—0.92—means that respondents in the 1988 survey who made a visit were less likely to have become pregnant relative to 1982 respondents, so the first visit had a slightly more protective effect in the 1988 survey than in 1982 survey (i.e., the level of protective effect increased slightly between 1982 and 1988). However, the hazard ratio for the interaction between a first visit and 1995 (1.1) means that women in the 1995 survey who saw a provider were more likely than those in the 1982 survey to have become pregnant unintentionally, and thus the overall protective effect decreased significantly between 1982 and 1995. By implication, the decrease in the protective effect of a first visit occurred between 1988 and 1995.*

According to the analysis that did not factor in the family planning visit variable (middle column of Table 2), the effect of initiating contraceptive use on the risk of an unintended pregnancy was dramatic—a reduction in risk by 81%, or a hazard ratio of 0.19.

When contraceptive initiation and family planning visit status are both included in the analysis (third column of Table 2), the hazard ratio of the risk of unintended pregnancy among those who initiated contraceptive use remains quite low (0.20); thus, such women were at a significantly lower risk of unintended conception, even when a family planning visit was taken into account. Notably, the hazard ratio for the effect of a family planning visit on the likelihood of an unintended pregnancy (0.88) while still less than 1.0, is nonetheless much closer to 1.0 than was the case when the analysis did not control for initiating use (hazard ratio of 0.57). Adding this control significantly reduced the effect of a family planning visit; thus, a substantial part of a visit’s protective effect appears to work through encouraging contraceptive initiation.

Overall, the protective effect of a first visit was lower in the 1995 survey than in the 1982 survey, which suggests that women who delayed a visit in 1991–1995 (compared with those in the same time period who made a visit promptly) did not lose as much by doing so as similar women who delayed a first visit in 1978–1982. This finding results largely from the fact that 1995 respondents who delayed a visit were more likely than 1982 respondents who delayed to have used a method independently of making a visit.

**Discussion**

American women have significantly improved their early contraceptive use. An increase in method use at first intercourse occurred both among those who visited family planning providers promptly and among those who did not. A shift toward condom use as a first method was apparent not only among women who put off a visit, but also among those who went for services before they became sexually active. This finding might be attributable to a greater awareness of AIDS and other STDs and to the desire of more women to protect themselves from diseases and from pregnancy.

The proportion of women who made a family planning visit before their first intercourse declined slightly over the period, while the interval between sexual initiation and a first visit increased among those who delayed. However, the proportion of women who unintentionally became pregnant before their first family planning visit declined regardless of the length of time until a first visit, implying that contraceptive protection during that interval improved overall. This decrease in risk occurred even as the median age at first intercourse declined over time. This finding is notable, given that research has shown that adolescents who begin having intercourse at the youngest ages run an especially high risk of unintended pregnancy.17

The bivariate and multivariate analyses provide some support for the notion that women who delay a first visit are catching up to those who see a provider early in terms of protection against pregnancy. As mentioned earlier, increased education about AIDS and pregnancy have doubtless contributed to this change in contraceptive use, specifically in condom use. But it is also possible that the increase in early contraceptive use is associated with the fact that early initiation of sexual intercourse has become more normative, and is no longer restricted to a population of high-risk youth. Thus, current cohorts of adolescents who now begin intercourse at the youngest ages run an especially high risk of unintended pregnancy.17

Figure 1. Percentage of women who unintentionally became pregnant between first coitus and first family planning visit, by length of that interval, according to survey year

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*The hazard ratios for a first family planning visit at each time period can be calculated by multiplying the ratio for a visit by each family planning visit interaction term. Since 1982 is the reference category, the hazard ratio for 1982 is simply 0.57. The hazard ratio for 1988 would be 0.57×0.92, or 0.53, and the hazard ratio for 1995 would be 0.57×1.13, or 0.65.