.7		9.3		0.0	
19	0.1		0.0		0.0		0.0	
20								
21 or older								
Never had intercourse	50.4		22.4		32.6		0.0	
Total Percent	100%		100%		100%		100%	
Adjusted Number (N)	1,348		281		86		4	
Number-unweighted (N)	1,414		245		56		1	

Table A9. Age at First Intercourse continued

Females Percent who first had intercourse at age:	Variable name: Marital Status							
	Married		Cohabiting		Formerly Married		Never Married	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<13	7.5	1.9	5.0	4.9	15.8	2.2	2.1	1.4
13	10.3	4.6	6.6	7.0	22.0	15.7	5.0	3.4
14	11.6	11.1	20.0	10.8	12.6	12.4	10.1	4.1
15	26.5	15.0	25.5	15.4	23.8	18.3	11.4	12.6
16	32.6	24.1	28.6	20.4	25.8	20.0	9.7	16.0
17	2.3	15.0	12.7	16.1	0.0	18.4	4.8	16.4
18	7.0	7.6	1.5	12.2	0.0	5.7	2.6	11.3
19	2.2	9.1	0.0	7.1	0.0	2.7	0.9	7.3
20		6.2		2.4		2.0		3.9
21 or older		5.3		3.8		2.6		3.7
Never had intercourse	0.0	0.0	0.0	0.0	0.0	0.0	53.4	19.9
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	358	2,506	374	1,000	50	492	8,142	4,948
Number-unweighted (N)	45	378	59	175	6	78	1,286	887

Males Percent who first had intercourse at age:	Variable name: Marital Status							
	Married		Cohabiting		Formerly Married		Never Married	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<13	11.5						3.9	
13	15.4						6.6	
14	7.7						10.4	
15	19.2						12.3	
16	23.1						11.9	
17	23.1						5.8	
18	0.0						3.5	
19	0.0						0.1	
20								
21 or older								
Never had intercourse	0.0						45.5	
Total Percent	100%						100%	
Adjusted Number (N)	26						1,700	
Number-unweighted (N)	19						1,705	

Table A9. Age at First Intercourse continued

Females Percent who first had intercourse at age:	Variable name: Grouped Religion								
	None		Protestant		Catholic		Other		
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	
<13	2.5	3.5	2.3	1.8	2.3	1.4	6.3	2.3	
13	9.3	4.8	4.6	5.7	4.9	2.9	3.8	6.6	
14	19.7	9.7	9.2	7.8	8.9	5.8	9.1	2.7	
15	15.2	14.5	13.5	14.5	10.9	13.1	6.1	10.2	
16	14.1	21.6	11.5	18.7	12.1	18.7	1.1	16.0	
17	5.6	12.5	4.1	16.6	7.4	16.7	0.6	17.9	
18	4.5	8.3	2.3	10.6	2.8	10.9	1.5	5.9	
19	0.8	8.9	1.0	6.8	0.6	8.5	1.6	6.2	
20		3.9		3.8		4.4		8.9	
21 or older		3.4		3.5		5.4		5.8	
Never had intercourse	28.4	8.9	51.4	10.3	50.2	12.3	70.0	17.5	
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%	
Number-weighted (N) in 000's	1,291	1,363	4,840	4,657	2,347	2,434	446	493	
Number-unweighted (N)	200	220	750	810	381	415	65	73	

Males Percent who first had intercourse at age:	Variable name: Grouped Religion								
	None		Protestant		Catholic		Other		
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	
<13	4.7		4.5		2.2		3.6		
13	9.5		6.3		6.4		5.4		
14	11.5		10.0		10.3		10.7		
15	15.0		12.0		10.3		19.6		
16	13.8		10.0		16.7		7.1		
17	7.9		6.4		4.2		0.0		
18	4.0		3.9		1.7		7.1		
19	0.4		0.0		0.0		0.0		
20									
21 or older									
Never had intercourse	33.2		46.7		48.2		46.4		
Total Percent	100%		100%		100%		100%		
Adjusted Number (N)	253		996		407		56		
Number-unweighted (N)	225		917		522		44		

Table A9. Age at First Intercourse continued

Females Percent who first had intercourse at age:	Variable name: Poverty Level					
	0-149%		150-299%		300+%	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24
<13	4.1	3.0	2.7	1.8	1.3	1.3
13	9.0	5.5	5.8	5.3	2.3	3.6
14	13.1	7.8	11.1	8.5	8.4	5.6
15	13.7	16.4	12.1	13.7	12.6	11.8
16	11.5	16.9	11.2	19.2	11.8	20.7
17	5.3	15.0	3.8	15.4	6.1	17.8
18	2.9	11.4	1.7	7.4	3.6	11.7
19	1.2	7.5	0.7	7.2	0.8	7.9
20		2.9		5.6		4.1
21 or older		2.2		4.7		5.3
Never had intercourse	39.1	11.4	50.9	11.4	53.2	10.3
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,300	2,793	3,406	3,203	3,217	2,951
Number-unweighted (N)	384	538	528	516	484	464

Males Percent who first had intercourse at age:	Variable name: Income					
	\$0-20,000		\$20,001-40,000		>\$40,001	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24
<13	8.2		3.3		2.0	
13	7.6		7.8		5.1	
14	13.9		9.3		8.7	
15	12.5		11.3		14.3	
16	10.9		15.1		10.9	
17	4.6		4.8		8.3	
18	1.6		3.5		4.5	
19	0.0		0.2		0.0	
20						
21 or older						
Never had intercourse	40.8		44.8		46.2	
Total Percent	100%		100%		100%	
Adjusted Number (N)	368		603		663	
Number-unweighted (N)	550		590		469	

Table A9. Age at First Intercourse continued

Females Percent who first had intercourse at age:	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<13	3.1	1.0	5.2	2.4	2.0	2.0	0.0	3.0
13	7.6	3.5	8.4	7.7	4.3	4.5	4.1	4.5
14	11.9	7.2	15.2	11.4	9.9	6.3	2.1	8.1
15	15.0	13.3	16.9	14.7	11.7	14.5	6.6	5.1
16	11.4	12.7	8.6	17.4	12.4	20.8	8.4	15.5
17	5.0	11.4	2.6	21.2	5.9	16.5	1.2	8.1
18	2.1	14.9	1.5	10.1	3.2	9.2	1.2	9.4
19	0.0	10.2	2.0	4.3	0.9	7.3	0.0	12.3
20		6.9		3.2		4.0		4.8
21 or older		5.8		1.4		4.3		5.3
Never had intercourse	44.0	13.0	39.6	6.1	49.6	10.7	76.5	23.8
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,140	1,145	1,395	1,304	5,926	6,022	463	476
Number-unweighted (N)	210	256	289	354	842	846	55	62

Males Percent who first had intercourse at age:	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<13	4.6		13.9		2.1		0.0	
13	8.3		13.5		5.2		6.2	
14	14.7		22.4		6.6		15.5	
15	12.4		14.7		12.0		10.3	
16	12.4		10.6		12.8		7.2	
17	7.3		4.1		6.8		0.0	
18	0.9		1.2		4.4		4.1	
19	0.5		0.0		0.0		0.0	
20								
21 or older								
Never had intercourse	39.0		19.6		50.1		56.7	
Total Percent	100%		100%		100%		100%	
Adjusted Number (N)	218		245		1,165		97	
Number-unweighted (N)	556		492		618		58	

Table A9. Age at First Intercourse continued

Females Percent who first had intercourse at age:	Variable name: Region								
	Northeast		Midwest		South		West		
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	
<13	1.4	0.4	2.7	3.9	3.5	2.1	1.9	0.6	
13	7.3	6.3	2.6	2.6	6.4	4.7	4.7	6.8	
14	11.3	6.7	10.2	7.7	10.4	7.0	10.7	7.5	
15	13.9	13.8	13.6	13.1	12.0	15.4	11.9	12.8	
16	11.3	15.8	10.9	19.9	14.5	20.1	7.6	18.3	
17	5.4	17.6	7.2	20.5	2.7	16.3	6.2	9.0	
18	1.9	11.3	2.8	9.6	2.4	8.7	3.6	11.6	
19	1.2	7.1	1.4	7.7	0.2	6.7	1.1	8.7	
20		5.4		4.0		4.2		4.0	
21 or older		3.9		3.6		4.5		4.2	
Never had intercourse	46.1	11.7	48.4	7.3	47.9	10.1	52.4	16.5	
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%	
Number-weighted (N) in 000's	1,717	1,415	2,005	2,560	3,139	2,947	2,063	2,024	
Number-unweighted (N)	273	246	319	425	489	518	315	329	

Females Percent who first had intercourse at age:	Variable name: Metro					
	MSA - Central City		MSA-Other		Not MSA	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24
<13	3.4	2.1	1.6	2.1	3.1	1.6
13	7.8	3.8	4.0	5.8	4.4	4.4
14	12.1	7.3	10.4	7.1	9.0	7.6
15	13.5	14.6	11.6	13.0	13.6	14.6
16	11.3	17.5	10.8	18.8	12.9	22.0
17	4.8	16.2	5.4	16.4	4.6	15.0
18	1.9	10.4	2.7	8.6	3.9	12.7
19	1.4	8.7	0.9	6.6	0.2	7.4
20		4.8		4.0		4.0
21 or older		4.2		5.0		1.9
Never had intercourse	43.8	10.2	52.6	12.5	48.2	8.8
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,900	3,096	3,911	4,085	2,112	1,765
Number-unweighted (N)	490	588	592	644	314	286

Table A9. Age at First Intercourse continued

Females Percent who first had intercourse at age:	Variable name:		Immigrant Status	
	US Born		Foreign Born	
	<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24
<13	2.6	2.1	1.8	1.0
13	5.4	5.0	4.7	3.4
14	11.1	7.5	3.7	5.0
15	13.0	14.2	7.6	10.6
16	11.3	19.6	14.8	13.2
17	5.1	16.4	4.1	13.2
18	2.8	9.9	1.2	11.5
19	0.9	7.0	0.0	12.2
20		4.0		6.8
21 or older		3.9		6.3
Never had intercourse	47.8	10.4	62.1	16.9
Total Percent	100%	100%	100%	100%
Number-weighted (N) in 000's	8,383	8,095	541	852
Number-unweighted (N)	1,316	1,367	80	151

Males Percent who first had intercourse at age:	Variable name:		Immigrant Status	
	US Born		Foreign Born	
	<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24
<13	3.8		6.1	
13	7.1		3.9	
14	10.3		10.6	
15	12.7		8.9	
16	12.6		7.8	
17	6.1		6.1	
18	3.4		4.5	
19	0.1		0.0	
20				
21 or older				
Never had intercourse	43.9		52.0	
Total Percent	100%		100%	
Adjusted Number (N)	1,546		179	
Number-unweighted (N)	1,488		236	

Table A9. Age at First Intercourse continued

Females Percent who first had intercourse at age:	Variable name: School Status								
	Working and school		In school only		Employed only		Neither		
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	
<13	1.9	1.2	2.0	1.9	3.2	1.7	6.7	6.7	3.6
13	3.4	2.9	4.7	2.6	6.5	5.1	13.8	13.8	7.5
14	7.2	4.0	10.8	4.2	11.0	8.4	20.7	20.7	9.8
15	11.7	11.7	11.8	9.0	15.2	13.7	17.6	17.6	19.6
16	14.0	13.9	6.1	18.4	24.9	21.4	15.3	15.3	18.8
17	7.8	13.7	2.1	15.9	8.3	16.2	7.6	7.6	18.3
18	2.4	15.2	1.8	9.5	6.1	8.3	4.2	4.2	9.2
19	0.9	8.2	0.8	8.8	1.0	7.8	0.9	0.9	5.4
20		4.7		2.4		4.9			3.4
21 or older		3.5		4.8		5.4			1.3
Never had intercourse	50.8	21.1	59.8	22.6	23.7	7.2	13.0	13.0	3.2
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,733	1,868	4,374	998	999	4,305	818	818	1,776
Number-unweighted (N)	417	301	679	161	161	713	139	139	343

Males Percent who first had intercourse at age:	Variable name: School Status								
	Working and school		In school only		Employed only		Neither		
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	
<13	2.5		4.3		2.8		9.5	9.5	
13	5.8		6.4		7.4		10.2	10.2	
14	10.1		11.0		8.4		10.9	10.9	
15	12.5		9.1		25.1		11.7	11.7	
16	13.0		8.6		20.5		14.6	14.6	
17	5.2		4.0		8.8		18.2	18.2	
18	4.5		2.0		5.6		4.4	4.4	
19	0.2		0.0		0.0		0.7	0.7	
20									
21 or older									
Never had intercourse	46.2		54.6		21.4		19.7	19.7	
Total Percent	100%		100%		100%		100%	100%	
Adjusted Number (N)	554		810		215		137	137	
Number-unweighted (N)	506		908		167		136	136	

Source(s): NSFG, NSAM
 Year of survey: 1995

Table A10. Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey (15-19 and 20-24) and socioeconomic variables

Females Percent whose first birth was at age:	Variable name: Education Level							
	High School Incomp.		High School Comp.		College Incomp.		College 4+	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	0.6	3.0	0.3	1.4	0.0	0.0	n/a	0.0
15	1.4	6.0	0.5	1.7	0.0	0.9	n/a	0.0
16	1.3	11.4	1.5	2.8	0.0	1.8	n/a	0.0
17	3.6	13.8	2.0	3.2	1.0	0.7	n/a	0.3
18	1.4	14.5	5.5	6.9	0.0	2.2	n/a	0.0
19	0.1	17.5	1.1	11.8	1.6	3.6	n/a	0.4
20		6.4		8.6		3.4	n/a	0.4
21 or older		10.9		13.9		4.9	n/a	5.3
Never had a birth	91.5	16.5	89.1	49.7	97.3	82.6	n/a	93.6
Total Percent	100%	100%	100%	100%	100%	100%		100%
Number-weighted (N) in 000's	6,659	1,243	1,482	2,900	783	3,434		1,369
Number-unweighted (N)	1,032	263	246	492	118	560		203

Females Percent whose first birth was at age:	Variable name: Marital Status							
	Married		Cohabiting		Formerly Married		Never Married	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	0.0	1.6	1.8	0.5	0.0	0.6	0.4	0.6
15	3.4	2.5	4.1	2.9	5.8	1.5	0.8	1.1
16	5.7	3.5	3.2	4.8	0.0	11.9	1.0	1.8
17	20.0	5.0	14.6	4.4	52.2	9.5	1.5	1.5
18	16.8	7.5	3.2	7.1	25.8	2.9	1.1	3.7
19	3.4	12.4	2.8	10.3	0.0	18.8	0.2	3.7
20		9.2		3.1		11.7		2.6
21 or older		18.9		7.8		11.1		3.5
Never had a birth	50.7	39.4	70.2	58.9	16.2	32.0	94.9	81.4
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	358	2,506	374	1,000	50	492	8,142	4,948
Number-unweighted (N)	45	378	59	175	6	78	1,286	887

Females Percent whose first birth was at age:	Variable name: Grouped Religion							
	None		Protestant		Catholic		Other	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	0.4	0.0	0.3	1.2	0.7	0.5	1.8	1.8
15	1.8	1.4	1.0	1.9	1.0	2.0	1.0	0.0
16	1.9	3.9	1.2	3.3	1.1	2.6	0.0	2.4
17	2.7	4.9	3.7	3.0	2.5	3.5	1.0	0.5
18	1.8	4.9	2.2	5.3	2.0	5.2	0.5	2.9
19	0.4	8.7	0.4	7.0	0.4	8.4	1.1	8.3
20		1.3		6.0		5.4		4.5
21 or older		7.0		9.7		7.4		11.0
Never had a birth	91.0	67.9	91.2	62.7	92.4	65.0	94.7	68.6
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,291	1,363	4,840	4,657	2,347	2,434	446	493
Number-unweighted (N)	200	220	750	810	381	415	65	73

Table A10. Age at First Birth continued

Females Percent whose first birth was at age:	Variable name: Poverty Status					
	0-149%		150-299%		300+%	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
<15	1.1	1.7	0.5	0.8	0.0	0.2
15	2.6	3.0	0.9	1.4	0.3	0.8
16	3.2	5.9	0.8	2.1	0.3	1.8
17	7.1	7.5	2.3	2.0	1.1	0.6
18	4.6	7.8	1.6	5.6	0.5	2.0
19	0.5	13.8	0.7	7.6	0.1	2.0
20		6.3		6.0		2.7
21 or older		7.9		13.1		4.8
Never had a birth	81.0	46.0	93.2	61.3	97.6	85.2
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,300	2,792	3,406	3,203	3,217	2,951
Number-unweighted (N)	384	538	528	516	484	464

Females Percent whose first birth was at age:	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	1.5	0.3	1.5	2.7	0.0	0.6	1.1	0.7
15	3.1	2.6	3.3	3.1	0.2	1.1	1.0	4.6
16	1.2	2.7	2.9	8.4	1.0	2.2	0.0	1.8
17	5.7	6.2	7.3	5.7	1.9	2.2	0.0	3.0
18	1.5	6.6	3.6	10.9	1.8	3.8	1.0	1.7
19	0.0	14.5	0.0	6.1	0.6	6.9	0.0	6.2
20		7.8		4.9		4.5		5.7
21 or older		10.2		9.1		8.7		4.7
Never had a birth	87.1	49.0	81.4	49.3	94.5	70.1	96.9	71.7
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,140	1,145	1,395	1,304	5,926	6,022	463	476
Number-unweighted (N)	210	256	289	354	842	846	55	62

Females Percent whose first birth was at age:	Variable name: Region							
	Northeast		Midwest		South		West	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	0.4	0.2	0.3	0.6	0.6	1.9	0.6	0.2
15	1.1	1.0	1.3	2.9	1.0	1.8	1.2	0.7
16	0.9	2.5	1.7	3.1	1.6	3.5	0.6	3.3
17	0.9	1.8	3.0	3.8	5.1	3.4	2.0	3.4
18	1.2	5.5	2.3	4.5	2.1	5.2	2.1	5.4
19	0.4	4.8	0.7	7.6	0.5	7.6	0.0	10.0
20		4.1		5.4		5.4		4.7
21 or older		7.9		9.7		9.2		7.5
Never had a birth	95.1	72.2	90.7	62.5	89.1	62.1	93.6	64.9
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,717	1,415	2,005	2,560	3,139	2,947	2,063	2,024
Number-unweighted (N)	273	246	319	425	489	518	315	329

Table A10. Age at First Birth continued

Females Percent whose first birth was at age:	Variable name: Metro					
	MSA-Central City		MSA-Other		Not MSA	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
<15	1.0	0.8	0.2	0.8	0.2	1.1
15	1.7	2.4	0.8	1.2	0.9	1.8
16	2.0	3.7	1.0	3.4	0.7	1.5
17	5.3	4.4	1.6	3.2	2.9	1.6
18	1.8	5.2	2.0	5.0	2.2	4.9
19	0.2	8.7	0.6	6.4	0.4	8.9
20		5.2		4.3		6.4
21 or older		9.9		5.6		13.9
Never had a birth	88.0	59.7	93.8	70.0	92.6	59.9
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,900	3,096	3,911	4,085	2,112	1,765
Number-unweighted (N)	490	588	592	644	314	286

Females Percent whose first birth was at age:	Variable name: Immigrant Status			
	US Born		Foreign Born	
	Age at survey		Age at survey	
	15-19	20-24	15-19	20-24
<15	0.4	0.9	0.8	0.4
15	1.1	1.7	1.7	2.3
16	1.3	3.2	0.6	2.9
17	2.7	3.3	10.1	2.8
18	2.0	4.8	1.1	7.4
19	0.5	7.1	0.0	12.9
20		4.9		6.3
21 or older		8.9		6.9
Never had birth	92.0	65.1	85.6	58.0
Total Percent	100%	100%	100%	100%
Number-weighted (N) in 000's	8,383	8,095	541	852
Number-unweighted (N)	1316	1367	80	151

Females Percent whose first birth was at age:	Variable name: School Status							
	Working and school		In school only		Employed only		Neither	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	0.2	0.0	0.4	0.3	0.7	0.7	1.4	2.6
15	0.4	0.6	1.0	1.2	1.5	1.7	3.5	3.2
16	0.6	0.7	0.7	3.8	2.4	2.9	4.9	6.0
17	0.7	0.4	1.2	2.4	8.6	2.5	14.7	8.7
18	0.2	1.5	0.6	3.7	4.8	4.4	11.8	11.3
19	0.6	1.9	0.0	5.6	0.9	7.9	1.5	14.3
20		1.9		1.8		3.7		13.4
21 or older		1.4		1.3		11.3		14.3
Never had a birth	97.3	91.5	96.0	80.0	81.2	64.8	62.2	26.2
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,733	1,868	4,374	998	999	4,305	818	1,776
Number-unweighted (N)	417	301	679	161	161	713	139	343

Source(s): NSFG
 Year of survey: 1995

Table A11. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables among those ever sexually active

Females	Variable name:		Education Level					
	High School Incomp.		High School Comp.		College Incomp.		College 4+	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0	0.0	0.0	0.0	0.0	0.0	n/a	0.0
Oral contraceptives	8.0	15.6	6.9	19.0	10.5	15.6		14.4
IUD	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Norplant	0.4	0.0	0.0	0.0	0.0	0.0		0.0
Depo Provera	0.1	0.0	0.6	0.0	0.0	0.0		0.0
Male condom	60.6	21.2	65.3	40.1	70.3	53.2		65.0
Diaphragm/Cap/f.condom	0.2	0.0	0.0	0.0	0.0	0.4		1.0
Foam/jelly/cream/suppository/sponge	0.0	0.7	0.3	1.1	0.0	0.2		0.0
Withdrawal	2.9	3.1	6.9	5.5	2.3	7.0		5.8
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.5	0.0	0.2		0.2
Other Methods	0.0	0.0	0.0	0.0	0.0	0.0		0.0
No Method	27.7	59.4	20.0	33.7	16.9	23.4		13.6
Total Percent	100%	100%	100%	100%	100%	100%		100%
Number-weighted (N) in 000's	3,022	1,233	1,031	2,703	500	2,844		1,138
Number-unweighted (N)	492	260	174	458	77	473		173

Males	Variable name:		Education Level					
	High School Incomp.		High School Comp.		College Incomp.		College 4+	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.5		0.0		0.0		0.0	
Oral contraceptives	10.8		7.5		5.2		0.0	
IUD	0.0		0.0		0.0		0.0	
Norplant	0.2		0.0		1.7		0.0	
Depo Provera	0.2		0.0		0.0		0.0	
Male condom	57.1		67.1		74.1		100.0	
Diaphragm/Cap/f.condom	0.2		0.0		0.0		0.0	
Foam/jelly/cream/suppository	0.2		0.5		0.0		0.0	
Withdrawal	1.9		3.3		5.2		0.0	
Rhythm (periodic abstinence)	0.0		0.5		0.0		0.0	
Other Methods	0.2		0.0		5.2		0.0	
No Method	28.9		21.1		8.6		0.0	
Total Percent	100%		100%		100%		100%	
Adjusted Number (N)	630		213		58		4	
Number-unweighted (N)	742		187		37		1	

Table A11. Contraceptive Method Used at First Intercourse continued

Females	Variable name: Marital Status								
	Married		Cohabiting		Formerly Married		Never Married		
	Age at survey		Age at survey		Age at survey		Age at survey		
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	
Sterilization	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Oral contraceptives	12.7	19.9	13.1	19.0	0.0	26.5	7.2	12.6	
IUD	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Norplant	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0	
Depo Provera	1.6	0.0	0.0	0.0	0.0	0.0	0.1	0.0	
Male condom	51.5	35.3	49.2	39.9	12.6	23.5	65.9	56.1	
Diaphragm/Cap/f.condom	0.0	0.8	0.0	0.0	0.0	0.0	0.2	0.1	
Foam/jelly/cream/suppository/sponge	0.0	1.0	0.0	1.3	0.0	0.0	0.1	0.2	
Withdrawal	1.8	6.4	1.3	4.2	0.0	7.3	4.2	5.4	
Rhythm (periodic abstinence)	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.5	
Other Method	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
No Method	32.4	36.5	36.5	35.6	87.4	42.7	22.0	25.1	
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	358	2,506	374	1,000	50	492	3,772	3,919	
Number-unweighted (N)	45	378	59	175	6	78	633	733	

Males	Variable name: Marital Status					
	Married				Never Married	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	12.0				0.0	
Oral contraceptives	4.0				9.8	
IUD	0.0				0.0	
Norplant	0.0				0.2	
Depo Provera	0.0				0.1	
Male condom	32.0				61.7	
Diaphragm/Cap/f.condom	0.0				0.1	
Foam/jelly/cream/suppository	0.0				0.1	
Withdrawal	0.0				2.5	
Rhythm (periodic abstinence)	0.0				0.1	
Other Methods	0.0				0.5	
No Method	52.0				24.9	
Total Percent	100%				100%	
Adjusted Number (N)	25				881	
Number-unweighted (N)	19				951	

Table A11. Contraceptive Method Used at First Intercourse continued

Females	Variable name: Grouped Religion							
	None		Protestant		Catholic		Other	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Oral contraceptives	6.4	18.1	10.0	18.4	5.8	13.1	4.4	11.1
IUD	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Norplant	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0
Depo Provera	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.0
Male condom	64.5	39.6	62.2	43.4	64.1	51.1	49.5	54.6
Diaphragm/Cap/f.condom	0.0	0.2	0.0	0.5	0.6	0.0	0.0	0.0
Foam/jelly/cream/suppository/sponge	0.0	1.3	0.1	0.6	0.0	0.2	0.0	0.0
Withdrawal	3.2	7.1	3.9	5.8	3.2	4.3	9.4	7.7
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.3	0.0	0.4	0.0	0.0
Other Methods	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
No Method	25.9	33.6	22.8	30.9	26.4	31.0	36.7	26.6
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	923	1,232	2,342	4,160	1,155	2,125	134	400
Number-unweighted (N)	140	202	381	734	198	368	24	60

Males	Variable name: Grouped Religion							
	None		Protestant		Catholic		Other	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0		0.6		0.0		0.0	
Oral contraceptives	13.7		10.0		6.8		3.3	
IUD	0.0		0.0		0.0		0.0	
Norplant	0.0		0.2		1.0		0.0	
Depo Provera	0.0		0.0		0.5		0.0	
Male condom	54.0		63.7		60.0		56.7	
Diaphragm/Cap/f.condom	0.0		0.0		0.0		0.0	
Foam/jelly/cream/suppository	0.0		0.2		0.0		0.0	
Withdrawal	1.9		2.6		2.4		3.3	
Rhythm (periodic abstinence)	0.0		0.2		0.0		0.0	
Other Methods	0.0		0.2		0.0		0.0	
No Method	30.4		22.3		29.3		36.7	
Total Percent	100%		100%		100%		100%	
Adjusted Number (N)	161		502		205		30	
Number-unweighted (N)	146		514		274		25	

Table A11. Contraceptive Method Used at First Intercourse continued

Females	Variable name: Poverty Level					
	0 - 149%		150 - 299%		300+%	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0	0.0	0.0	0.0	0.0	0.0
Oral contraceptives	7.4	14.3	8.3	18.3	8.3	17.0
IUD	0.0	0.0	0.0	0.0	0.0	0.0
Norplant	0.3	0.0	0.4	0.0	0.0	0.0
Depo Provera	0.4	0.0	0.2	0.0	0.0	0.0
Male condom	57.2	38.0	63.9	43.4	66.6	54.6
Diaphragm/Cap/f.condom	0.0	0.4	0.4	0.4	0.0	0.1
Foam/jelly/cream/suppository/sponge	0.2	0.3	0.0	0.6	0.0	0.8
Withdrawal	3.6	6.1	4.6	4.8	2.9	6.3
Rhythm (periodic abstinence)	0.0	0.6	0.0	0.3	0.0	0.0
Other Method	0.0	0.0	0.0	0.0	0.0	0.0
No Method	30.8	40.3	22.0	32.2	22.1	21.2
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,398	2,474	1,654	2,821	1,501	2,623
Number-unweighted (N)	241	486	266	463	236	415

Males	Variable name: Income					
	\$0-20,000		\$20,001-40,000		>\$40,001	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0		0.9		0.0	
Oral contraceptives	11.7		12.5		5.8	
IUD	0.0		0.0		0.0	
Norplant	0.5		0.0		0.3	
Depo Provera	0.0		0.0		0.3	
Male condom	53.4		59.6		67.8	
Diaphragm/Cap/f.condom	0.0		0.0		0.0	
Foam/jelly/cream/suppository	0.0		0.3		0.0	
Withdrawal	0.0		1.6		5.0	
Rhythm (periodic abstinence)	0.0		0.0		0.3	
Other Methods	0.5		0.0		0.0	
No Method	34.0		25.1		20.5	
Total Percent	100%		100%		100%	
Adjusted Number (N)	206		319		342	
Number-unweighted (N)	327		335		253	

Table A11. Contraceptive Method Used at First Intercourse continued

Females	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Oral contraceptives	2.1	13.0	13.9	17.2	7.9	17.3	0.0	14.6
IUD	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Norplant	0.0	0.0	0.6	0.0	0.2	0.0	0.0	0.0
Depo Provera	0.0	0.0	0.5	0.0	0.2	0.0	0.0	0.0
Male condom	48.8	25.7	48.8	35.8	70.1	52.5	49.7	28.8
Diaphragm/Cap/f.condom	1.1	0.0	0.0	0.4	0.0	0.4	0.0	0.0
Foam/jelly/cream/suppository/sponge	0.0	0.0	0.4	0.6	0.0	0.6	0.0	2.3
Withdrawal	4.8	5.3	4.0	2.6	2.6	5.8	27.1	16.8
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.9	0.0	0.1	0.0	1.5
Other method	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
No Method	43.2	56.1	31.8	42.5	18.9	23.5	23.3	36.0
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	623	997	842	1,223	2,979	5,336	109	362
Number-unweighted (N)	115	226	178	337	434	752	16	49

Males	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0		0.0		0.5		0.0	
Oral contraceptives	8.9		11.7		9.8		0.0	
IUD	0.0		0.0		0.0		0.0	
Norplant	0.8		0.0		0.2		0.0	
Depo Provera	0.0		0.5		0.0		0.0	
Male condom	50.0		50.0		66.9		58.8	
Diaphragm/Cap/f.condom	0.0		0.0		0.0		0.0	
Foam/jelly/cream/suppository	0.0		0.5		0.2		0.0	
Withdrawal	3.2		1.6		2.0		11.8	
Rhythm (periodic abstinence)	0.0		0.0		0.2		0.0	
Other Methods	0.0		0.5		0.5		0.0	
No Method	37.1		35.1		19.8		29.4	
Total Percent	100%		100%		100%		100%	
Adjusted Number (N)	124		188		562		34	
Number-unweighted (N)	314		361		277		18	

Table A11. Contraceptive Method Used at First Intercourse continued

Females Percent using each method at first intercourse	Variable name: Region							
	Northeast		Midwest		South		West	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Oral contraceptives	4.7	12.8	9.3	18.9	9.2	17.8	7.9	14.2
IUD	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Norplant	0.8	0.0	0.0	0.0	0.3	0.0	0.0	0.0
Depo Provera	0.0	0.0	0.0	0.0	0.2	0.0	0.6	0.0
Male condom	68.5	58.1	65.6	49.7	63.2	43.0	53.6	33.9
Diaphragm/Cap/f.condom	0.7	0.0	0.0	0.0	0.0	0.4	0.0	0.8
Foam/jelly/cream/suppository/sponge	0.0	0.9	0.0	0.6	0.0	0.8	0.3	0.0
Withdrawal	2.5	4.8	3.0	5.2	1.6	5.2	9.3	7.9
Rhythm (periodic abstinence)	0.0	0.2	0.0	0.6	0.0	0.0	0.0	0.3
Other Method	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
No Method	22.7	23.1	22.2	25.0	25.4	32.8	28.3	42.9
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	916	1,249	1,034	2,336	1,636	2,649	968	1,684
Number-unweighted (N)	155	219	171	390	261	473	156	282

Females Percent using each method at first intercourse	Variable name: Metro					
	MSA-Central City		MSA-Other		Not MSA	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0	0.0	0.0	0.0	0.0	0.0
Oral contraceptives	8.3	16.9	6.4	15.4	10.4	18.7
IUD	0.0	0.0	0.0	0.0	0.0	0.0
Norplant	0.0	0.0	0.4	0.0	0.4	0.0
Depo Provera	0.2	0.0	0.0	0.0	0.5	0.0
Male condom	54.9	39.6	69.0	49.8	64.1	45.9
Diaphragm/Cap/f.condom	0.4	0.9	0.0	0.0	0.0	0.0
Foam/jelly/cream/suppository/sponge	0.0	0.3	0.2	0.9	0.0	0.4
Withdrawal	3.7	5.7	4.3	6.3	3.0	4.4
Rhythm (periodic abstinence)	0.0	0.5	0.0	0.2	0.0	0.0
Other Methods	0.0	0.0	0.0	0.0	0.0	0.0
No Method	32.4	36.2	19.8	27.4	21.6	30.5
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,628	2,762	1,831	3,555	1,094	1,601
Number-unweighted (N)	282	538	295	567	166	259

Table A11. Contraceptive Method Used at First Intercourse continued

Females	Variable name:		Immigrant Status	
	US Born		Foreign Born	
	<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24
Sterilization	0.0	0.0	0.0	0.0
Oral contraceptives	8.2	17.4	3.9	8.5
IUD	0.0	0.0	0.0	0.0
Norplant	0.3	0.0	0.0	0.0
Depo Provera	0.2	0.0	0.0	0.0
Male condom	63.3	47.2	51.9	26.8
Diaphragm/Cap/f.condom	0.2	0.3	0.0	0.0
Foam/jelly/cream/suppository/sponge	0.1	0.5	0.0	1.2
Withdrawal	3.9	5.6	0.0	7.2
Rhythm (periodic abstinence)	0.0	0.3	0.0	0.3
Other Method	0.0	0.0	0.0	0.0
No Method	23.8	28.7	44.2	56.0
Total Percent	100%	100%	100%	100%
Number-weighted (N) in 000's	4,348	7,217	205	701
Number-unweighted (N)	709	1,236	34	128

Males	Variable name:		Immigrant Status	
	US Born		Foreign Born	
	<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24
Sterilization	0.4		0.0	
Oral contraceptives	10.2		3.7	
IUD	0.0		0.0	
Norplant	0.2		0.0	
Depo Provera	0.1		0.0	
Male condom	62.3		45.7	
Diaphragm/Cap/f.condom	0.0		0.0	
Foam/jelly/cream/suppository	0.1		0.0	
Withdrawal	1.9		8.6	
Rhythm (periodic abstinence)	0.1		0.0	
Other Methods	0.5		0.0	
No Method	24.1		42.0	
Total Percent	100%		100%	
Adjusted Number (N)	826		81	
Number-unweighted (N)	847		123	

Table A11. Contraceptive Method Used at First Intercourse continued

Females	Variable name:							
	School Status							
	Working and school		In school only		Employed only		Neither	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
Percent using each method at first intercourse	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Oral contraceptives	6.7	11.3	7.4	15.2	6.7	18.9	13.7	16.4
IUD	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Norplant	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Depo Provera	0.0	0.0	0.2	0.0	0.0	0.0	0.8	0.0
Male condom	70.6	61.6	65.0	49.0	60.1	45.1	45.0	30.8
Diaphragm/Cap/f.condom	0.0	0.0	0.0	1.1	0.0	0.4	0.9	0.0
Foam/jelly/cream/suppository/sponge	0.0	0.0	0.0	0.0	0.4	1.0	0.0	0.4
Withdrawal	4.2	5.8	3.4	5.8	4.8	6.0	2.5	4.9
Rhythm (periodic abstinence)	0.0	0.0	0.0	0.7	0.0	0.4	0.0	0.0
Other Method	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
No Method	17.6	21.2	23.9	28.2	27.9	28.3	37.0	47.5
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,346	1,474	1,742	763	762	3,971	703	1,710
Number-unweighted (N)	217	243	280	128	124	662	122	331

Males	Variable name:							
	School Status							
	Working and school		In school only		Employed only		Neither	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
Percent using each method at first intercourse	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0		0.0		1.8		0.0	
Oral contraceptives	9.9		9.1		11.4		7.9	
IUD	0.0		0.0		0.0		0.0	
Norplant	0.7		0.3		0.0		0.0	
Depo Provera	0.0		0.3		0.0		0.0	
Male condom	66.7		63.4		51.8		51.5	
Diaphragm/Cap/f.condom	0.0		0.3		0.0		0.0	
Foam/jelly/cream/suppository	0.0		0.0		0.0		1.0	
Withdrawal	3.5		0.9		4.2		1.0	
Rhythm (periodic abstinence)	0.4		0.0		0.0		0.0	
Other Method	0.4		0.0		0.0		3.0	
No Method	18.4		25.9		30.7		35.6	
Total Percent	100%		100%		100%		100%	
Adjusted Number (N)	282		352		166		101	
Number-unweighted (N)	292		431		129		114	

Source(s): NSFG, NSAM
 Year of survey: 1995

Table A12. Percentage distribution according to current contraceptive method used by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables among currently sexually active

Females	Variable name: Level of Education							
	High School Incomp.		High School Complete		College Incomplete		College 4+	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.4	14.1	0.0	2.8	0.0	1.4		0.0
Oral contraceptives	30.5	31.2	41.8	44.4	47.1	50.9		61.3
IUD	0.0	0.2	0.0	0.5	0.0	0.3		0.0
Norplant	2.9	8.5	0.0	3.7	0.0	2.1		1.3
Depo Provera	9.1	7.5	5.4	6.5	2.8	2.9		2.6
Condoms	27.8	24.2	28.3	22.6	32.7	25.2		26.0
Diaphragm/Cap/f.condom	0.0	0.0	0.0	0.8	0.0	0.8		1.3
Foam/jelly/cream/suppository/sponge	1.1	1.8	0.0	0.7	0.0	2.2		1.4
Withdrawal	3.2	2.6	4.7	3.1	1.5	4.3		1.9
Rhythm (periodic abstinence)	1.6	0.5	0.0	1.0	0.0	1.2		0.7
Other methods	0.0	2.2	0.0	1.7	0.0	0.4		0.0
No method used	23.5	7.3	19.7	12.3	15.9	8.1		3.5
Total Percent	100%	100%	100%	100%	100%	100%		100%
Number-weighted (N) in 000's	1,893	919	765	1,908	370	2,156		967
Number-unweighted (N)	309	193	130	326	57	351		149

Males	Variable name: Level of Education							
	High School Incomp.		High School Complete		College Incomplete		College 4+	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.6		0.9		0.0			0.0
Oral contraceptives	29.0		31.5		43.9			100.0
IUD	0.0		0.0		0.0			0.0
Norplant	2.7		0.9		0.0			0.0
Depo Provera	1.5		1.8		0.0			0.0
Condoms	44.0		42.3		31.7			0.0
Diaphragm/Cap/f.condom	0.0		0.0		0.0			0.0
Foam/jelly/cream/suppository	0.6		0.0		0.0			0.0
Withdrawal	1.2		1.8		4.9			0.0
Rhythm (periodic abstinence)	0.3		0.0		0.0			0.0
Other Methods	0.6		0.0		0.0			0.0
No method used	19.5		20.7		19.5			0.0
Total Percent	100%		100%		100%			100%
Adjusted Number (N)	334		111		41			4
Number-unweighted (N)	407		118		28			1

Table A12. Current Contraceptive Method Used continued

Females	Variable name:		Marital Status							
	Married		Cohabiting		Formerly Married		Never Married			
	Age at survey		Age at survey		Age at survey		Age at survey			
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24		
Sterilization	3.6	5.5	0.0	2.5	0.0	11.8	0.0	0.0	1.5	
Oral contraceptives	36.8	49.5	47.4	50.3	21.2	33.6	34.4	47.1		
IUD	0.0	0.9	0.0	0.2	0.0	0.0	0.0	0.0		
Norplant	4.9	3.3	4.2	4.6	7.6	6.0	1.2	3.0		
Depo Provera	18.2	5.6	14.3	6.4	0.0	2.8	5.9	3.9		
Condoms	17.7	18.1	18.7	24.2	0.0	15.8	30.8	29.5		
Diaphragm/Cap/f.condom	0.0	0.8	0.0	1.8	0.0	1.8	0.0	0.3		
Foam/jelly/cream/suppository/sponge	0.0	1.6	2.2	1.8	16.5	3.6	0.4	1.1		
Withdrawal	0.0	4.9	0.0	0.8	0.0	4.4	4.0	2.7		
Rhythm (periodic abstinence)	3.3	0.6	2.9	1.8	0.0	0.0	0.6	1.1		
Other methods	0.0	2.6	0.0	0.8	0.0	2.0	0.0	0.0		
No method used	15.5	6.6	10.3	4.9	54.7	18.2	22.7	9.7		
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%		
Number-weighted (N) in 000's	230	1,873	222	829	38	374	2,537	2,874		
Number-unweighted (N)	30	279	36	144	5	58	425	538		

Males	Variable name:		Marital Status							
	Married		Cohabiting		Formerly Married		Never Married			
	Age at survey		Age at survey		Age at survey		Age at survey			
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24		
Sterilization	0.0						0.6			
Oral contraceptives	60.0						30.0			
IUD	0.0						0.0			
Norplant	0.0						2.1			
Depo Provera	5.0						1.1			
Condoms	5.0						43.8			
Diaphragm/Cap/f.condom	0.0						0.0			
Foam/jelly/cream/suppository	0.0						0.4			
Withdrawal	0.0						1.9			
Rhythm (periodic abstinence)	0.0						0.2			
Other Methods	0.0						0.6			
No method used	30.0						19.2			
Total Percent	100%						100%			
Adjusted Number (N)	20						473			
Number-unweighted (N)	16						542			

Table A12. Current Contraceptive Method Used continued

Females	Variable name: Religion								
	None		Protestant		Catholic		Other		
	Age at survey		Age at survey		Age at survey		Age at survey		
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	
Sterilization	0.0	5.7	0.5	3.7	0.0	2.6	0.0	0.0	0.0
Oral contraceptives	34.9	39.5	37.4	51.8	33.4	46.6	14.3	32.9	
IUD	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	
Norplant	2.5	2.9	0.7	2.8	2.8	3.8	8.1	10.5	
Depo Provera	9.0	5.1	8.1	4.4	5.1	5.6	3.1	2.2	
Condoms	26.1	26.6	26.6	21.6	32.0	24.7	52.3	43.4	
Diaphragm/Cap/f.condom	0.0	1.8	0.0	0.7	0.0	0.4	0.0	0.0	
Foam/jelly/cream/suppository/sponge	0.0	1.5	1.1	2.0	0.4	0.9	0.0	0.0	
Withdrawal	1.0	2.8	3.9	3.1	4.2	4.0	0.0	2.2	
Rhythm (periodic abstinence)	0.0	2.2	1.2	0.7	1.5	0.8	0.0	0.0	
Other methods	0.0	0.7	0.0	1.4	0.0	0.5	0.0	1.5	
No method used	26.5	11.2	20.4	7.7	20.6	9.0	22.2	7.3	
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%	
Number-weighted (N) in 000's	565	978	1,614	3,068	779	1,615	71	290	
Number-unweighted (N)	90	160	261	541	131	277	14	41	

Males	Variable name: Religion								
	None		Protestant		Catholic		Other		
	Age at survey		Age at survey		Age at survey		Age at survey		
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	
Sterilization	2.3		0.4		0.0		0.0		
Oral contraceptives	29.9		32.4		30.2		27.3		
IUD	0.0		0.0		0.0		0.0		
Norplant	1.1		1.8		1.7		18.2		
Depo Provera	0.0		1.8		0.9		9.1		
Condoms	37.9		42.3		44.0		27.3		
Diaphragm/Cap/f.condom	0.0		0.0		0.0		0.0		
Foam/jelly/cream/suppository	2.3		0.4		0.0		0.0		
Withdrawal	2.3		2.1		0.9		0.0		
Rhythm (periodic abstinence)	0.0		0.4		0.0		0.0		
Other Methods	0.0		0.0		2.6		0.0		
No method used	24.1		18.5		19.8		18.2		
Total Percent	100%		100%		100%		100%		
Adjusted Number (N)	87		281		116		11		
Number-unweighted (N)	92		292		155		13		

Table A12. Current Contraceptive Method Used continued

Females	Variable name: Poverty Level					
	0 - 149%		150 - 299%		300+%	
	Percent using each method					
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0	8.5	0.8	2.1	0.0	0.5
Oral contraceptives	33.5	43.1	34.8	46.4	37.5	52.6
IUD	0.0	0.5	0.0	0.5	0.0	0.0
Norplant	4.3	4.4	0.0	3.4	1.4	2.7
Depo Provera	12.6	4.9	6.2	6.1	4.1	3.1
Condoms	30.1	19.6	25.2	26.1	30.4	26.8
Diaphragm/Cap/f.condom	0.0	0.0	0.0	1.0	0.0	1.1
Foam/jelly/cream/suppository/sponge	1.4	1.3	0.0	1.6	0.7	1.7
Withdrawal	1.2	3.6	6.1	2.8	2.6	3.4
Rhythm (periodic abstinence)	0.0	1.1	1.1	0.8	1.8	1.0
Other method	0.0	0.8	0.0	0.8	0.0	1.6
No method used	16.9	12.3	25.9	8.3	21.5	5.5
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	919	1,841	1,047	2,083	1,062	2,026
Number-unweighted (N)	155	356	170	342	171	321

Males	Variable name: Income					
	\$0-20,000		\$20,001-40,000		>\$40,001+	
	Percent using each method					
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	1.0		0.0		1.1	
Oral contraceptives	23.8		32.8		35.6	
IUD	0.0		0.0		0.0	
Norplant	3.8		2.8		0.0	
Depo Provera	1.9		1.7		0.5	
Condoms	31.4		46.9		43.1	
Diaphragm/Cap/f.condom	0.0		0.0		0.0	
Foam/jelly/cream/suppository	0.0		0.0		1.1	
Withdrawal	1.0		0.0		3.7	
Rhythm (periodic abstinence)	0.0		0.0		0.5	
Other Methods	0.0		0.0		0.0	
No method used	37.1		15.8		14.4	
Total Percent	100%		100%		100%	
Adjusted Number (N)	105		177		188	
Number-unweighted (N)	168		201		158	

Table A12. Current Contraceptive Method Used continued

Females	Variable name: Race and Ethnicity								
	Hispanic		Black-NH		White-NH		Other-NH		
	Age at survey		Age at survey		Age at survey		Age at survey		
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	
Sterilization	0.0	4.3	0.0	6.5	0.0	2.8	12.7	2.3	
Oral contraceptives	28.0	36.5	22.1	39.1	40.7	51.8	18.2	37.1	
IUD	0.0	1.5	0.0	0.2	0.0	0.2	0.0	0.0	
Norplant	6.2	5.9	2.6	4.7	0.8	2.6	0.0	6.4	
Depo Provera	10.0	5.2	13.3	6.3	5.6	4.3	0.0	4.0	
Condoms	25.0	24.1	32.7	30.4	28.2	22.1	25.0	37.8	
Diaphragm/Cap/f.condom	0.0	0.0	0.0	0.6	0.0	1.0	0.0	0.0	
Foam/jelly/cream/suppository/sponge	0.8	0.5	1.2	1.5	0.5	1.8	0.0	0.0	
Withdrawal	2.0	3.1	1.4	1.5	3.6	3.6	21.1	3.8	
Rhythm (periodic abstinence)	1.8	1.1	2.0	0.0	0.6	1.1	0.0	2.4	
Other method	0.0	0.7	0.0	0.2	0.0	1.4	0.0	0.0	
No method used	26.2	17.1	24.6	9.0	20.0	7.3	22.9	6.3	
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%	
Number-weighted (N) in 000's	362	647	544	935	2,058	4,094	64	275	
Number-unweighted (N)	71	152	113	254	302	577	10	36	

Males	Variable name: Race and Ethnicity								
	Hispanic		Black-NH		White-NH		Other-NH		
	Age at survey		Age at survey		Age at survey		Age at survey		
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	
Sterilization	0.0		0.8		0.7		0.0		
Oral contraceptives	17.8		25.2		39.4		11.5		
IUD	0.0		0.0		0.0		0.0		
Norplant	2.7		3.4		1.1		7.7		
Depo Provera	1.4		3.4		0.7		0.0		
Condoms	46.6		47.1		38.6		42.3		
Diaphragm/Cap/f.condom	0.0		0.0		0.0		0.0		
Foam/jelly/cream/suppository	0.0		0.0		0.7		0.0		
Withdrawal	1.4		0.0		2.5		0.0		
Rhythm (periodic abstinence)	0.0		0.0		0.4		0.0		
Other Methods	0.0		0.0		0.7		0.0		
No method used	30.1		20.2		15.2		38.5		
Total Percent	100%		100%		100%		100%		
Adjusted Number (N)	73		119		277		26		
Number-unweighted (N)	175		224		145		14		

Table A12. Current Contraceptive Method Used continued

Females	Variable name:		Region							
	Northeast		Midwest		South		West			
	Age at survey		Age at survey		Age at survey		Age at survey			
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24		
Sterilization	0.0	4.0	1.3	3.2	0.0	5.0	0.0	1.2		
Oral contraceptives	31.6	41.3	42.2	51.6	34.5	47.2	33.5	47.1		
IUD	0.0	0.7	0.0	0.1	0.0	0.5	0.0	0.0		
Norplant	0.0	1.1	0.5	3.3	2.6	3.2	3.5	6.2		
Depo Provera	7.4	5.3	8.8	4.0	6.4	5.5	7.7	3.8		
Condoms	29.5	29.8	26.9	22.9	33.4	22.1	20.5	25.7		
Diaphragm/Cap/f.condom	0.0	1.5	0.0	0.4	0.0	0.6	0.0	0.9		
Foam/jelly/cream/suppository/sponge	0.5	1.0	1.0	1.3	1.0	2.3	0.0	1.0		
Withdrawal	4.9	2.8	1.0	3.5	3.2	3.4	4.5	3.0		
Rhythm (periodic abstinence)	2.6	1.4	0.0	0.7	0.7	0.6	1.1	1.6		
Other method	0.0	0.0	0.0	1.6	0.0	1.7	0.0	0.0		
No method used	23.6	11.0	18.4	7.4	18.2	8.0	29.1	9.4		
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%		
Number-weighted (N) in 000's	636	988	655	1,729	1,116	2,056	620	1,177		
Number-unweighted (N)	108	169	110	294	176	358	102	198		

Females	Variable name:		Metro			
	MSA-Central City		MSA-other		Not MSA	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0	4.1	0.0	2.4	1.0	5.2
Oral contraceptives	32.7	41.8	34.4	47.7	40.2	56.1
IUD	0.0	0.4	0.0	0.3	0.0	0.0
Norplant	3.2	5.1	1.3	2.8	0.7	2.5
Depo Provera	8.8	4.6	5.4	3.9	8.8	6.7
Condoms	26.7	26.5	31.6	27.4	26.0	13.9
Diaphragm/Cap/f.condom	0.0	0.7	0.0	0.6	0.0	1.2
Foam/jelly/cream/suppository/sponge	1.4	2.0	0.0	1.5	0.8	0.8
Withdrawal	1.6	3.0	3.6	3.5	5.1	3.2
Rhythm (periodic abstinence)	1.8	0.4	0.6	1.1	0.7	1.4
Other method	0.0	1.0	0.0	1.1	0.0	1.0
No method used	23.8	10.4	23.1	7.6	16.7	8.0
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	996	2,006	1,237	2,715	795	1,229
Number-unweighted (N)	171	389	203	434	122	196

Table A12. Current Contraceptive Method Used continued

Females	Variable name: Immigrant Status			
	US Born		Foreign Born	
	Age at survey		Age at survey	
	15-19	20-24	15-19	20-24
Sterilization	0.3	3.7	0.0	2.3
Oral contraceptives	35.7	48.2	27.1	40.3
IUD	0.0	0.2	0.0	1.8
Norplant	1.4	3.2	11.0	6.9
Depo Provera	7.6	4.8	3.0	4.3
Condoms	28.2	24.3	35.2	24.7
Diaphragm/Cap/f.condom	0.0	0.8	0.0	0.0
Foam/jelly/cream/suppository/sponge	0.6	1.7	2.2	0.0
Withdrawal	3.5	3.2	0.0	4.3
Rhythm (periodic abstinence)	0.8	0.7	4.9	3.3
Other Method	0.0	1.2	0.0	0.0
No method used	21.8	8.3	16.6	12.0
Total Percent	100%	100%	100%	100%
Number-weighted (N) in 000's	2,894	5,420	134	530
Number-unweighted (N)	473	927	23	92

Males	Variable name: Immigrant Status			
	US Born		Foreign Born	
	Age at survey		Age at survey	
	15-19	20-24	15-19	20-24
Sterilization	0.7		0.0	
Oral contraceptives	32.5		19.5	
IUD	0.0		0.0	
Norplant	1.8		2.4	
Depo Provera	1.5		0.0	
Condoms	40.2		63.4	
Diaphragm/Cap/f.condom	0.0		0.0	
Foam/jelly/cream/suppository	0.4		0.0	
Withdrawal	2.0		0.0	
Rhythm (periodic abstinence)	0.2		0.0	
Other Methods	0.7		0.0	
No method used	20.1		14.6	
Total Percent	100%		100%	
Adjusted Number (N)	453		41	
Number-unweighted (N)	495		63	

Table A12. Current Contraceptive Method Used continued

Females	Variable name: School Status									
	Working and school		In school only		Employed only		Neither			
	Age at survey		Age at survey		Age at survey		Age at survey			
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0	1.0	0.8	3.0	0.0	3.1	0.0	7.7	0.0	7.7
Oral contraceptives	42.1	57.0	26.8	51.1	41.7	45.1	33.0	42.3	33.0	42.3
IUD	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.1	0.0	0.1
Norplant	0.5	2.1	1.4	3.3	4.0	3.7	2.7	4.3	2.7	4.3
Depo Provera	5.4	1.5	7.8	1.8	4.9	5.9	14.3	6.2	5.9	14.3
Condoms	23.8	28.7	32.8	19.5	25.7	24.4	32.2	22.1	24.4	32.2
Diaphragm/Cap/f.condom	0.0	1.3	0.0	1.0	0.0	0.8	0.0	0.0	0.8	0.0
Foam/jelly/cream/suppository/sponge	0.5	1.3	0.9	1.1	1.1	1.9	0.0	0.9	1.9	0.0
Withdrawal	5.2	0.8	3.0	6.5	3.6	2.9	0.0	5.1	2.9	0.0
Rhythm (periodic abstinence)	0.0	0.9	1.5	0.0	1.1	1.1	1.8	1.0	1.1	1.8
Other Method	0.0	0.4	0.0	0.0	0.0	1.5	0.0	1.0	1.5	0.0
No method used	22.5	5.0	25.1	12.7	18.0	9.0	16.0	9.3	9.0	16.0
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	960	1,155	1,064	560	571	3,091	433	1,144	3,091	433
Number-unweighted (N)	151	188	175	94	93	513	77	224	513	77

Males	Variable name: School Status									
	Working and school		In school only		Employed only		Neither			
	Age at survey		Age at survey		Age at survey		Age at survey			
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Sterilization	0.0		0.0		2.9		0.0		0.0	
Oral contraceptives	33.1		29.6		37.9		23.6		37.9	
IUD	0.0		0.0		0.0		0.0		0.0	
Norplant	2.0		1.7		1.9		1.8		1.9	
Depo Provera	1.3		1.1		1.0		3.6		1.0	
Condoms	42.4		45.8		34.0		43.6		34.0	
Diaphragm/Cap/f.condom	0.0		0.0		0.0		0.0		0.0	
Foam/jelly/cream/suppository	0.0		1.1		0.0		0.0		0.0	
Withdrawal	3.3		0.6		0.0		5.5		0.0	
Rhythm (periodic abstinence)	0.0		0.6		0.0		0.0		0.0	
Other Method	0.0		1.1		0.0		0.0		0.0	
No method used	17.9		18.4		22.3		21.8		22.3	
Total Percent	100%		100%		100%		100%		100%	
Adjusted Number (N)	151		179		103		55		103	

Source(s): NSFG, NSAM
 Year of survey: 1995

Table A13. Percentage distribution according to socioeconomic measures by age and gender

Age	Level of Education				Total Percent	Number (n)
	High School Incomplete	High School Complete	College Incomplete	College 4+		
Youth aged 15-19						
males	78.4	16.4	5.0	0.2	100%	1723
females	74.6	16.6	8.8	0.0	100%	8923481
Youth aged 20-24						
males					100%	
females	13.9	32.4	38.4	15.3	100%	8946412

Age	Marital/cohabitation status				Total Percent	Number (n)
	Currently Married	Currently Cohabiting	Formerly married/cohab.	Never Married		
Youth aged 15-19						
males	1.5			98.5	100%	1729
females	4.0	4.2	0.6	91.2	100%	8923480
Youth aged 20-24						
males						
females	28.0	11.2	5.5	55.3	100%	8946413

Age	Income Poverty	Family income/poverty status			Total Percent	Number (n)
		\$0-20,000 0-149%	\$20,001-40,000 150-299%	>\$40,001 300+%		
Youth aged 15-19						
males (income)		22.5	36.9	40.5	100%	1,638
females (poverty)		25.8	38.2	36.1	100%	8,923,480
Youth aged 20-24						
males						
females		31.2	35.8	33.0	100%	8,946,413

Age	Region/province of the country				Total Percent	Number (n)
	Northeast	Midwest	South	West		
Youth aged 15-19						
males						
females	19.2	22.5	35.2	23.1	100%	8923480
Youth aged 20-24						
males						
females	15.8	28.6	32.9	22.6	100%	8946413

Age	Race/ethnicity - groups as applicable for country				Total Percent	Number (n)
	White	Black	Hispanic	Other		
Youth aged 15-19						
males	67.4	14.3	12.6	5.7	100%	1729
females	66.4	15.6	12.8	5.2	100%	8923480
Youth aged 20-24						
males						
females	67.3	14.6	12.8	5.3	100%	8946413

Table A13. Socioeconomic Measures by Age continued

Age	Religion					Number (n)
	None	Protestant	Catholic	Other	Total Percent	
Youth aged 15-19						
males	14.7	58.1	23.9	3.3	100%	1718
females	14.5	54.2	26.3	5.0	100%	8923481
Youth aged 20-24						
males						
females	15.2	52.0	27.2	5.5	100%	8946413

Age	Immigrant status		Total Percent	Number (n)
	Native born	Foreign born		
Youth aged 15-19				
males	89.6	10.4	100%	1,729
females	93.9	6.1	100%	8,923,481
Youth aged 20-24				
males				
females	90.5	9.5	100%	8,946,412

Age and gender	School status				Total Percent	Number (n)
	In School Only	School + employed	Employed only	Neither		
Youth aged 15-19					100%	
males	47.3	32.3	12.5	7.9	100%	1719
females	49.0	30.6	11.2	9.2	100%	8923481
Youth aged 20-24					100%	
males					100%	
females	20.9	11.2	48.1	19.8	100%	8946414

Source(s): NSFG, NSAM
 Year of survey: 1995

Summary Tables

Table A14. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey (15-19 and 20-24), gender and socioeconomic variables

Females Percent who first had intercourse at age:	Variable name: Level of Education							
	High School Incomp.		High School		College Incomplete		College 4+	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19 N/A	20-24
<15	21.1	33.7	13.0	17.3	6.5	9.0		2.6
<18	45.0	83.5	60.8	71.5	45.8	55.4		45.7
<20	45.7	95.2	69.5	88.9	64.0	74.3		65.3
20+		99.0		93.9		83.0		84.1
Never had intercourse	54.2	0.9	30.4	6.0	36.1	16.9		16.0
Total Percent	100%	100%	100%	100%	100%	100%		100%
Number-weighted (N) in 000's	6,659	1,243	1,482	2,900	783	3,434		1,369
Number-unweighted (N)	1,032	263	246	492	118	560		203

Males Percent who first had intercourse at age:	Variable name: Level of Education							
	High School Incomp.		High School		College Incomplete		College 4+	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	21.7		21.0		9.4		100.0	
<18	48.1		65.8		58.3		100.0	
<20	49.7		77.5		67.6		100.0	
Never had intercourse	50.4		22.4		32.6		0.0	
Total Percent	100%		100%		100%		100%	
Adjusted Number (N)	1,348		281		86		4	
Number-unweighted (N)	1,414		245		56		1	

Females Percent who first had intercourse at age:	Variable name: Marital Status							
	Married		Cohabiting		Formerly Married		Never Married	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	29.4	17.6	31.6	22.7	50.4	30.3	17.2	8.9
<18	90.8	71.7	98.4	74.6	100.0	87.0	43.1	53.9
<20	100.0	88.4	99.9	93.9	100.0	95.4	46.6	72.5
20+		99.9		100.1		100.0		80.1
Never had intercourse	0.0	0.0	0.0	0.0	0.0	0.0	53.4	19.9
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	358	2,506	374	1,000	50	492	8,142	4,948
Number-unweighted (N)	45	378	59	175	6	78	1,286	887

Males Percent who first had intercourse at age:	Variable name: Marital Status							
	Married		Cohabiting		Formerly Married		Never Married	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	34.6						20.9	
<18	100.0						50.9	
<20	100.0						54.5	
Never had intercourse	0.0						45.5	
Total Percent	100%						100%	
Adjusted Number (N)	26						1,700	
Number-unweighted (N)	19						1,705	

Summary Table A14. Age at First Intercourse continued

Females Percent who first had intercourse at age:	Variable name: Grouped Religion							
	None		Protestant		Catholic		Other	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	31.5	18.0	16.1	15.3	16.1	10.1	19.2	11.6
<18	66.4	66.6	45.2	65.1	46.5	58.6	27.0	55.7
<20	71.7	83.8	48.5	82.5	49.9	78.0	30.1	67.8
20+		91.1		89.8		87.8		82.5
Never had intercourse	28.4	8.9	51.4	10.3	50.2	12.3	70.0	17.5
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,291	1,363	4,840	4,657	2,347	2,434	446	493
Number-unweighted (N)	200	220	750	810	381	415	65	73

Males Percent who first had intercourse at age:	Variable name: Grouped Religion							
	None		Protestant		Catholic		Other	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	25.7		20.8		18.9		19.7	
<18	62.4		49.2		50.1		46.4	
<20	66.8		53.1		51.8		53.5	
Never had intercourse	33.2		46.7		48.2		46.4	
Total Percent	100%		100%		100%		100%	
Adjusted Number (N)	253		996		407		56	
Number-unweighted (N)	225		917		522		44	

Females Percent who first had intercourse at age:	Variable name: Poverty Level					
	0-149%		150-299%		300+%	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
<15	26.2	16.3	19.6	15.6	12.0	10.5
<18	56.7	64.6	46.7	63.9	42.5	60.8
<20	60.8	83.5	49.1	78.5	46.9	80.4
20+		88.6		88.8		89.8
Never had intercourse	39.1	11.4	50.9	11.4	53.2	10.3
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,300	2,793	3,406	3,203	3,217	2,951
Number-unweighted (N)	384	538	528	516	484	464

Males Percent who first had intercourse at age:	Variable name: Income					
	\$0-20,000		\$20,001-40,000		>\$40,001	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
<15	29.7		20.4		15.8	
<18	57.7		51.6		49.3	
<20	59.3		55.3		53.8	
Never had intercourse	40.8		44.8		46.2	
Total Percent	100%		100%		100%	
Adjusted Number (N)	368		603		663	
Number-unweighted (N)	550		590		469	

Summary Table A14. Age at First Intercourse continued

Females Percent who first had intercourse at age:	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	22.6	11.7	28.8	21.5	16.2	12.8	6.2	15.6
<18	54.0	49.1	56.9	74.8	46.2	64.6	22.4	44.3
<20	56.1	74.2	60.4	89.2	50.3	81.1	23.6	66.0
20+		86.9		93.8		89.4		76.1
Never had intercourse	44.0	13.0	39.6	6.1	49.6	10.7	76.5	23.8
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,140	1,145	1,395	1,304	5,926	6,022	463	476
Number-unweighted (N)	210	256	289	354	842	846	55	62

Males Percent who first had intercourse at age:	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	27.6		49.8		13.9		21.7	
<18	59.7		79.2		45.5		39.2	
<20	61.1		80.4		49.9		43.3	
Never had intercourse	39.0		19.6		50.1		56.7	
Total Percent	100%		100%		100%		100%	
Adjusted Number (N)	218		245		1,165		97	
Number-unweighted (N)	556		492		618		58	

Females Percent who first had intercourse at age:	Variable name: Region							
	Northeast		Midwest		South		West	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	20.0	13.4	15.5	14.2	20.3	13.8	17.3	14.9
<18	50.6	60.6	47.2	67.7	49.5	65.6	43.0	55.0
<20	53.7	79.0	51.4	85.0	52.1	81.0	47.7	75.3
20+		88.3		92.6		89.7		83.5
Never had intercourse	46.1	11.7	48.4	7.3	47.9	10.1	52.4	16.5
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,717	1,415	2,005	2,560	3,139	2,947	2,063	2,024
Number-unweighted (N)	273	246	319	425	489	518	315	329

Females Percent who first had intercourse at age:	Variable name: Metro					
	MSA - Central City		MSA-Other		Not MSA	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24
<15	23.3	13.2	16.0	15.0	16.5	13.6
<18	52.9	61.5	43.8	63.2	47.6	65.2
<20	56.2	80.6	47.4	78.4	51.7	85.3
20+		89.6		87.4		91.2
Never had intercourse	43.8	10.2	52.6	12.5	48.2	8.8
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,900	3,096	3,911	4,085	2,112	1,765
Number-unweighted (N)	490	588	592	644	314	286

Summary Table A14. Age at First Intercourse continued

Females Percent who first had intercourse at age:	Variable name: Immigrant Status			
	US Born		Foreign Born	
	<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24
<15	19.1	14.6	10.2	9.4
<18	48.5	64.8	36.7	46.4
<20	52.2	81.7	37.9	70.1
20+		89.6		83.2
Never had intercourse	47.8	10.4	62.1	16.9
Total Percent	100%	100%	100%	100%
Number-weighted (N) in 000's	8,383	8,095	541	852
Number-unweighted (N)	1,316	1,367	80	151

Males Percent who first had intercourse at age:	Variable name: Immigrant Status			
	US Born		Foreign Born	
	<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24
<15	21.2		20.6	
<18	52.6		43.4	
<20	56.1		47.9	
Never had intercourse	43.9		52.0	
Total Percent	100%		100%	
Adjusted Number (N)	1,546		179	
Number-unweighted (N)	1,488		236	

Females Percent who first had intercourse at age:	Variable name: School Status							
	Working and school		In school only		Employed only		Neither	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	12.5	8.1	17.5	8.7	20.7	15.2	41.2	20.9
<18	46.0	47.4	37.5	52.0	69.1	66.5	81.7	77.6
<20	49.3	70.8	40.1	70.3	76.2	82.6	86.8	92.2
20+		79.0		77.5		92.9		96.9
Never had intercourse	50.8	21.1	59.8	22.6	23.7	7.2	13.0	3.2
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,733	1,868	4,374	998	999	4,305	818	1,776
Number-unweighted (N)	417	301	679	161	161	713	139	343

Males Percent who first had intercourse at age:	Variable name: School Status							
	Working and school		In school only		Employed only		Neither	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<15	18.4		21.7		18.6		30.6	
<18	49.1		43.4		73.0		75.1	
<20	53.8		45.4		78.6		80.2	
Never had intercourse	46.2		54.6		21.4		19.7	
Total Percent	100%		100%		100%		100%	
Adjusted Number (N)	554		810		215		137	
Number-unweighted (N)	506		908		167		136	

Source(s): NSFG, NSAM
 Year of survey: 1995

Table A15. Summary table: Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey (15-19 and 20-24) and socioeconomic variables

Females Percent whose first birth was at age:	Variable name: Education Level							
	High School Incomp.		High School Comp.		College Incomp.		College 4+	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<20	8.4		10.9	27.8	2.6	9.2		0.7
Never had a birth	91.5	16.5	89.1	49.7	97.3	82.6	n/a	93.6
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	6,659	1,243	1,482	2,900	783	3,434		1,369
Number-unweighted (N)	1,032	263	246	492	118	560		203

Females Percent whose first birth was at age:	Variable name: Marital Status							
	Married		Cohabiting		Formerly Married		Never Married	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<20	49.3	32.5	29.7	30.0	83.8	45.2	5.0	12.4
Never had a birth	50.7	39.4	70.2	58.9	16.2	32.0	94.9	81.4
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	358	2,506	374	1,000	50	492	8,142	4,948
Number-unweighted (N)	45	378	59	175	6	78	1,286	887

Females Percent whose first birth was at age:	Variable name: Grouped Religion							
	None		Protestant		Catholic		Other	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<20	9.0	23.8	8.8	21.7	7.7	22.2	5.4	15.9
Never had a birth	91.0	67.9	91.2	62.7	92.4	65.0	94.7	68.6
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,291	1,363	4,840	4,657	2,347	2,434	446	493
Number-unweighted (N)	200	220	750	810	381	415	65	73

Females Percent whose first birth was at age:	Variable name: Poverty Status					
	0-149%		150-299%		300+%	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
<20	19.1	39.7	6.8	19.5	2.3	7.4
Never had a birth	81.0	46.0	93.2	61.3	97.6	85.2
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,300	2,792	3,406	3,203	3,217	2,951
Number-unweighted (N)	384	538	528	516	484	464

Summary Table A15. Age at First Birth continued

Females Percent whose first birth was at age:	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<20	13.0	32.9	18.6	36.9	5.5	16.8	3.1	18.0
Never had a birth	87.1	49.0	81.4	49.3	94.5	70.1	96.9	71.7
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,140	1,145	1,395	1,304	5,926	6,022	463	476
Number-unweighted (N)	210	256	289	354	842	846	55	62

Females Percent whose first birth was at age:	Variable name: Region							
	Northeast		Midwest		South		West	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<20	4.9	15.8	9.3	22.5	10.9	23.4	6.5	23.0
Never had a birth	95.1	72.2	90.7	62.5	89.1	64.9	93.6	64.9
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	1,717	1,415	2,005	2,560	3,139	2,024	2,064	2,024
Number-unweighted (N)	273	246	319	425	489	518	315	329

Females Percent whose first birth was at age:	Variable name: Metro					
	MSA-Central City		MSA-Other		Not MSA	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
<20	12.0	25.2	6.2	20.0	7.3	19.8
Never had a birth	88.0	59.7	93.8	70.0	92.6	59.9
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,900	3,096	3,911	4,085	2,112	1,765
Number-unweighted (N)	490	588	592	644	314	286

Females Percent whose first birth was at age:	Variable name: Immigrant Status			
	US Born		Foreign Born	
	Age at survey		Age at survey	
	15-19	20-24	15-19	20-24
<20	8.0	21.0	14.3	28.7
Never had birth	92.0	65.1	85.6	58.0
Total Percent	100%	100%	100%	100%
Number-weighted (N) in 000's	8,383	8,095	541	852
Number-unweighted (N)	1316	1367	80	151

Females Percent whose first birth was at age:	Variable name: School Status							
	Working and school		In school only		Employed only		Neither	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
<20	2.7	5.1	3.9	17.0	18.9	20.1	37.8	46.1
Never had a birth	97.3	91.5	96.0	80.0	81.2	64.8	62.2	26.2
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N) in 000's	2,733	1,868	4,374	998	999	4,305	818	1,776
Number-unweighted (N)	417	301	679	161	161	713	139	343

Source(s): NSFG, NSAM
Year of survey: 1995

Summary Tables

Table A16. Percentage distribution according to the contraceptive method used at first sex by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables among those ever sexually active

Females	Variable name: Education Level							
	High School Incomp.		High School Comp.		College Incomp.		College 4+	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	8.0	15.6	6.9	19.0	10.5	15.6		14.4
Male condom	60.6	21.2	65.3	40.1	70.3	53.2		65.0
Other Method	3.6	3.8	7.8	7.1	2.3	7.8		7.0
No Method	27.7	59.4	20.0	33.7	16.9	23.4		13.6
Number-weighted (N) in 000's	3,022	1,233	1,031	2,703	500	2,844		1,138
Number-unweighted (N)	492	260	174	458	77	473		173

Males	Variable name: Education Level							
	High School Incomp.		High School Comp.		College Incomp.		College 4+	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	10.8		7.5		5.2		0.0	
Male condom	57.1		67.1		74.1		100.0	
Other Method	3.4		4.3		12.1		0.0	
No Method	28.9		21.1		8.6		0.0	
Adjusted Number (N)	630		213		58		4	
Number-unweighted (N)	742		187		37		1	

Females	Variable name: Marital Status							
	Married		Cohabiting		Formerly Married		Never Married	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	12.7	19.9	13.1	19.0	0.0	26.5	7.2	12.6
Male condom	51.5	35.3	49.2	39.9	12.6	23.5	65.9	56.1
Other Method	3.4	8.3	1.3	5.5	0.0	7.3	4.9	6.2
No Method	32.4	36.5	36.5	35.6	87.4	42.7	22.0	25.1
Number-weighted (N) in 000's	358	2,506	374	1,000	50	492	3,772	3,919
Number-unweighted (N)	45	378	59	175	6	78	633	733

Males	Variable name: Marital Status					
	Married				Never Married	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	4.0				9.8	
Male condom	32.0				61.7	
Other Method	12.0				3.6	
No Method	52.0				24.9	
Adjusted Number (N)	25				881	
Number-unweighted (N)	19				951	

Summary Table A16. Contraceptive Use at First Intercourse continued

Females	Variable name: Grouped Religion							
	None		Protestant		Catholic		Other	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	6.4	18.1	10.0	18.4	5.8	13.1	4.4	11.1
Male condom	64.5	39.6	62.2	43.4	64.1	51.1	49.5	54.6
Other Method	3.2	8.6	4.9	7.2	3.8	4.9	9.4	7.7
No Method	25.9	33.6	22.8	30.9	26.4	31.0	36.7	26.6
Number-weighted (N) in 000's	923	1,232	2,342	4,160	1,155	2,125	134	400
Number-unweighted (N)	140	202	381	734	198	368	24	60

Males	Variable name: Grouped Religion							
	None		Protestant		Catholic		Other	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	13.7		10.0		6.8		3.3	
Male condom	54.0		63.7		60.0		56.7	
Other Method	1.9		4.0		3.9		3.3	
No Method	30.4		22.3		29.3		36.7	
Adjusted Number (N)	161		502		205		30	
Number-unweighted (N)	146		514		274		25	

Females	Variable name: Poverty Level					
	0 - 149%		150 - 299%		300+%	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	7.4	14.3	8.3	18.3	8.3	17.0
Male condom	57.2	38.0	63.9	43.4	66.6	54.6
Other Method	4.5	7.4	5.6	6.1	2.9	7.2
No Method	30.8	40.3	22.0	32.2	22.1	21.2
Number-weighted (N) in 000's	1,398	2,474	1,654	2,821	1,501	2,623
Number-unweighted (N)	241	486	266	463	236	415

Males	Variable name: Income					
	\$0-20,000		\$20,001-40,000		>\$40,001	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	11.7		12.5		5.8	
Male condom	53.4		59.6		67.8	
Other Method	1.0		2.8		5.9	
No Method	34.0		25.1		20.5	
Adjusted Number (N)	206		319		342	
Number-unweighted (N)	327		335		253	

Summary Table A16. Contraceptive Use at First Intercourse continued

Females	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	2.1	13.0	13.9	17.2	7.9	17.3	0.0	14.6
Male condom	48.8	25.7	48.8	35.8	70.1	52.5	49.7	28.8
Other Method	5.9	5.3	5.5	4.5	3.0	6.9	27.1	20.6
No Method	43.2	56.1	31.8	42.5	18.9	23.5	23.3	36.0
Number-weighted (N) in 000's	623	997	842	1,223	2,979	5,336	109	362
Number-unweighted (N)	115	226	178	337	434	752	16	49

Males	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	8.9		11.7		9.8		0.0	
Male condom	50.0		50.0		66.9		58.8	
Other Method	4.0		3.1		3.6		11.8	
No Method	37.1		35.1		19.8		29.4	
Adjusted Number (N)	124		188		562		34	
Number-unweighted (N)	314		361		277		18	

Females	Variable name: Region							
	Northeast		Midwest		South		West	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	4.7	12.8	9.3	18.9	9.2	17.8	7.9	14.2
Male condom	68.5	58.1	65.6	49.7	63.2	43.0	53.6	33.9
Other Method	4.0	5.9	3.0	6.4	2.1	6.4	10.2	9.0
No Method	22.7	23.1	22.2	25.0	25.4	32.8	28.3	42.9
Number-weighted (N) in 000's	916	1,249	1,034	2,336	1,636	2,649	968	1,684
Number-unweighted (N)	155	219	171	390	261	473	156	282

Females	Variable name: Metro					
	MSA-Central City		MSA-Other		Not MSA	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	8.3	16.9	6.4	15.4	10.4	18.7
Male condom	54.9	39.6	69.0	49.8	64.1	45.9
Other Method	4.3	7.4	4.9	7.4	3.9	4.8
No Method	32.4	36.2	19.8	27.4	21.6	30.5
Number-weighted (N) in 000's	1,628	2,762	1,831	3,555	1,094	1,601
Number-unweighted (N)	282	538	295	567	166	259

Summary Table A16. Contraceptive Use at First Intercourse continued

Females	Variable name: Immigrant Status			
	US Born		Foreign Born	
	<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24
Percent using each method at first intercourse				
Oral contraceptives	8.2	17.4	3.9	8.5
Male condom	63.3	47.2	51.9	26.8
Other Method	4.7	6.7	0.0	8.7
No Method	23.8	28.7	44.2	56.0
Number-weighted (N) in 000's	4,348	7,217	205	701
Number-unweighted (N)	709	1,236	34	128

Males	Variable name: Immigrant Status			
	US Born		Foreign Born	
	<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24
Percent using each method at first intercourse				
Oral contraceptives	10.2		3.7	
Male condom	62.3		45.7	
Other Method	3.3		8.6	
No Method	24.1		42.0	
Adjusted Number (N)	826		81	
Number-unweighted (N)	847		123	

Females	Variable name: School Status							
	Working and school		In school only		Employed only		Neither	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Percent using each method at first intercourse								
Oral contraceptives	6.7	11.3	7.4	15.2	6.7	18.9	13.7	16.4
Male condom	70.6	61.6	65.0	49.0	60.1	45.1	45.0	30.8
Other Method	5.1	5.8	3.6	7.6	5.2	7.8	4.2	5.3
No Method	17.6	21.2	23.9	28.2	27.9	28.3	37.0	47.5
Number-weighted (N) in 000's	1,346	1,474	1,742	763	762	3,971	703	1,710
Number-unweighted (N)	217	243	280	128	124	662	122	331

Males	Variable name: School Status							
	Working and school		In school only		Employed only		Neither	
	<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>		<i>Age at survey</i>	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Percent using each method at first intercourse								
Oral contraceptives	9.9		9.1		11.4		7.9	
Male condom	66.7		63.4		51.8		51.5	
Other Method	5.0		1.8		6.0		5.0	
No Method	18.4		25.9		30.7		35.6	
Adjusted Number (N)	282		352		166		101	
Number-unweighted (N)	292		431		129		114	

Source(s): NSFG, NSAM
Year of survey: 1995

Summary Tables

Table A17. Percentage distribution according to current contraceptive method used by age of respondent at the survey (15-19 and 20-24), gender and socioeconomic variables among those currently sexually active

Females	Variable name: Education Level							
	High School Incomp.		High School Comp.		College Incomp.		College 4+	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	30.5	31.2	41.8	44.4	47.1	50.9		61.3
Male condom	27.8	24.2	28.3	22.6	32.7	25.2		26.0
IUD/Norplant/Depo	12.0	16.2	5.4	10.7	2.8	5.3		3.9
Other Method	6.3	21.2	4.7	10.1	1.5	10.3		5.3
No Method	23.5	7.3	19.7	12.3	15.9	8.1		3.5
Number-weighted (N) in 000's	1,893	919	765	1,908	370	2,156		967
Number-unweighted (N)	309	193	130	326	57	351		149

Males	Variable name: Education Level							
	High School Incomp.		High School Comp.		College Incomp.		College 4+	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	29.0		31.5		43.9		100.0	
Male condom	44.0		42.3		31.7		0.0	
IUD/Norplant/Depo	4.2		2.7		0.0		0.0	
Other Method	3.3		2.7		4.9		0.0	
No Method	19.5		20.7		19.5		0.0	
Adjusted Number (N)	334		111		41		4	
Number-unweighted (N)	407		118		28		1	

Females	Variable name: Marital Status							
	Married		Cohabiting		Formerly Married		Never Married	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	36.8	49.5	47.4	50.3	21.2	33.6	34.4	47.1
Male condom	17.7	18.1	18.7	24.2	0.0	15.8	30.8	29.5
IUD/Norplant/Depo	23.1	9.8	18.5	11.2	7.6	8.8	7.1	6.9
Other Method	6.9	16.0	5.1	9.5	16.5	23.6	5.0	6.7
No Method	15.5	6.6	10.3	4.9	54.7	18.2	22.7	9.7
Number-weighted (N) in 000's	230	1,873	222	829	38	374	2,537	2,874
Number-unweighted (N)	30	279	36	144	5	58	425	538

Males	Variable name: Marital Status							
	Married		Cohabiting		Formerly Married		Never Married	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-20	20-25
Oral contraceptives	60.0							30.0
Male condom	5.0							43.8
IUD/Norplant/Depo	5.0							3.2
Other Method	0.0							3.7
No Method	30.0							19.2
Adjusted Number (N)	20							473
Number-unweighted (N)	16							542

Summary Table A17. Current Contraceptive Method Used continued

Females	Variable name: Grouped Religion							
	None		Protestant		Catholic		Other	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	34.9	39.5	37.4	51.8	33.4	46.6	14.3	32.9
Male condom	26.1	26.6	26.6	21.6	32.0	24.7	52.3	43.4
IUD/Norplant/Depo	11.5	8.0	8.8	7.2	7.9	10.4	11.2	12.7
Other Method	1.0	14.7	6.7	11.6	6.1	9.2	0.0	3.7
No Method	26.5	11.2	20.4	7.7	20.6	9.0	22.2	7.3
Number-weighted (N) in 000's	565	978	1,614	3,068	779	1,615	71	290
Number-unweighted (N)	90	160	261	541	131	277	14	41

Males	Variable name: Grouped Religion							
	None		Protestant		Catholic		Other	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	29.9		32.4		30.2		27.3	
Male condom	37.9		42.3		44.0		27.3	
IUD/Norplant/Depo	1.1		3.6		2.6		27.3	
Other Method	6.9		3.3		3.5		0.0	
No Method	24.1		18.5		19.8		18.2	
Adjusted Number (N)	87		281		116		11	
Number-unweighted (N)	92		292		155		13	

Females	Variable name: Poverty Level					
	0 - 149%		150 - 299%		300+%	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	33.5	43.1	34.8	46.4	37.5	52.6
Male condom	30.1	19.6	25.2	26.1	30.4	26.8
IUD/Norplant/Depo	16.9	9.8	6.2	10.0	5.5	5.8
Other Method	2.6	15.3	8.0	9.1	5.1	9.3
No Method	16.9	12.3	25.9	8.3	21.5	5.5
Number-weighted (N)	919	1,841	1,047	2,083	1,062	2,026
Number-unweighted (N)	155	356	170	342	171	321

Males	Variable name: Income					
	\$0-20,000		\$20,001-40,000		>\$40,001	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	23.8		32.8		35.6	
Male condom	31.4		46.9		43.1	
IUD/Norplant/Depo	5.7		4.5		0.5	
Other Method	2.0		0.0		6.4	
No Method	37.1		15.8		14.4	
Adjusted Number (N)	105		177		188	
Number-unweighted (N)	168		201		158	

Summary Table A17. Current Contraceptive Method Used continued

Females	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	28.0	36.5	22.1	39.1	40.7	51.8	18.2	37.1
Male condom	25.0	24.1	32.7	30.4	28.2	22.1	25.0	37.8
IUD/Norplant/Depo	16.2	12.6	15.9	11.2	6.4	7.1	0.0	10.4
Other Method	4.6	9.7	4.6	10.3	4.7	11.7	33.8	8.5
No Method	26.2	17.1	24.6	9.0	20.0	7.3	22.9	6.3
Number-weighted (N) in 000's	362	647	544	935	2,058	4,094	64	275
Number-unweighted (N)	71	152	113	254	302	577	10	36

Males	Variable name: Race and Ethnicity							
	Hispanic		Black-NH		White-NH		Other-NH	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	17.8		25.2		39.4		11.5	
Male condom	46.6		47.1		38.6		42.3	
IUD/Norplant/Depo	4.1		6.8		1.8		7.7	
Other Method	1.4		0.8		5.0		0.0	
No Method	30.1		20.2		15.2		38.5	
Adjusted Number (N)	73		119		277		26	
Number-unweighted (N)	175		224		145		14	

Females	Variable name: Region							
	Northeast		Midwest		South		West	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	31.6	41.3	42.2	51.6	34.5	47.2	33.5	47.1
Male condom	29.5	29.8	26.9	22.9	33.4	22.1	20.5	25.7
IUD/Norplant/Depo	7.4	7.1	9.3	7.4	9.0	9.2	11.2	10.0
Other Method	8.0	10.7	3.3	10.7	4.9	13.6	5.6	7.7
No Method	23.6	11.0	18.4	7.4	18.2	8.0	29.1	9.4
Number-weighted (N) in 000's	636	988	655	1,729	1,116	2,056	620	1,177
Number-unweighted (N)	108	169	110	294	176	358	102	198

Females	Variable name: Metro					
	MSA-Central City		MSA-Other		Not MSA	
	Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	32.7	41.8	34.4	47.7	40.2	56.1
Male condom	26.7	26.5	31.6	27.4	26.0	13.9
IUD/Norplant/Depo	12.0	10.1	6.7	7.0	9.5	9.2
Other Method	4.8	11.2	4.2	10.2	7.6	12.8
No Method	23.8	10.4	23.1	7.6	16.7	8.0
Number-weighted (N) in 000's	996	2,006	1,237	2,715	795	1,229
Number-unweighted (N)	171	389	203	434	122	196

Summary Table A17. Current Contraceptive Method Used continued

Females Percent using each method	Variable name: Immigrant Status			
	US Born		Foreign Born	
	Age at survey		Age at survey	
	15-19	20-24	15-19	20-24
Oral contraceptives	35.7	48.2	27.1	40.3
Male condom	28.2	24.3	35.2	24.7
IUD/Norplant/Depo	9.0	8.2	14.0	13.0
Other Method	5.2	11.3	7.1	9.9
No Method	21.8	8.3	16.6	12.0
Number-weighted (N) in 000's	2,894	5,420	134	530
Number-unweighted (N)	473	927	23	92

Males Percent using each method	Variable name: Immigrant Status			
	US Born		Foreign Born	
	Age at survey		Age at survey	
	15-19	20-24	15-19	20-24
Oral contraceptives	32.5		19.5	
Male condom	40.2		63.4	
IUD/Norplant/Depo	3.3		2.4	
Other Method	4.0		0.0	
No Method	20.1		14.6	
Adjusted Number (N)	453		41	
Number-unweighted (N)	495		63	

Females Percent using each method	Variable name: School Status							
	Working and school		In school only		Employed only		Neither	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	42.1	57.0	26.8	51.1	41.7	45.1	33.0	42.3
Male condom	23.8	28.7	32.8	19.5	25.7	24.4	32.2	22.1
IUD/Norplant/Depo	5.9	3.6	9.2	5.1	8.9	10.1	17.0	10.6
Other Method	5.7	5.7	6.2	11.6	5.8	11.3	1.8	15.7
No Method	22.5	5.0	25.1	12.7	18.0	9.0	16.0	9.3
Number-weighted (N) in 000's	960	1,155	1,064	560	571	3,091	433	1,144
Number-unweighted (N)	151	188	175	94	93	513	77	224

Males Percent using each method	Variable name: School Status							
	Working and school		In school only		Employed only		Neither	
	Age at survey		Age at survey		Age at survey		Age at survey	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Oral contraceptives	33.1		29.6		37.9		23.6	
Male condom	42.4		45.8		34.0		43.6	
IUD/Norplant/Depo	3.3		2.8		2.9		5.4	
Other Method	3.3		3.4		2.9		5.5	
No Method	17.9		18.4		22.3		21.8	
Adjusted Number (N)	151		179		103		55	
Number-unweighted (N)	170		234		83		68	

Source(s): NSFG, NSAM
 Year of survey: 1995