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Patterns and Correlates of Parental and Formal Sexual and Reproductive Health Communication for Adolescent Women in the United States, 2002–2008

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A B S T R A C T

Purpose: To investigate patterns and correlates of sexual and reproductive health (SRH) communication among adolescent women in the United States between 2002 and 2008.
Methods: We used data with regard to adolescent women (aged 15–19 years) from the National Survey of Family Growth (between 2002 and 2006–2008, n = 2,326). Multivariate analyses focused on sociodemographic characteristics and SRH communication from parental and formal sources.
Results: Seventy-five percent of adolescent women had received parental communication on abstinence (60%), contraception (56%), sexually transmitted infections (53%), and condoms (29%); 9% received abstinence-only communication. Formal communication (92%) included abstinence (87%) and contraceptive (71%) information; 66% received both, whereas 21% received abstinence-only. Between 2002 and 2006–2008, parental (not formal) communication increased (7%, $p < .001$), including the abstinence communication (4%, $p = .03$). Age, sexual experience, education, mother's education, and poverty were positively associated with SRH communication.
Conclusions: Between 2002 and 2008, receipt of parental SRH communication, especially abstinence, was increasingly common among United States adolescents. Strategies to promote comprehensive communication may improve adolescents' SRH outcomes.

Comprehensive sexual and reproductive health (SRH) information is required for informed sexual decision-making, risk behavior reduction, and health promotion across the lifespan [1]. Adolescents, who are at the stage of cognitive and sexual development, are in need of comprehensive information [1], especially poor and minority adolescents in the United States who disproportionately suffer negative SRH outcomes [2].

An understanding of the variety of sources from which adolescents receive SRH information can provide insights into SRH needs, improve knowledge, and promote SRH well-being [3]. Communication from informal sources, including parents and especially mothers, has been linked with positive SRH outcomes including delayed sexual debut, fewer sexual partners, greater contraceptive and condom use, and negative views of unintended pregnancy [4,5]. Formal communication from schools, churches, and other community sources, although difficult to assess but recently the primary focus of research, has also been shown to reduce adolescents' sexual risk-taking behavior [6].

Between 1988 and 1995, expansion of sex education in the United States provided at least some formal instruction to nearly

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Table 1
Receipt of parental and formal sexual and reproductive health communication by U.S. adolescents, 2002 to 2006–2008

Sexual and reproductive health communication	Total (N = 2,326) n (%)	2002 (N = 1,065) n (%)	2006–2008 (N = 1,261) n (%)	2002 vs. 2006–2008 *p* value
Received any parental and/or formal communication[a]	2,251 (97)	1,025 (96)	1,226 (97)	.12
Both parental and formal	1,615 (70)	700 (66)	915 (73)	.004
Only formal	517 (22)	270 (25)	247 (20)	.001
Only parental	119 (5)	55 (5)	64 (5)	.62
Neither parental or formal	75 (3)	40 (3)	35 (3)	.08
Received any parental communication[b]	1,734 (75)	755 (71)	979 (78)	<.001
Any contraceptive communication	1,309 (56)	581 (55)	728 (58)	.23
Contraceptive methods	1,170 (50)	531 (50)	639 (51)	.89
Where to get contraception	881 (38)	391 (37)	490 (39)	.89
Using condoms	668 (29)	301 (28)	367 (29)	.85
STIs	1,237 (53)	554 (52)	683 (54)	.13
HIV[c]	—	—	508 (40)	NA
How to say no to sex (abstinence)	1,391 (60)	614 (58)	777 (62)	.03
Only abstinence parental communication	199 (9)	81 (8)	118 (9)	.18
Received any formal communication	2,132 (92)	970 (91)	1,162 (92)	.63
Methods of contraception	1,643 (71)	749 (70)	894 (71)	.72
STIs[c]	—	—	1,187 (51)	NA
HIV[c]	—	—	508 (40)	NA
How to say no to sex (abstinence)	2,030 (87)	921 (87)	1,109 (88)	.54
Only abstinence formal communication	489 (21)	221 (21)	268 (21)	.51
Both abstinence and contraceptive formal communication	1,541 (66)	700 (66)	841 (66)	.85

Results are presented as frequencies with percentages and *p* values (*p*) from chi-square comparisons between survey years.
STI = sexually transmitted infection; HIV = human immunodeficiency syndrome; NA = not applicable.
[a] Significant differences found between those receiving parental versus formal communication $p = .01$ for total sample and for 2002 but not for 2006.
[b] Does not include informal HIV communication since asked only in 2006–2008.
[c] Asked only in 2006–2008.

all adolescents [7]. However, after 1995, policy efforts, social attention, and funding have been directed toward abstinence education [1,8], which has corresponded with rising teen pregnancy and sexually transmitted infection (STI) rates and stalled progress in contraceptive use [1,2,6,8].

It is within this broader sociopolitical context that we need an improved understanding of recent patterns in SRH communication and whether potential socioeconomic disparities in SRH communication help explain current inequities in SRH among young U.S. women.

Methods

We used data from the National Survey of Family Growth, a nationally representative SRH survey of women and men aged 15–44 years residing in the United States. Data were collected cross-sectionally via household, in-person interviews in 2002 (n = 12,571), and then ongoing from 2006 to 2008 (n = 13,495). The response rate was 79% and 75% in cycles 6 and 7. Restricting the analysis to adolescent women (15–19 years), our final sample included 2,326 adolescents: 1,065 from 2002, and 1,261 from 2006 to 2008. The study was approved by Princeton University's Institutional Review Board.

Adolescents were asked whether they had ever talked with a parent about SRH topics, including contraception (methods, where to get contraception, and how to use a condom), STIs, and how to say no to sex (referred to as abstinence [1,5,7]). Between 2006 and 2008, adolescents were asked about human immunodeficiency virus. Adolescents were also asked whether they had ever received formal communication from schools, churches, or community centers on abstinence and methods of contraception.

We evaluated the following sociodemographic characteristics as potential determinants of SRH communication based on previous research [1,5,7]: age, race/ethnicity, education, income, poverty, employment, insurance, birthplace, residence, religiosity, mother's education, childhood family situation, age of mother at the time of first birth, age at menarche, sexual intercourse experience, age at coitus, number of recent sexual partners, cohabitation and/or marriage, pregnancies, parity, and gynecologic diagnoses.

We used descriptive statistics to estimate sociodemographic characteristics and SRH communication. We conducted bivariate tests to compare SRH communication by survey year and across sociodemographics. We used multivariate logistic regression to estimate the influence of each characteristic on receipt of SRH communication. We retained variables with $p < .05$ in final models. Finally, we tested for trends over time and examined potential disparate changes in associations using interaction terms for survey year. Weighted data accounted for the stratified sampling design; standard errors and tests of significance were computed using the svy series of commands in Stata 11.0 (StataCorp, College Station, TX).

Results

Receipt of SRH communication is presented in Table 1. Nearly all adolescents received SRH communication (97%). Of the 75% who had received parental communication (75%), information was provided on STIs (53%) and contraception (56%), including contraceptive methods (50%), where to get contraception (38%), and how to use condoms (29%). How to say no to sex (abstinence) was most common (60%), with 9% receiving abstinence-only communication. Between 2002 and 2006–2008, parental communication increased (7%, $p < .001$), including abstinence communication (4%, $p = .03$).

Receipt of formal SRH communication was nearly universal (92%), more so on abstinence (87%) than on contraceptive methods (71%); two-thirds received formal communication on both,