

Supporting Statement B for Request for Clearance:

NATIONAL SURVEY OF FAMILY GROWTH, 2015-2018

OMB No. 0920-0314
(expires April 30, 2015)

April 3, 2015

Contact Information:

Anjani Chandra, Ph.D., Health Scientist
Principal Investigator and Team Lead
National Survey of Family Growth Team
Division of Vital Statistics/Reproductive Statistics Branch
CDC/National Center for Health Statistics
3311 Toledo Road, Room 7419
Hyattsville, MD. 20782
301-458-4138
301-458-4033 (fax)
achandra@cdc.gov

**Supporting Statement for Request for Clearance:
NATIONAL SURVEY OF FAMILY GROWTH,
Continuous Interviewing, 2015-2018**

**SECTION B
Collection of Information Employing Statistical Methods**

Table of Contents for Supporting Statement B

1. Respondent Universe and Sampling Methods.....	2
2. Procedures for the Collection of Information.....	5
3. Methods to Maximize Response Rates and Deal with Nonresponse.....	10
4. Tests of Procedures or Methods to be Undertaken.....	14
5. Individuals Consulted on Statistical Aspects and Individual Collecting and/or Analyzing Data.....	14
List of Attachments	16
References	17

*(The reference list includes all references cited throughout the NSFG OMB submission,
with the exception of Attachment M, which includes a separate reference list.)*

NOTE: *The sample design of the 2015-2019 NSFG is similar in most respects to the sample design of the 2006-2010 and 2011-2015 surveys. An abridged description of the sample design for the 2011-15 NSFG is included as part of the User's Guide for the 2011-13 NSFG public use files (http://www.cdc.gov/nchs/nsfg/nsfg_2011_2013_puf.htm). Further details, which apply to the NSFG sample design beyond 2011 as well, are contained in 2 reports on the 2006-2010 NSFG (Lepkowski et al., 2010; Lepkowski et al., 2013).*

1. Respondent Universe and Sampling Methods

Summary—The National Survey of Family Growth (NSFG) is based on a national area probability sample. To control costs, a nationally representative sample of 35 Primary Sampling Units (PSUs) is selected each year, but the majority of PSU's are rotated each year, resulting in a total national sample of 117 PSU's by the end of 4 years of interviewing. The data will be collected annually and continuously. Each year, about 15,000 households will be contacted, in order to yield approximately 5,000 interviews annually. Each year of data is an independent national sample, but the desired sample size and precision for several key estimates and statistics will be attained after about 4 years of interviewing (Sept 2015- June 2019).

Target Population. The target population of the National Survey of Family Growth has long been the household population 15-44 years of age. For the 2015-19 data collection, it is proposed that the age range for respondents will be expanded to 15-49 years of age, however the overall sample size and burden are not expected to increase. The NSFG sample excludes current residents of military bases and institutions (e.g., long-term hospitals, jails, prisons). College students temporarily away from their homes at college are included by sampling them at their home address; they can be interviewed either at home or at college.

Details of the NSFG Sample Design

The sample is selected in 5 stages.

- (1) 117 Primary Sampling Units (Metropolitan Statistical Areas (MSAs), counties, or groups of adjacent counties) are selected at random from the 2,149 PSUs on the sampling frame comprised of the 50 United States plus the District of Columbia over the four year period. PSUs are stratified according to attributes such as Census Division, MSA status, and size, then one or two PSUs are selected from each stratum with the probability of selection proportionate to population size—that is, PSUs with large populations have a larger chance of selection than PSUs with smaller populations. The three PSUs with the largest populations have a probability of selection equal to 1.0, and are included every year.
- (2) Within each of those 117 PSU's, Secondary Sampling Units (SSUs) or sample segments are selected. A segment is a geographical area (e.g., a neighborhood or a group of blocks in cities or an area bounded by roads in a rural area). It can contain as few as 50 structures in a rural area or several hundred in a densely settled urban area. One or two interviewers are assigned to a PSU, and twelve SSUs per interviewer are selected. Each interviewer's 12 segments are divided into 4 groups; 1 group of SSUs is released to each interviewer each calendar year.
- (3) Trained interviewers update commercially-available lists of housing units within an SSU. If a commercially-available listing is unavailable, interviewers visit the geographically-

delimited segment and prepare a list of housing unit addresses

- (4) Once the addresses are listed or verified within an SSU, a sample of housing units is selected for the study.
- (5) After an advance letter is sent to each selected household informing them about the study (**Attachment H1**), a trained survey interviewer visits the household to collect a household roster (or screener), in order to see if someone 15-49 years of age lives there. If more than one person is 15-49 and eligible, then one person is selected at random for the main interview, using a sampling algorithm which assigns a slightly higher probability of selection to teens 15-19, Hispanics, and Blacks.

The *rotating* feature of the PSUs permits a cost efficiency of ongoing sampling and data collection operations by using the field interviewing staff and funding in an optimal manner. It further offers at any single year a full national sample for the study, albeit with standard errors of estimates larger than those of the 4-year cumulative sample.

Group quarters with special living arrangements, such as dormitories, institutions, convents, or institutional group homes (for convicts, the frail elderly, or the developmentally disabled) may be listed but will not be selected for interviewing, because they are outside the scope of a sample of the household population. Dormitory residents who otherwise live with their parents will be sampled at their parents' homes. Members of the active duty military who live in civilian housing (not on military bases) will be eligible for the sample. The NSFG is a personal, in-home survey. Telephone contacts are permitted only to arrange appointments for interviews after the screener has been conducted, and for verification interviews (**Attachment K**) to ensure that the household was screened and, if applicable, the selected household member completed an interview.

2. Procedures for the Collection of Information

The sample size targets for the NSFG are as follows:

**Sample Size Targets for NSFG Continuous Interviewing 2011-2019
with 2002 (Cycle 6) and 2006-10 sample sizes shown for comparison**

	<u>Cycle 6</u> 2002	<u>4-year</u> Continuous 2006-2010	<u>4-year</u> Continuous 2011-2015	<u>4-year</u> Continuous 2015-2019*
TOTAL	12,571	22,682	20,000	20,000
15-19	2,271	4,662	4,000	4,000
20-49*	10,300	18,020	16,000	16,000
Male	4,928	10,403	9,000	9,000
Female	7,643	12,279	11,000	11,000
Hispanic	2,712	5,132	4,000	4,000
Black	2,460	4,389	4,000	4,000
White & other	7,399	13,161	12,000	12,000

**Subject to change based on available funding and fieldwork conditions*

***The NSFG age range will be expanded to 15-49 beginning in September 2015.*

The sample sizes cumulated in 2015-2019 will allow more reliable national estimates for policy-relevant demographic populations, of relatively infrequent family formation activities, and of societal changes that impact the lives of children and adults, continuing the critical data collection role the NSFG has played in the past. The NSFG is the only national source of men and women's experience with adopting children and is a rich and invaluable source for information on fathers' interactions with children they live with and children they live apart from. It provides data on teen's sexual activity (or lack thereof) by age, race and Hispanic origin to augment the birth certificate information and highlight trends and differentials in birth rates. Other demographic groups that this sample size will allow to be studied more reliably include: infertile women 35 years of age and older and persons who are at potentially higher risk of HIV because of their sexual behavior.

The current contractor for the NSFG is the University of Michigan's Institute for Social Research (ISR; Mick Couper, Project Director, and Heidi Guyer, Field Director). Under the

supervision and monitoring of NCHS, ISR recruits and trains the interviewers for the NSFG and carries out the fieldwork. The main steps in the fieldwork are described below.

Main steps in NSFG field work:

- (1) Before contacting households, the contractor will send an advance letter and informational brochure to all sampled households. These materials, in English and Spanish, explain who is sponsoring the NSFG, who is conducting the interviews, why the survey is being done, and the voluntary and confidential nature of the survey. NCHS staff and NSFG-trained personnel at the University of Michigan are available by phone through 800 numbers to answer any questions householders who receive the advance materials may have. The letters and informed consent materials are shown in **Attachments H1-H3**.
- (2) Approximately 1 week after the advance materials are mailed, interviewers go to the sampled households. When the housing unit is found to be occupied and there is a person (18 or older) at home, the screener interview (**Attachment H4**) is conducted. The purpose of the screener is to list the persons living in the household and their ages, and if one or more are 15-49 years of age, to select one. Age, race, and Hispanic origin are collected in the screener because teenagers, Blacks, and Hispanics are selected at somewhat higher rates than other persons.
- (3) When a person 15-17 years of age is selected to be interviewed, signed parental consent is obtained before the interviewer introduces the survey to the teenager. A parent letter and consent form will be used to explain the survey to the minor's mother, father, or legal guardian, and ask for their written consent. If the parent gives consent, then the interviewer introduces the survey to the 15-17 year old, and asks whether the teenager is willing to do the survey. If the teen is willing, he or she signs the "Minor Assent" form (**Attachment H3**), and proceeds to the interview. If either the parent does not give consent for the interview or the minor does not assent to be interviewed, the case is treated as a refusal.
Emancipated minors - 15-17 year-olds who are married, cohabiting, or living away from their parents for other reasons are rare in a sample of this size. Emancipated minors

have been excluded from the continuous NSFG because the number of emancipated minors selected for the NSFG is so small that excluding this group is unlikely to have any noticeable impact on estimates. Using current IRB rules, however, including them would require special procedures that are too complex and too costly for the NSFG.

- (4) When a person 18-49 years of age is selected to be interviewed, the interviewer gives the selected person an Adult Consent Form (**Attachment H3**), which explains the survey and requests signed consent. If the selected person agrees to do the survey but refuses to sign the form, the interviewer can offer to begin the interview, and ask for a signature at the end of the interview; the interviewer may also sign for the respondent.
- (5) The interviewer gives the respondent \$40 as a “token of appreciation.” The respondent can keep the incentive even if he or she does not finish the interview. (Break-offs are rare in this survey—less than 1 percent.)
- (6) Then the interview is conducted using the female or male questionnaires shown in **Attachments C5 and C6**, using a laptop computer. The interview is divided into two parts. The interviewer administers the first part. This use of the programmed questionnaires makes the interviewer's job easier and reduces interviewer errors because she does not need to determine question wording or routing herself by reading a paper questionnaire. In addition to producing higher quality interview data, the use of the computer also helps to protect respondent confidentiality because the laptop screen can be blanked with a single key stroke or the laptop cover can be closed if another person enters the area where the interview is being collected.
- (7) Finally, at the end of the interviewer-administered interview, the interviewer gives the respondent a set of headphones and the computer, and shows the respondent how to make simple entries on the computer. The respondent then completes a 15-20 minute ACASI section. The interviewer cannot see or hear what questions the respondent is being asked over the headphones, and cannot see or hear the answers that the respondent enters into the computer. Moreover, no one in the household can hear or see either the questions or the answers. This increased privacy has been found to increase the reporting of sensitive behaviors.

While the respondent is filling out the ACASI part of the interview, the interviewer completes the Interview Observation Form using a cellphone application (**Attachment L**). This formalizes the field notes that have been collected in less structured form since the 1973 NSFG, on the location where the interview was done, documenting whether there were interruptions during the interview, and the interviewer's assessment of the quality of the data. (The Interview Observation Form is filled out only by the interviewer; no questions are asked of the respondent.)

- (8) At the end of the ACASI section, the respondent "locks" the computer and returns it to the interviewer. The interviewer then turns off the computer, thanks the respondent, and leaves. Once the respondent locks the interview, the interviewer cannot back up and see the respondent's answers or answers to the questions that came before ACASI.

Quality control

Computer-assisted interviewing improves data quality in several ways:

- (a) Interviewer errors are reduced because interviewers do not have to follow complex routing instructions; the computer does it for them. Interviewer errors in following skip patterns were a principal cause of missing data in paper and pencil interviewing.
- (b) Respondent errors are also reduced with CAPI interviewing. The NSFG contract requires that selected consistency checks be programmed into the questionnaire so that inconsistent answers can be corrected or explained while the interview is still in progress. We continue to work on identifying and resolving logical inconsistencies earlier and more efficiently than in the past, to improve data quality and expedite data release.
- (c) Coding and coding errors are also reduced using CAPI interviewing, and this makes it possible to prepare the data for analysis faster and more accurately. In Continuous Interviewing, earlier cases (e.g., year 1) are being used to discover and correct errors before they affect later cases (e.g., year 2).
- (d) The "Verification" interview is a quality control procedure in which a random sample of 10% of both screened households and interviewed respondents are contacted (usually by telephone) after the interview to verify that the interview was conducted.

Verification of households confirms there was no one in the household 15-49 years of age; verification of respondents confirms that the person was interviewed and all procedures (signed a permission form, token of appreciation received, entered responses his- or herself in ACASI) were followed. **(Attachment K)**

- (e) Editing -- Completed interviews and associated comments entered by interviewers (called F2s because the interviewer uses the F2 function key) are reviewed by Contractor staff. Discrepancies in the data or F2 comments about data issues are shared with NCHS staff to determine the proper course of action. If the case warrants changing, editing of the data is performed by the Contractor. NCHS also performs regular and thorough checks of the quality of monthly data files, as it has in past NSFG survey years.
- (f) Imputation -- Approximately 650 of the most frequently used and central variables (called “Recodes”) are imputed when they have missing values because the respondent refused to answer, didn’t know the answer, or otherwise did not give a valid response. On most of these variables, missing data was less than 1 percent. Income had the largest percentage of missing data, with slightly more than 10% of cases with missing values. For information on the imputation procedure used by the NSFG since 2002, see Lepkowski et al., 2006 and Lepkowski et al., 2013.

Two basic types of imputation were used for these variables (out of about 6,000 variables on the data file):

- regression model-based imputation (used for most variables)
- logical imputation (for a few variables with only a handful of missing cases).

The large majority of imputations are being done by multiple regression imputation using the University of Michigan’s Imputation and Variance Estimation software, which is called “IVEWARE.” As in previous cycles, the public use data files have imputation “flags”—variables that show that a value was imputed--so that data users can assess for themselves whether imputation affects the estimates. Imputation rarely affects estimates in the NSFG because, as noted above, the levels of missing data are generally very low.

(g) Estimation -- Estimation refers to the process of producing weighted numbers and percentages for the population from sample data. For each case, a weight is generated which estimates the number of persons in the population that each sampled person represents. For example, if a woman represents 5,000 women in the US household population, her sample weight is 5,000. The weight for each respondent is created in 4 basic steps:

- inflation by the reciprocal of the probability of selection,
- adjustment for sampling nonresponse based on the probability of completing a screener and the probability that a completed screener results in a completed interview
- post-stratification to independent control totals within age, race/Hispanic origin, and sex categories, provided by the Census Bureau, and
- trimming of a small number of extreme weights.

Probabilities of selection vary because black, Hispanic, and teenage respondents are slightly oversampled, and because selected respondents who have not completed a main interview are sub-sampled for Phase 2 of data collection). Adjustments for non-response are made by multivariate (logistic regression) methods. Post-stratification to control totals is done within cells defined by race and Hispanic origin, age, and sex.

Variances are estimated using a Taylor Series linearization approach similar to that used in the 2002 and 2006-2010 NSFGs, as described by Lepkowski et al., 2013. Codes were generated that allow data users to compute variances using Taylor Series linearization, Balanced Half-Sample Replication, or Jackknife replication methods (Lepkowski et al., 2010; Rust, 1985). A similar procedure will be used to produce the data files for 2015-19.

3. Methods to Maximize Response Rates and Deal with No-response

As discussed above, we use Advance Letters, highly trained interviewers; a web site; toll-free numbers at both the University of Michigan and at NCHS; customized follow-up letters to address particular concerns selected respondents may have about the survey; special

interviewer training on non-response, to encourage participation and “avert refusals”; and active survey management using daily paradata, which is data about the fieldwork, to allocate interviewer effort most cost-effectively. Our principal guidance in dealing with non-response is our experience in the 2002, 2006-2010, and 2011-2013 NSFGs, have been documented in a number of published reports (Groves et al., 2005; Groves and Heeringa, 2006; Groves et al., 2009; Lepkowski et al., 2010; Lepkowski et al., 2013).

Procedures are listed separately for non-contacts, and for refusals. For non-contacts, the following procedures are used:

- (a) interviewers, when listing or confirming housing units within sample segments, document units that have access impediments (e.g., locked apartment buildings, or security guards at a community entrance gate). Interviewers will schedule calls on such cases earlier in the field period than others,
- (b) observations are made by the interviewer regarding best times to reach the sampled household, and
- (c) multiple calls are made to the sampled household, at different times of the day and different days of the week.

For refusals, interviewers are trained to avert refusals by understanding and learning to respond to the concerns that potential respondents express. Interviewers are in ongoing contact with their supervisors, allowing interviewers to seek guidance on individual problems they encounter. Throughout this process interviewers are explicitly instructed to treat the sample person’s concerns as legitimate questions that deserve thoughtful answers. Letters addressing specific respondent concerns are mailed to an individual’s household with the intent of allaying these concerns (**Attachment H5**). The NSFG approach is to answer respondents’ questions and to respect the decisions they ultimately make about participating in the survey. Emphatic or “hard” refusals are accepted as final.

Guidance to interviewers in continuous interviewing is based on the research and experience cited above, and on extensive paradata collected and recorded by interviewers and other field staff. These data are summarized using logistic regression equations into a total

propensity to respond for an entire segment. These data (and case-specific observations entered into the contractor's sample management system) can be used to guide further actions on individual cases. (*Paradata are discussed further in Lepkowski et al., 2013.*)

Incentives - Given that even the good survey practices described above are unlikely to attain an 80% response rate with the budget available to the NSFG, in Section A9, we requested OMB clearance in 2014 to continue to increase our \$40 cash incentive to \$60. Previous research (Singer E, 2002; Kulka R, 2002; Groves RM, Couper MP, Presser S, et al.; 2006; Davern M, Rockwood TH, Sherrod R, and Campbell S, 2003; **Attachments D1** and **D2**) suggests that, for long, sensitive, in-person surveys, incentives do help raise response rates and help to control fieldwork costs when standard good survey practice is not enough.

Incentives at the \$40 level appear to be especially effective among minorities, teenagers, and low-income people. That observation is consistent with the NSFG's experience in the 2002, 2006-2010, and 2011-2013. Given that interviewer labor costs about \$25 an hour (including indirect costs and supervisor time), this \$40 amount quickly pays for itself because it saves interviewers time and maintains our average hours per completed case.

At the same time, we have also found (see **Attachment D1**) that incentives of \$80 during Phase II sampling (given to just 6% of completed interviews in 2006-2010) are necessary to increase participation from higher-income, married, or college-educated respondents. These groups may also have some distinctive behavioral patterns that would be under-represented if we did not use the follow-up to bring them into the sample.

In response to gradually and steadily declining response rates and increasing resistance rates since the 2002 NSFG, in September 2013 the NSFG launched an experiment testing a higher incentive amount in Phase 1. The experiment randomized area segments to two different treatments: the current \$40 or an experimental amount of \$60. The Phase 2 incentive was the same for both arms: all respondents received \$80 for completing the interview. Although the \$60 incentive resulted in an increased response rate in Phase 1, it did not increase overall response rates. Nor did it lead to reductions in nonresponse bias relative to the \$40 incentive. The incentive increase did result in an increased response rates in Phase I, leading to

a higher overall yield. There was not sufficient evidence to justify changing protocol to an increased incentive.

Nonresponse Bias Analysis

Attachment M describes our approach to measuring and managing nonresponse bias in the NSFG. Procedures to measure and reduce nonresponse bias are built into the daily paradata monitoring of the study. NSFG has the following data resources to warn us of possible nonresponse bias and allow us to act to reduce it during each quarter of fieldwork:

- 1) The NSFG's paradata include observations from interviewers. Their observations include information such as whether the building is locked or access is blocked by other barriers, and assessments of whether the household includes children, whether the respondent is in a sexual relationship, and other characteristics that are correlated with non-response on NSFG outcome variables.
- 2) Key statistics (percent married, percent who have had a child, etc.) are tracked to see if they change when calling effort is increased.
- 3) The response rates of 12 age-race-gender groups that are strongly correlated with many NSFG estimates (e.g., Hispanic males 20-44; black females 15-19) are monitored daily. If response rates are unequal, that inequality could cause biased estimates. By monitoring response rates daily, effort can then be increased on groups with lagging response rates so, that by the end of the quarter, variation in response rates across groups is minimized.
- 4) A two-phase sampling scheme is used. At the end of 10 weeks of fieldwork, a probability sample of non-respondents is selected. Incentives are increased for the selected cases, and different fieldwork techniques are used. Response rates and sample composition can be compared before and after "phase two" of fieldwork.
- 5) Alternative post-survey adjustments for nonresponse can be compared.

These efforts build upon the 2006-2010 and 2011-2013 NSFGs, using essentially the same design, but with continuous improvements in monitoring as more information about field work is obtained to further minimize nonresponse error.

A more complete description of these activities appears in **Attachment M**.

4. Tests of Procedures or Methods to be Undertaken

Given the nature and magnitude of the questionnaire changes being made for 2015, the first several weeks of interviewing in 2015 will serve as the pretest for the new span of continuous interviewing. The 2015 questionnaires will have gone through significant instrument testing at ISR and at NCHS, which should uncover and allow resolution of any issues with the interview specifications. Based on a similarly extensive period of testing prior to the 2011-2015 span of interviewing, we expect the “pretest” interviews to go well and that they will be of sufficient quality to be included in the final data files released publically. We will also ensure that average interview lengths stay within the approved limits of 80 minutes for female respondents and 60 minutes for male respondents, making question cuts or other modifications as necessary.

Crossover study of sexual orientation question from NHIS: As noted in supporting statement, part A, the NSFG will include a crossover study of the NHIS question on sexual orientation relative to the current NSFG question. This study, involving a 50-50 random split of respondents, will begin in September 2015, and will assess the distributions based on questions placed in the identical location within ACASI. The study is expected to continue at least through September 2017, at which point results will be evaluated. Once findings from the cross-over study have been assessed, it is likely the NSFG will then continue with the NHIS question for 100% of the respondents, as this question has been developed, tested and iteratively refined at NCHS (Dahlhamer et al., 2014; Ward et al., 2014).

5. Individuals Consulted on Statistical Aspects and Individual Collecting and/or Analyzing Data

The statistical consultants (on NSFG sample design, variance estimation, and statistical methods) for NCHS are:

Van L. Parsons, Ph.D.
Mathematical Statistician
NCHS Office of Research and Methodology
301-458-4421 vparsons@cdc.gov

Yulei He, Ph.D.
Mathematical Statistician
NCHS Office of Research and Methodology
301-458-4533 wdq7@cdc.gov

The NSFG sample selection, data collection, and receipt/approval of contract deliverables are supervised for NCHS by:

Joyce C. Abma, Ph.D.
Contracting Officer Representative, NSFG
NCHS, Room 7309
3311 Toledo Road
Hyattsville, MD 20782
301-458-4058 jabma@cdc.gov

The NSFG sample selection, data collection, and production of contract deliverables are supervised for the contractor by:

Mick Couper, Ph.D., Project Director, NSFG, and
Associate Director, Survey Research Center,
University of Michigan
426 Thompson St, Ann Arbor, MI 48104
734-647-3577 mcouper@isr.umich.edu

James Wagner, Ph.D.
Senior Mathematical Statistician, NSFG
Institute for Social Research
University of Michigan
426 Thompson Street, Ann Arbor, MI 48104
734-647-5600 jameswag@isr.umich.edu

The person responsible for the analysis of the survey is:

Anjani Chandra, Ph.D, Principal Investigator for NCHS
Health Scientist and NSFG Team Lead
NCHS, Room 7419
3311 Toledo Road
Hyattsville, MD 20782
301-458-4138 achandra@cdc.gov

LIST OF ATTACHMENTS

A. Authorizing legislation

- A1. National Survey of Family Growth, National Center for Health Statistics
- A2. Office of Family Planning, Office of Population Affairs
- A3. Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH
- A4. Children's Bureau, ACF
- A5. Assistant Secretary for Planning and Evaluation, HHS
Division of HIV/AIDS Prevention, CDC
Division of Sexually Transmitted Disease Prevention, CDC
Division of Reproductive Health, CDC
- A6. Office of Planning, Research, & Evaluation, ACF
- A7. Division of Cancer Prevention and Control, CDC
- A8. Division of Birth Defects and Developmental Disabilities, CDC

B. 60-day Federal Registry Notice

- B1. 60-Day Notice for the National Survey of Family Growth, 2015
- B2. Public Comment on 60-Day Notice

C. NSFG Questionnaires, 2013 and 2015

- C1. 2013 Female CAPI-lite
- C2. 2013 Male CAPI-lite
- C3. 2015 Female CAPI-lite showing markup of substantive revisions since 2013
- C4. 2015 Male CAPI-lite showing markup of substantive revisions since 2013
- C5. 2015 Female CAPI-lite clean version
- C6. 2015 Male CAPI-lite clean version
- C7. Summary of questionnaire changes for 2015

D. Memoranda from other offices and agencies

- D1. NCHS Public Affairs Office
- D2. Healthy People 2020 Health Objectives on Family Planning, HIV, STDs
- D3. Office of Population Affairs
- D4. NICHD, NIH
- D5. Children's Bureau, ACF, DHHS
- D6. OASPE (Office of the Assistant Secretary for Planning and Evaluation)
- D7. Office of Planning, Research, & Evaluation, ACF, DHHS
- D8. Division of HIV/AIDS Prevention, CDC
- D9. Division of Sexually Transmitted Disease Prevention, CDC
- D10. Division of Cancer Prevention and Control, CDC
- D11. Division of Birth Defects and Developmental Disabilities, CDC
- D12. Division of Reproductive Health
- D13. Office of Adolescent Health, DHHS

E. Consultation outside the agency

- E1. Report of the NSFG Review Group for the NCHS Board of Scientific Counselors, April, 2010
- E2. Report on Nov 15-17 visit to CDC
- E3. Agenda for the 2012 NSFG Research Conference
- E4. Summary materials from Nov 2013 ACA Advisory Workshop
- E5. Summary materials from Apr 2014 Advisory Workshop

- F. Partial list of publications from the Survey**
 - F1. List of publications from the 2002 NSFG
 - F2. List of publications from the 2006-2010 NSFG
- G. A Review of the Use of Incentives in the NSFG**
 - G1. Incentive Use Experiments in the NSFG
 - G2. 2013-14 incentive experiment and results memo
- H. Respondent Materials for the NSFG**
 - H1. Advance Household and Advance Respondent Letters
 - H2. Brochures and Letter of Authorization.
 - H3. Consent Forms
 - H4. Screener Questionnaire
 - H5. Letters to Address Respondent Concerns and Avert Refusals
- I. IRB Approval Form for NSFG Protocol #2011-11**
- J. Justifications for Sensitive Questions in the Self-Administered (ACASI) part of the NSFG**
- K. Verification Questionnaires**
 - K1. Screener Verification
 - K2. Main Interview Verification
- L. Interviewer Observation Form**
- M. Non-Response Bias Analyses for the continuous NSFG**

REFERENCES

- Abma J, Chandra A, Mosher W, Peterson L, Piccinino L. 1997. Fertility, Family Planning, and Women's Health: New Data from the 1995 National Survey of Family Growth. Vital and Health Statistics 23(19). Hyattsville, MD: National Center for Health Statistics.
- Abma J, Driscoll A, Moore K. 1998. Differing Degrees of Control over First Intercourse and Young Women's First Partners: Data from the 1995 National Survey of Family Growth. Family Planning Perspectives 30(1):12-18.
- Abma J, Martinez G, Mosher W, Dawson B. 2004. Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2002. Vital and Health Statistics 23(24). Hyattsville, MD: National Center for Health Statistics.
- Adimora AA, Schoenbach VJ, Doherty IA. 2007. Concurrent sexual partnerships among men in the United States. American Journal of Public Health 97(12):2230-2237.
- Adimora AA, Schoenbach VJ, Taylor EM, Khan MR, Schwartz MJ. 2011. Concurrent Partnerships, Nonmonogamous Partners, and Substance Use Among Women in the United States. American Journal of Public Health 101(1): 128-136.

- Adimora AA, Hughes, JP, Wang, J, Haley, DF, Colin, CE et al. 2014. Characteristics of multiple and concurrent partnerships among women at high risk of HIV infection. Journal of Acquired Immune Deficiency Syndromes 65(1): 99-106.
- American College of Obstetrics & Gynecology, 2013. Addressing health risks of noncoital sexual activity. No. 582. <http://www.acog.org/-/media/Committee-Opinions/Committee-on-Adolescent-Health-Care/co582.pdf?dmc=1&ts=20150122T1302073957>.
- American College of Obstetrics and Gynecology. 2011. Tobacco Use and Women's Health. No. 503. <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Tobacco-Use-and-Womens-Health>
- Andersen BA, Ostergaard L, Puho E, MV Skriver & HC Schonheyder. 2005. Ectopic Pregnancies and Reproductive Capacity after Chlamydia Trachomatis Positive and Negative Test Results: A Historical Follow-Up Study. Sexually Transmitted Diseases 32(6):377-381.
- Anderson JE, Brackbill R, Mosher W. 1996. Condom Use for Disease Prevention among Unmarried U.S. Women. Family Planning Perspectives 28(1):25-28.
- Anderson JE, Carey JW, Taveras S. 2000. HIV Testing among the General US Population and Persons at Increased Risk: Information from National Surveys, 1987-1996. American Journal of Public Health 90(7):1089-1095.
- Anderson JE, Chandra A, Mosher WD. 2005. HIV Testing in the United States, 2002. Advance Data No. 363. Hyattsville, MD: National Center for Health Statistics.
- Anderson JE, Mosher WD, Chandra A. 2006. Measuring HIV Risk in the US Population aged 15-44: Results of the 2002 NSFG. Advance Data No. 377. Hyattsville, MD: National Center for Health Statistics.
- Anderson JE, Sansom S. 2006. HIV Testing Among U.S. Women During Prenatal Care: Findings from the 2002 National Survey of Family Growth. Maternal and Child Health Journal 10(5):413-417.
- Aral S, Mosher W, Cates W Jr. 1991. Self-reported Pelvic Inflammatory Disease in the United States, 1988. Journal of the American Medical Association 266(18):2570-2573.
- Aral SO, Leichliter JS. 2010. Non-monogamy: risk factor for STI transmission and acquisition and determinant of STI spread in populations. Sexually Transmitted Infections 86(3):29-36.
- Badgett LMV, Durso LE, Schneebaum A. 2013. New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community. The Williams Institute.
- Baggaley RF, White RG, Boily MC. 2008. Systematic review of orogenital HIV-1 transmission probabilities. International Journal of Epidemiology. 37(6):1255-65.
- Baggaley RF, Dimitrov D, Owen BN, Pickles M, Butler AR, Masse B, Boily M-C. 2013. Heterosexual anal intercourse: a neglected risk factor for HIV? American Journal of Reproductive Immunology 69 (Suppl. 1): 95-105.
- Bauer GR, Jairam JA. 2008. Are lesbians really women who have sex with women (WSW)? Methodological concerns in measuring sexual orientation in health research. Women and Health 48(4):383-408.
- Bauer GR, Jairam JA, Baidoobonso SM. 2010. Sexual Health, Risk Behaviors, and Substance Use in Heterosexual-Identified Women with Female Sex Partners: 2002 US National Survey of Family Growth. Sex Transm Dis 37(9):531-537.

- Boehmer U, Bowen DJ, Bauer GR. 2007. Overweight and Obesity in Sexual-Minority Women: Evidence from Population-Based Data. American Journal of Public Health 97(6): 1-7.
- Boyer D, Fine D. 1992. Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment. Family Planning Perspectives 24:4-11, 19.
- Bramlett MD, Mosher WD. 2002. Cohabitation, Marriage, Divorce, and Remarriage in the United States. Vital and Health Statistics 23(22). Hyattsville, MD: National Center for Health Statistics.
- Bankole A, Darroch JE, Singh S. 1999. Determinants of Trends in Condom Use in the United States, 1988-1995. Family Planning Perspectives 31(6):264-271.
- Brewer, T. H., Zhao, W., Metsch, L. R., Coltes, A., & Zenilman, J. 2007. High-risk behaviors in women who use crack: Knowledge of HIV serostatus and risk behavior. Annals of Epidemiology. 17: 533-539.
- Brewster KL, Tillman KH. 2008. Who's Doing It? Patterns and Predictors of Youths' Oral Sexual Experiences. Journal of Adolescent Health 42(1): 73-80.
- Brown JW, Villarruel AM, Oakley D, Eribes C. 2003. Exploring Contraceptive Pill Taking Among Hispanic Women in the United States. Health Education and Behavior 30(6):663-682.
- Brunner LR, Hogue CJ. 2005. The role of body weight in oral contraceptive failure: results from the 1995 national survey of family growth. Annals of Epidemiology 15(7):492-9, Jan 2005.
- Brunner-Huber LR, Toth JL. 2007. Obesity and Oral Contraceptive Failure: Findings from the 2002 National Survey of Family Growth. American Journal of Epidemiology 166(11):1306-1311.
- Bryant-Genevier MM, Martin CE, Terplan M. 2014. Reproductive Health Needs Among Drug Treatment Clients. Obstetrics and Gynecology 123(1): 1045.
- Callegaria LS, Nelsonc KM, Arterburnd DE, Pragera SW, Schiffa MS, Bimla Schwarzg E. 2014. Factors associated with lack of effective contraception among obese women in the United States. Contraception 90:265-71.
- Cates W Jr, Rolfs RT Jr, Aral SO. 1990. Sexually Transmitted Diseases, Pelvic Inflammatory Disease, and Infertility: An Epidemiologic Update. Epidemiologic Reviews 12:199-220.
- Cates W Jr, Wasserheit JN, Marchbanks PA. 1994. Pelvic Inflammatory Disease and Tubal Infertility: The Preventable Conditions. Annals of the NY Academy of Sciences 709:179-95.
- Centers for Disease Control and Prevention. 2011. Characteristics associated with HIV infection among heterosexuals in urban areas with high AIDS prevalence – 24 Cities, United States, 2006-2007. MMWR. 60(31):1045-1049.
- Centers for Disease Control and Prevention. HIV surveillance report. 2012. Vol 24.
- Chabot MJ, Lewis C, de Bocanegra HT, Darney P. 2011. Correlates of Receiving Reproductive Health Care Services Among U.S. Men Aged 15 to 44 Years. American Journal of Men's Health 5(4):358-366.
- Chandra A. 1995. Health Aspects of Pregnancy and Childbirth: United States, 1982 and 1988. Vital and Health Statistics 23(18). Hyattsville, MD: National Center for Health Statistics.

- Chandra A, GM Martinez, WD Mosher, JC Abma & J Jones. 2005. Fertility, Family Planning, and Reproductive Health of U.S. Women: Data from the 2002 National Survey of Family Growth. Vital and Health Statistics 23(25). Hyattsville, MD: National Center for Health Statistics.
- Chandra A, Mosher WD, Copen CE, Sionean C. 2011. Sexual Behavior, Sexual Attraction, and Sexual Identity in the United States: Data from the 2006-2008 National Survey of Family Growth. National Health Statistics Reports No. 36. Hyattsville, MD: National Center for Health Statistics.
- Chandra A, Billioux VG, Copen CE, Balaji A, DiNenno E. 2012a. HIV Testing in the U.S. Household Population Aged 15-44: Data From the National Survey of Family Growth, 2006-2010. National Health Statistics Reports No. 58. Hyattsville, MD: National Center for Health Statistics.
- Chandra A, Billioux VG, Copen CE, Sionean C. 2012b. HIV Risk-related Behaviors in the United States Household Population aged 15-44: Data from the National Survey of Family Growth, 2002 and 2006-2010. National Health Statistics Reports No 46. Hyattsville, MD: National Center for Health Statistics.
- Chandra A, Copen CE, Mosher, WD. 2012c. Sexual Behavior, Sexual Attraction, and Sexual Identity in the United States: Data from the 2006-2010 National Survey of Family Growth. In Amanda Baumle (Ed.) International Handbook on the Demography of Sexuality. New York, NY. Springer Publishing Company.
- Chandra A, Copen CE, Stephen EH. 2013. Infertility and impaired fecundity in the United States, 1982-2010: Data from the National Survey of Family Growth. National Health Statistics Reports No. 67. Hyattsville, MD: National Center for Health Statistics.
- Chandra A, Copen CE, Stephen EH. 2014. Infertility service use in the United States: Data from the National Survey of Family Growth, 1982-2010. National Health Statistics Reports No. 73. Hyattsville, MD: National Center for Health Statistics.
- Cherpes TL, Meyn LA, Hillier SL. 2005. Cunnilingus and vaginal intercourse are risk factors for herpes simplex virus type 1 acquisition in women. Sexually Transmitted Diseases. 32(2):84-9.
- Chesson HW, Blandford JM, Gift TL, Tao G, Irwin KL. 2004. The Estimated Direct Medical Cost of Sexually Transmitted Diseases among American Youth, 2000. Perspectives on Sexual and Reproductive Health 36(1):11-19.
- Child Trends, Inc. 2005. New Data on Oral Sex Among Teens. Child Trends DataBank Indicator. Child Trends, Inc., Washington, DC.
- Child Trends, Inc. 2014. Adolescents Who Have Ever Been Raped. <http://www.childtrends.org/?indicators=adolescents-who-have-ever-been-raped>
- Copen CE, Chandra A, Martinez G. 2012. Prevalence and timing of oral sex with opposite-sex partners among females and males aged 15-24 years: United States, 2007-2010. National Health Statistics Reports No. 56. Hyattsville, MD: National Center for Health Statistics.
- Dahlhamer JM, Galinsky AM, Joestl SS, Ward BW. Sexual orientation in the 2013 National Health Interview Survey: A quality assessment. Vital Health Stat 2(169). 2014.
- Daniels K, Daugherty J, Jones J. Current contraceptive status among women aged 15-44: United States, 2011-2013. NCHS Data Brief No. 173. Hyattsville, MD: National Center for Health Statistics. 2014.
- Darroch D, Landry D, Oslak S. 1999. Sexual Partnership Patterns as a Behavioral Risk Factor for Sexually Transmitted Diseases. Family Planning Perspectives 31(5):228-236.

- Davern M, Rockwood TH, Sherrod R, and Campbell S. Prepaid Monetary Incentives and Data Quality in Face-to-Face Interviews: Data from the 1996 Survey of Income and Program Participation Incentive Experiment. Public Opinion Quarterly 67: 139-147. 2003.
- D'Souza G, Cullen K, Bowie J, Thorpe R, Fakhry C. 2014. Differences in Oral Sexual Behaviors by Gender, Age, and Race Explain Observed Differences in Prevalence of Oral Human Papillomavirus Infection. PLoS ONE 9(1): e86023. doi:10.1371/journal.pone.0086023
- Edwards S, Carne C. 1998. Oral Sex and the Transmission of Non-viral STIs. Sexually Transmitted Infections 74:95-100.
- Eisenberg ML, Shindel AW, Smith JF, Breyer BN, Lipshultz LI. 2010. Socioeconomic, Anthropomorphic, and Demographic Predictors of Adult Sexual Activity in the United States: Data from the National Survey of Family Growth. Journal of Sexual Medicine 7(1):50-8.
- Eng TR & WT Butler, eds. 1997. The Hidden Epidemic: Confronting Sexually Transmitted Diseases. Washington, DC: Institute of Medicine and National Academy Press.
- Finer L, JE Darroch & S Singh. 1999. Sexual Partnership Patterns as a Behavioral Risk Factor for Sexually Transmitted Diseases. Family Planning Perspectives 31(5):228-236.
- Ford C, Pence BW, Miller WC, Resnick MD, Bearinger LH, Pettingell S, Cohen M. 2005. Predicting Adolescents' Longitudinal Risk for Sexually Transmitted Infection: Results from the National Longitudinal Study of Adolescent Health. Archives of Pediatrics and Adolescent Medicine. 159(July).
- Ford JL. 2011. Racial and Ethnic Disparities in Human Papillomavirus Awareness and Vaccination among Young Adult Women. Public Health Nursing 28(6):485-93.
- Freeman P, Walker BC, Harris DR, Garofalo R, Willard N et al. Methamphetamine use and risk for HIV among young men who have sex with men in 8 US cities. Archives of Pediatric and Adolescent Medicine. 165(8):736-740. 2011.
- Fryer CD, Hirsch R, Porter KS et al. 2007. Drug use and sexual behaviors reported by adults: United States, 1999-2002. Advance Data No. 384. Hyattsville, MD: National Center for Health Statistics.
- Fu H, Darroch JE, Henshaw SK, Kolb E. 1998. Measuring the Extent of Abortion Underreporting in the 1995 NSFG. Family Planning Perspectives 30(3):128-33, 8.
- Gates GJ. Sexual minorities in the 2008 General Social Survey: Coming out and demographic characteristics. The Williams Institute. 2010.
- Gibson-Davis C, Rackin H. 2014. Marriage or Carriage? Trends in Union Context and Birth Type by Education. Journal of Marriage and Family 76:506-19.
- Gillum RF, Sullins DP. 2008. Cigarette smoking during pregnancy: Independent associations with religious participation. Southern Medical Journal 101(7):686-692.
- Goodwin PY, Mosher WD, Chandra A. 2010. Marriage and cohabitation in the United States: A statistical portrait based on Cycle 6 (2002) of the National Survey of Family Growth. Vital Health Stat 23(28). Hyattsville, MD: National Center for Health Statistics.

- Groves R, Benson G, Mosher W, et al. Plan and Operation of Cycle 6 of the National Survey of Family Growth. Vital and Health Statistics 1(42). Hyattsville, MD: National Center for Health Statistics. 2005. Available at: http://www.cdc.gov/nchs/data/series/sr_01/sr01_042.pdf.
- Groves RM, Couper MP, Presser S, et al. Experiments in Producing Nonresponse Bias. Public Opinion Quarterly 70: 720-736. 2006.
- Groves R and Heeringa SG. Responsive Design for Household Surveys: Tools for actively controlling survey errors and costs. Journal of the Royal Statistical Society A169, Part 3: 439-457. 2006.
- Groves R, Mosher WD, et al. 2009. Planning and Development of the Continuous National Survey of Family Growth. Vital and Health Statistics 1(48). Hyattsville, MD: National Center for Health Statistics. 2009. Available at: http://www.cdc.gov/nchs/data/series/sr_01/sr01_048.pdf.
- Haderxhanaj LT, Leichliter JS, Aral SO, Chesson HW. 2014a. Sex in a Lifetime: Sexual Behaviors in the United States by Lifetime Number of Sex Partners, 2006-2010. Sexually Transmitted Diseases 41(6):345-52.
- Haderxhanaj LT, Dittus PJ, Loosier PS, Rhodes SD, Bloom FR, Leichliter JS. 2014b. Acculturation, Sexual Behaviors, and Health Care Access Among Hispanic and Non-Hispanic White Adolescents and Young Adults in the United States, 2006-2010. Journal of Adolescent Health 55(5):716-19.
- Hall KS, Moreau C, Trussell J. 2013. The Link Between Substance Use and Reproductive Health Service Utilization Among Young US Women. Substance Abuse 34:283-1.
- Halpern-Felsher BL, Cornell JL, Kropp KY, Tschann JM. 2005. Oral versus Vaginal Sex among Adolescents: Perceptions, Attitudes, and Behavior. Pediatrics 115:845-851.
- Hamilton DT, Morris M. 2010. Consistency of self-reported sexual behavior in surveys. Archives of Sexual Behavior. 39(4):842- 60.
- Hatcher RA, Trussell J, Nelson AL, Cates W Jr, Kowal, D, Policar, MS. 2011. Contraceptive Technology. 20th revised ed. New York, NY: Ardent Media, Inc.
- Hawkins DA. 2001. Oral Sex and HIV Transmission. Sexually Transmitted Infections 77:307-308.
- Hewitt M, Devesa S, Breen N. 2002. Papanicolaou Test Use Among Reproductive-Age Women at High Risk for Cervical Cancer: Analyses of the 1995 National Survey of Family Growth. American Journal of Public Health 92(4):666-669.
- Hillis SD, Owens LM, Marchbanks PA, Amsterdam LF, MacKenzie WR. 1997. Recurrent Chlamydial Infections Increase the Risks of Hospitalization for Ectopic Pregnancy and Pelvic Inflammatory Disease. American Journal of Obstetrics and Gynecology 176 (1 Pt 1):103-7.
- Institute of Medicine. 2011. The health of lesbian, gay, bisexual and transgender people: Building a better understanding. The National Academies Press. Washington , D.C.
- Jagannathan R. 2001. Relying on Surveys to Understand Abortion Behavior: Some Cautionary Evidence. American Journal of Public Health 91(11):1825-1831.
- Jeffries WL, Dodge B. 2007. Male Bisexuality and Condom Use at Last Encounter: Results from a National Survey. Journal of Sex Research 44(3): 278-289, Aug 2007.
- Jeffries WL. 2009. A comparative analysis of homosexual behaviors, sex role preferences, and anal sex proclivities

- in Latino and non-Latino men. Archives of Sexual Behavior. 35(5): 765-778.
- Jeffries WL. 2009. Sociodemographic, sexual and HIV and other sexually transmitted disease risk profiles of nonhomosexual-identified men who have sex with men. American Journal of Public Health 99(6):1042-1045.
- Jeffries WL. 2010. HIV Testing Among Bisexual Men in the United States. AIDS Education and Prevention 22(4):356-70.
- Jeffries WL. 2011. The Number of Recent Sex Partners Among Bisexual Men in the United States. Perspect Sex Reprod Health 43(3):151-7.
- Jones E, Forrest JD. 1992. Underreporting of Abortion in Surveys of U.S. Women: 1976 to 1988. Demography 29(1):113-126.
- Jones RK, Kost K. 2007. Underreporting of Induced and Spontaneous Abortion in the United States: An Analysis of the 2002 National Survey of Family Growth. Studies in Family Planning 38(3): 187-197.
- Kandel, D, Kandel, E. 2015. The Gateway Hypothesis of substance abuse: Developmental, biological and societal perspectives. Acta Paediatrica, International Journal of Paediatrics 104(2) 130-137.
- Kaneshiro B, Edelman A, Carlson N, Nichols M, Jensen J. 2008a. The relationship between body mass index and unintended pregnancy: Results from the 2002 National Survey of Family Growth. Contraception 77:234-238.
- Kaneshiro B, Jensen JT, Carlson NE, Harvey SM, Nichols MD, Edelman AB. 2008b. Body mass index and sexual behavior. Obstetrics and Gynecology 112(3): 586-592.
- Kaneshiro, B. 2012. Contraceptive Use Among Obese Women. Seminars in Reproductive Medicine 30(6): 459-464.
- Kirby D, G Lepore & J Ryan. 2005. Sexual risk and protective factors: Factors affecting teen sexual behavior, pregnancy, childbearing, and sexually transmitted disease—Which are important? Which can you change? Washington, DC: The National Campaign to Prevent Teen Pregnancy.
- Kulka R. The Use of Incentives to Survey 'Hard to Reach' Respondents. Pages 256-287 in Federal Committee on Statistical Methodology, Statistical Policy Working Paper No. 23, Volume 2. 2002.
- Lansky A, Finlayson T, Johnson C, Holtzman D, Wejnert C, Mitsch A, Gust D, Chen R, Mizuno Y, Crepaz N. 2014. Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections. PLOS ONE 9(5):e97596.
- Laumann EO, Gagnon JH, Michael RT, and Michaels S. 1994. The Social Organization Sexuality: Sexual Practices in the United States. Chicago: University of Chicago Press.
- Leichliter JS, Chandra A, Liddon N, Fenton KA, Aral SO. 2007. Prevalence and Correlates of Heterosexual Anal and Oral Sex in Adolescents and Adults in the United States. Journal of Infectious Diseases 196 (15 December): 1852-1859.
- Leichliter J, Aral S. 2009. Black women in the United States decrease their number of recent sex partners: temporal trends from the national survey of family growth. Sexually Transmitted Diseases 36(1):1-3.

- Leichliter JS, Chesson HW, Sternberg M, Aral SO. 2010. The concentration of sexual behaviours in the USA: a closer examination of subpopulations. Sex Transm Infect 86(3):45-51.
- Leichliter JS, Chandra A, Aral SO. 2013. Correlates of Self-Reported Pelvic Inflammatory Disease Treatment in Sexually Experienced Reproductive-Aged Women in the United States, 1995 and 2006-2010. Sexually Transmitted Diseases 40(5):413-18.
- Lepkowski JM, Mosher WD, Davis KE, et al. National Survey of Family Growth, Cycle 6: Sample design, weighting, imputation, and variance estimation. National Center for Health Statistics. Vital Health Stat 2(142). 2006. Available at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_142.pdf.
- Lepkowski J, et al. 2010. The 2006-2010 National Survey of Family Growth: Sample Design and Analysis of a Continuous Survey. Vital and Health Statistics 2(150). Hyattsville, MD: National Center for Health Statistics. 2010. Available at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_150.pdf
- Lepkowski J, Mosher WD, Groves RM, et al. 2013. Responsive Design, Weighting, and Variance Estimation in the 2006-2010 National Survey of Family Growth. Vital and Health Statistics 2 (158). Hyattsville, MD: National Center for Health Statistics. 2013. Available at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_158.pdf
- Lindberg LD, Jones R, Santelli JS. 2008. Noncoital sexual activities among adolescents. Journal of Adolescent Health. 43(3): 231-238.
- Manlove J, Terry-Humen E, Ikramullah E. 2006. Young Teenagers and Older Sexual Partners: Correlates and Consequences for Males and Females. Perspectives on Sexual and Reproductive Health 38(4):197-207.
- Martinez GM, Chandra, A, Abma JC, Jones J, Mosher WD. 2006. Fertility, Contraception, and Fatherhood: Data on Men and Women from the 2002 National Survey of Family Growth. Vital and Health Statistics 23(26). Hyattsville, MD: National Center for Health Statistics.
- Martinez GM, Copen CE, Abma JC. 2011. Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2006-2010 National Survey of Family Growth. Vital and Health Statistics 23(31).
- Martinez GM, Chandra A, Febo-Vazquez I, Mosher WD. 2013. Use of family planning and related medical services among women aged 15-44 in the United States: National Survey of Family Growth, 2006-2010. National Health Statistics Reports No. 68. Hyattsville, MD: National Center for Health Statistics. 2013.
- Martinez GM, Daniels K, Chandra A. 2012. Fertility of men and women aged 15-44 years in the United States: National Survey of Family Growth, 2006-2010. National Health Statistics Reports No. 51. Hyattsville, MD: National Center for Health Statistics.
- McCabe J, Brewster KL, Tillman KH. 2011. Patterns and Correlates of Same-Sex Sexual Activity among U.S. Teenagers and Young Adults. Perspect Sex Reprod Health 43(3):142-50.
- McNally J, Mosher W. 1991. AIDS-Related Knowledge and Behavior among Women 15-44 Years of Age: United States, 1988. Advance Data No. 200. Hyattsville, MD: National Center for Health Statistics.
- Miller HG, Cain VS, Rogers DM, Gribble JN, Turner CF. 1999. Correlates of Sexually Transmitted Bacterial Infections among US Women in 1995. Family Planning Perspectives 31(5):228-236.
- Moore KA, Nord C, Peterson J. 1989. Nonvoluntary sexual activity among adolescents. Family Planning Perspectives, 21(3): 110-114.

- Mosher WD, Pratt WF. 1993. AIDS-related Behavior among Women 15-44 Years of Age: United States, 1988 and 1990. Advance Data No. 239. Hyattsville, MD: National Center for Health Statistics.
- Mosher W, Chandra A, Jones J. 2005. Sexual Behavior and Selected Health Measures: Men and Women 15-44 Years of Age, United States, 2002. Advance Data No. 362. Hyattsville, MD: National Center for Health Statistics.
- Mosher WD, Jones J. 2010. Use of contraception in the United States: 1982-2008. National Center for Health Statistics. Vital Health Stat 23(29).
- Mullany, B, Barlow, A, Neault, N, Trudy B, Hastings, R, Coho-Mescal, V, Lorenzo, C, Walkup, JT. 2013. Consistency in the reporting of sensitive behaviors by adolescent American Indian women: A comparison of interviewing methods. American Indian and Alaskan Native Mental Health Research 20(2): 42-51.
- Nearns J, Baldwin JA, Clayton H. 2009. Social, behavioral, and health care factors associated with recent testing among sexually active non-Hispanic black women in the United States. Women's Health Issues 19(1):52-60.
- Owusu-Edusei, K, Chesson, HW, Gift, TL, Guoyu, T, Mahajan, R, Ocfemia, M, Kent, C. 2013. The estimated medical cost of selected sexually transmitted infections in the United States, 2008. Sexually transmitted Diseases 40(3): 197-201.
- Page R, Ellison C, Lee J. 2009. Does religiosity affect health risk behaviors in pregnant and postpartum women? Maternal and Child Health Journal 13(5):621-32.
- Petersen H, Walker CK, Kahn JG, Washington AE, Eschenbach DA, Faro S. 1991. Pelvic Inflammatory Disease: Key Treatment Issues and Options. Journal of the American Medical Association 266(18):2605-11.
- Reese, BM, Haydon, AA, Herring, AH, Halpern, CT. 2013. The association between sequences of sexual initiation and the likelihood of teenage pregnancy. Journal of Adolescent Health 52(2): 228-233.
- Remez L. 2000. Oral Sex Among Adolescents: Is it Sex or is it Abstinence? Family Planning Perspectives 32(6):298-304.
- Rothenberg RB, Scarlett M, del Rio C, Reznik D, O'Daniels C. 1998. Oral Transmission of HIV. Acquired Immune Deficiency Syndromes 12:2095-2105.
- Rust, K. 1985. Variance estimation for complex estimators in sample surveys. J Official Stat 1:381-97.
- Ryan S, Franzetta K, Manlove J, Schelar E. 2008. Older Sexual Partners During Adolescence: Links to Reproductive Health Outcomes in Young Adulthood. Perspectives on Sexual and Reproductive Health 40(1):17-26.
- Sanders SA, Reinisch JM. 1999. Would You say You 'Had Sex' if...? Journal of the American Medical Association 281:275-277.
- Santelli J, Lindberg LD, Finer LB, Singh S. 2000. The Association of Sexual Behaviors with Socioeconomic Status, Family Structure, and Race/Ethnicity among U.S. Adolescents. American Journal of Public Health 90(10):1582-1588.
- Satterwhite CL, Torrone E, Meites E, Dunne EF, Mahajan R, Ocfemia MC, Su J, Xu F, Weinstock H. 2013. Sexually transmitted infections among US women and men: prevalence and incidence estimates, 2008. Sexually Transmitted Diseases 40(3):187-93.

- Schuster MA, RM Bell & DE Kanouse. 1996. The Sexual Practices of Adolescent Virgins: Genital Sexual Activities of High School Students Who Have Never Had Vaginal Intercourse. American Journal of Public Health 86(11):1570-1576.
- Singer E. The Use of Incentives to Reduce Nonresponse in Household Surveys,” pages 163-178 in R Groves et al. (editors), Survey Nonresponse. Wiley. 2002.
- Stockman JJ, Campbell JC, Celentano DD. 2010. Sexual violence and STD risk behaviors among a nationally representative sample of heterosexual American women: The importance of sexual coercion. Journal of Acquired Immune Deficiency Syndromes 53(1):136-143.
- Tao G, Tian LH, Peterman TA. 2007. Estimating Chlamydia Screening Rates by Using Reported Sexually Transmitted Disease Test for Sexually Active Women aged 16 to 25 Years in the United States. Sexually Transmitted Diseases 34(3): 180-2.
- Tao G. 2008. Sexual Orientation and Related Viral Sexually Transmitted Disease Rates among US Women Aged 15 to 44 Years. American Journal of Public Health 98 (6): 1007-1009
- The White House Office of National AIDS Policy. 2010. National HIV/AIDS Strategy for the United States. Washington, DC: White House, July 13 2010.
- The White House Office of National AIDS Policy. 2014. National HIV/AIDS Strategy: Update of 2014 Federal Actions to Achieve National Goals and Improve Outcomes Along the HIV Care Continuum. Washington, D.C: White House. December 2014.
- Turner C, Ku L, Rogers S, Lindberg L, Pleck JH, Sonenstein FL. 1998. Adolescent Sexual Behavior, Drug Use and Violence: New Survey Technology Detects Elevated Prevalence among U.S. Males. Science 280:867-73.
- Turner CF, Villarroel M, Chromy J et al. 2005. Same-Gender Sex among US Adults: Trends across the 20th Century and During the 1990s. Public Opinion Quarterly, 69(3):439-62.
- US Department of Health and Human Services. 2014. The health consequences of smoking—50 years of progress: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2014. <http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf>.
- Vahratian A. 2009. Prevalence of overweight and obesity among women of childbearing age: results from the 2002 National Survey of Family Growth. Maternal and Child Health Journal 13(2):268-73.
- van Gelder MMHJ, Reefhuis J, Herron AM, Williams ML, Roeleveld N. 2011. Reproductive Health Characteristics of Marijuana and Cocaine Users: Results from the 2002 National Survey of Family Growth. Perspectives on Sexual and Reproductive Health 43(3):164-72.
- Volpe E, Hardie T, Cerulli C, Sommers M, Morrison-Beedy D. 2013. What’s age got to do with it? Partner age difference, power, intimate partner violence, and sexual risk in urban adolescents. Journal of Interpersonal Violence 28(10): 2068-2087.
- Ward BW, Dahlhamer JM, Galinsky AM, Joestl SS. Sexual orientation and health among U.S. adults: National Health Interview Survey, 2013. National health statistics reports; no 77. Hyattsville, MD: National Center for Health Statistics. 2014.
- Wheldon CW, Kirby RS. 2013. Are There Differing Patterns of Health Care Access and Utilization Among Male Sexual Minorities in the United States? Journal of Gay & Lesbian Social Services 25:24-36.

Williams CM, Brett KM, Abma JC. 2009. Coercive first intercourse and unintended first births. Violence Victims 24(3):351-63.

Williams CM, Clear ER, Coker AL. 2013. Sexual Coercion and Sexual Violence at First Intercourse Associated With Sexually Transmitted Infections. Sexually Transmitted Diseases 40(10): 771-75.

Wilson JB. 1993. Human Immunodeficiency Virus Antibody Testing in Women 15-44 Years of Age: U.S., 1990. Advance Data No. 238. Hyattsville, MD: National Center for Health Statistics.

Xu F, Sternberg MR, Markowitz LE. 2010. Men who have sex with men in the United States: Demographic and behavioral characteristics and prevalence of HIV and HSV-2 infection: Results from National Health and Nutrition Examination Survey, 2001-2006. Sexually Transmitted Diseases 37(6):399-405.