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Pregnancy Preferences and Contraceptive Use among US Women

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Abstract

Objectives—An understanding of the relationship between individuals' pregnancy preferences and contraceptive use is essential for appropriate patient-centered counseling and care. We examined the relationship between women's pregnancy preferences and contraceptive use using a new prospective measure, the Desire to Avoid Pregnancy (DAP) scale.

Study Design—As part of a study examining women's suspicion and confirmation of new pregnancies, we recruited patients aged 15 – 45 from seven reproductive health and primary health facilities in Arizona, New Jersey, New Mexico, South Carolina, and Texas in 2016–2017. We used multivariable logistic, multinomial logistic, and linear regression models to examine the associations among DAP scores (range: 0 – 4) and contraceptive use outcomes and identify factors associated with discordance between DAP and use of contraception.

Results—Participants with a greater preference to avoid pregnancy had higher odds of contraceptive use (aOR=1.63, 95% CI: 1.31, 2.04) and used contraceptives more consistently (a β =8.9 percentage points, 95% CI: 5.2, 12.7). Nevertheless, 63% of women with low preference to avoid pregnancy reported using a contraceptive method. Higher preference to avoid pregnancy was not associated with type of contraceptive method used: women with the full range of pregnancy preferences reported using all method types.

Conclusion—When measured using a rigorously developed instrument, pregnancy preferences were associated with contraceptive use and consistency of use. However, our findings challenge

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assumptions that women with the highest preference against pregnancy use more effective methods and that women who might welcome pregnancy do not use contraception.

Implications—Women’s preferences about pregnancy contribute significantly to their use of contraception. However, health care providers and researchers should consider that contraceptive features besides effectiveness in preventing pregnancy shape contraceptive decision-making and use.

Keywords

pregnancy intention; pregnancy preferences; pregnancy risk; contraceptive use; inconsistency in contraceptive use; United States

Introduction

Determining the contribution of pregnancy “intentions” to contraceptive non-use and unintended pregnancy continues to be one of the more stubborn research challenges in reproductive health [1–3]. Pregnancy intent has been repeatedly found to be associated with fertility and related behavior [4–6]. However, there is little consensus on the strength of the relationship between pregnancy intention and contraceptive behavior and what accounts for discordance, such as contraceptive non-use and inconsistent use among women who report they do not desire pregnancy [7–11].

Research findings are inconsistent. Analyses of the 2002 National Survey of Family Growth (NSFG) found that for women “at risk” for unintended pregnancy – sexually active women aged 15–44 who were not pregnant, not sterilized nor seeking pregnancy – there was no relationship between desire for a baby at any point in the future and contraceptive use [12]. Similarly, analyses of nationally representative data of “at risk” women in the United States aged 18–29 found that neither the importance of avoiding pregnancy nor anticipated feelings if pregnancy were to occur were associated with contraceptive use or method type [3,13]. In contrast, research on a national sample of women aged 18–39, not restricted to “at risk” women, found that only reported importance of avoiding pregnancy was associated with consistent contraceptive use; happiness if pregnancy were to occur was not [14]. Large-scale cohort studies from California, Michigan, and Utah have had mixed results: positive attitudes toward pregnancy were associated with inconsistent contraceptive use [9,11]; strong motivation to avoid pregnancy alone increased the odds of using contraception consistently [10]; and long-acting reversible contraceptive uptake depended on the pregnancy intention measure used [15].

These variations in findings are attributable, in part, to differences in study populations assessed and measures used. Study populations have differed by age and demographics, with some including individuals holding the full ranges of pregnancy intentions, and others restricting to those considered “at risk” of unintended pregnancy or not desiring pregnancy [12,16,17]. Contraceptive outcomes have also varied, with some examining contraceptive use or method type, and others assessing consistency of use, discontinuation, or method switching [3,10,14,18,19]. Studies have operationalized “pregnancy intention” in different ways, including trying to get pregnant, desired number of children, and importance of

avoiding pregnancy, and they have utilized diverse measurement approaches (prospective vs. retrospective approaches; categorical or Likert scaled questions) [3,10,11,14,15,18]. Typically, measures have not been formally developed and evaluated nor accounted for the diverse feelings and preferences women may have about a potential pregnancy [20].

In this study, we use a newly developed instrument, the Desire to Avoid Pregnancy scale, to examine the relationship between pregnancy preferences and contraceptive behaviors among reproductive aged women from diverse states [20]. We adopt the term “preferences” instead of “intentions,” in line with the DAP’s theoretic grounding, to acknowledge that individuals often do not have clear intentions, particularly for context-specific outcomes [21]. We assess multiple contraceptive outcomes, including contraceptive use, method type, and consistency of use. We also examine factors associated with discordance between reported pregnancy preferences and contraceptive use. Elucidating how women’s pregnancy preferences affect contraceptive use is critical not only for understanding the underlying factors shaping contraceptive use, but also for guiding appropriate patient-centered contraceptive counseling protocols and clinical care.

Materials and Methods

2.1 Participants and Procedures

In 2016–2017, as part of a study examining how women discover new pregnancies, we recruited participants from seven reproductive health and primary healthcare facilities in Arizona, New Jersey, New Mexico, South Carolina, and Texas. States represented the planned locations of future longitudinal research with the DAP measure. A trained research assistant approached all women in the waiting room, and eligible women (aged 15–45 years, sexually active in the last year, not sterilized, and willing to participate in the anonymous survey) provided verbal informed consent. Ninety-nine percent of women who were screened completed a 30-minute tablet survey on sociodemographic characteristics, relationships, and contraceptive use. Participants who reported that they were not pregnant or did not know whether they were pregnant responded to the pregnancy preferences items. Participants received a \$20 gift card for completing the study. The study received approval from the University of California San Francisco Institutional Review Board in July 2015 (IRB #15–16504).

Overall, 810 women enrolled in the study. Among them, 198 reported current pregnancy. Of the remaining 602, 27 were called into their clinical appointment before completing the DAP or were missing more than half of DAP responses for one domain, leaving 575 women with complete DAP scores. Among these, 66 had not had sex with a male within 30 days, leaving 509 women in contraceptive use analyses.

2.2 Measures

The primary outcome was use of any contraceptive method currently or over the last month: long-acting reversible contraception (LARC), including intrauterine devices and the subdermal implant; short-acting reversible contraception (SARC), including oral contraceptive pills, the vaginal ring, transdermal patch, and Depot medroxyprogesterone

injection; or male condoms, the only barrier method used by participants. We also examined contraceptive method type used (LARC, SARC, condom, none). We categorized the few participants using more than one method according to the more effective method [22] and the few using withdrawal alone or natural methods as no method. For sensitivity analyses, we also examined a version of the method type variable with separate categories for withdrawal and natural method users and dual method users (using both a LARC or SARC method plus condoms). Finally, we measured consistency of contraceptive use in the prior month by asking respondents to indicate the percentage of acts of sexual intercourse during which contraception was used by selecting a response on a line that ranged from 0 – 100%.

The primary independent variable was pregnancy preferences, measured using the Desire to Avoid Pregnancy (DAP) scale [20]. The DAP scale is the first purposefully developed and evaluated psychometric scale that measures the ranges of women's preferences regarding a potential future pregnancy. The 14-item scale allows for uncertainty and ambiguity in preferences, captures feelings about both a potential pregnancy (within three months) and child (within a year), and has items covering three domains: desires, emotions, and perceived consequences (Cronbach's $\alpha=0.95$). Participants respond to each item on a Likert scale (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree); the scale includes items worded both negatively (a baby would make it harder for me to achieve other things in my life) and positively (thinking about a pregnancy makes me feel excited). Scores are averaged across the items to range from 0 to 4, with 4 indicating higher preference to avoid pregnancy and a lower score indicating greater openness to pregnancy. We also examined quartiles of DAP scores.

Sociodemographic covariables included age (years), self-reported race/ethnicity, parity, relationship status (married/main partner and cohabiting, married/main partner and not cohabiting, not married or having a main partner), education (highest grade completed), receiving public assistance, and state of recruitment. We also included household poverty (below or above 100% Federal Poverty Level [FPL] or missing).

2.3 Analyses

We used bivariable linear regression analysis to assess differences in pregnancy preferences by participant characteristics. Then, we used logistic, multinomial logistic, and linear regression models to examine the associations among pregnancy preferences and any contraceptive use, method type, and consistency of use, respectively, controlling for respondent characteristics. We derived predicted means and percentages from these models. To identify factors associated with discordance between pregnancy preferences and contraceptive use, we used logistic regression models examining contraceptive non-use among women in the highest DAP quartile (DAP Q4; high preference to avoid pregnancy) and contraceptive use among women in the lowest DAP quartile (DAP Q1; low preference to avoid pregnancy). For analyses, we used STATA version 15 (College Station, TX).

3. Results

The 575 participants were on average 27 years old (range: 15–45), and 48% identified as Latina, 27% as black, 16% as white, and 9% as multiracial or other (Table 1). About half

were married or had a main partner with whom they lived, and 14% reported no main partner. Thirty-eight percent were nulliparous. Sixty-one percent of participants had completed high school or earned a GED, and 10% had a college degree or more. Forty-three percent of women lived in a household below 100% FPL. Among women who had had sex in the last 30 days, 21% reported not using any contraceptive method, while 17% used LARC, 31% used SARC, and 20% used condoms.

Participants' DAP scores covered the full range from 0 – 4, with a mean of 2.2 (SD=1.1) (Figure 1). The distribution was slightly left skewed, with the lowest quartile of scores ranging 0 – 1.43 and the highest ranging from 3.01 – 4.00. Compared to participants cohabiting with a main partner (mean DAP: 1.86), those with a main partner but not cohabiting (mean: 2.50; $\beta=0.64$, 95% CI: 0.45, 0.82) and those with no main partner (mean: 2.54; $\beta=0.67$, 95% CI: 0.43, 0.92) had higher DAP scores (high preference to avoid pregnancy) (Table 2). Women living below 100% FPL had lower DAP scores compared to those living above 100% FPL (means: 2.02 vs. 2.31; $\beta=-0.28$, 95% CI: -0.47, -0.10).

Desire to avoid pregnancy was strongly associated with use of contraception. The mean DAP score among women not using contraception was 1.75 (SD=1.13) compared to 2.30 (SD=1.03) for women using any method. The odds of contraceptive use increased 64% for each increasing point on the DAP scale (OR=1.64; 95% CI: 1.35–2.00) (Table 3, Figure 1). This relationship was unchanged in the multivariable model (adjusted OR [aOR]=1.63; 95% CI: 1.31–2.04). Results were also unchanged when withdrawal and natural family planning users (n=30) were included as contraceptive users (mean DAP: 1.64 (SD=1.10) for no method vs. 2.29 (SD=1.04) for using contraception (aOR=1.70; 95% CI: 1.33–2.19).

Among women in the lowest DAP quartile (Q1), the predicted percentage of those using contraception was 63%; this percentage increased with increasing desire to avoid pregnancy: 75% for the second (Q2), 81% for the third (Q3), and 87% for the highest DAP quartile (Q4). For method type, higher DAP score was associated with increased odds of using LARC (aOR=1.73; 95% CI: 1.30, 2.30), SARC (aOR=1.68; 95% CI: 1.30, 2.16), and condoms (aOR=1.55, 95% CI: 1.18, 2.04), vs. no method (Table 4). However, there were no differences in DAP scores among the method types (mean DAP: 2.25 (SD=1.07) for LARC; 2.32 (SD=1.01) for SARC; 2.34 (SD=1.05) for condoms), and women with a broad range of DAP scores (from 0–4) used each method type. When considering the 41 dual method users as a separate group, results were similar (mean DAP: 2.56 (SD=0.93) for dual; 2.20 (SD=1.06) for LARC; 2.27 (SD=1.02) for SARC; 2.35 (SD=1.05) for condoms). Among all sexually active women, a greater desire to avoid pregnancy was also associated with more consistent contraceptive use (adjusted β [a β]=8.9 percentage points, 95% CI: 5.2, 12.7) (Table 5). However, DAP scores were not significantly associated with contraceptive consistency among SARC and condom users only (a β =2.2, 95% CI: -1.6, 6.1).

Despite the strong association between pregnancy preferences and contraceptive use, a predicted 63% of women in the lowest DAP quartile, Q1, nevertheless reported using a contraceptive method, and a predicted 13% of women in the highest DAP quartile, Q4, reported not using a method. Among those in Q1, women living in poverty had higher odds of using contraception (aOR=2.56 vs. not living in poverty, 95% CI: 1.02, 6.41), as did

nulliparous women (aOR=3.09 vs. parous women, 95% CI: 1.13, 8.46) (Table 6). For those in Q4, participant characteristics were not significantly associated with contraceptive non-use.

4. Discussion

In this investigation of pregnancy preferences and contraceptive use, Desire to Avoid Pregnancy score was the factor most strongly associated with both contraceptive use and consistency of use. Pregnancy preferences, however, were not associated with the types of contraceptive methods women used. Interesting discordance between pregnancy preferences and contraceptive use emerged, with 63% of women with the lowest DAP scores nonetheless using contraception. Nulliparous women and those living in poverty were more likely to report contraceptive use while having a low DAP score, demonstrating openness to pregnancy.

Researchers have posited that women who are strongly motivated to prevent pregnancy might use more effective methods, while those more open to the possibility of pregnancy might be satisfied relying on less effective methods [13,19]. Indeed, among 1,000 privately insured women not intending pregnancy, feeling that preventing pregnancy was very important was associated with LARC or SARC use, but not condom use [19], findings also reflected in NSFG data [23]. Our results are consistent with these two studies in terms of finding LARC and SARC users had comparable pregnancy preferences, but they run counter to prior studies for condom users, who, in our study, had similar preferences to avoid pregnancy as those using more effective methods. Our finding of no differences in contraceptive method types used by DAP score – and the broad range of DAP scores among women using each method type – support work indicating that a variety of features, other than effectiveness at preventing pregnancy, drive women’s selection of a contraceptive method [24,25]. Even for women with strong preferences to avoid pregnancy, overemphasizing effectiveness in contraceptive counseling may not lead to contraceptive uptake and satisfaction if other contraceptive features are not addressed [26].

Significant research has documented discrepancies between stated pregnancy intentions and contraceptive behavior, focusing on women who do not intend pregnancy yet are not using contraception or are doing so inconsistently [7,8,10,27]. In this study, a more surprising discordance emerged: while about 13% of women with a high preference to avoid pregnancy reported no use of contraception, nearly two-thirds of those with low preference to avoid pregnancy nevertheless used contraception. This apparent discordance is likely related to the many individual, interpersonal, and contextual factors that contribute to contraceptive decision-making and use [28]. First, women use contraception for reasons other than pregnancy prevention, including other medical reasons and sexually transmitted disease prevention [29]. Second, women may use contraception when they might prefer not to because they feel pressured to by partners, family or providers, or they are unable to have a long-acting device removed [3,30,31]. Nulliparous women and those living in poverty were most likely to use contraception while not preferring to avoid pregnancy, suggesting that such factors might apply more to these women. Notably, the DAP scale is designed to measure how respondents feel about potential pregnancy in the next three months and

childbearing within a year; it does not address preferences beyond that timeframe [20]. Some women may want to delay pregnancy but would be open to a pregnancy sooner. Nonetheless, our finding of discordance may help explain prior research that births occurring after contraceptive failure are reported as wanted births [32].

Our finding that over half of women with low DAP scores used contraception points to a potential limitation of guiding contraceptive counseling by pregnancy preferences alone. The Centers for Disease Control and the American College of Obstetricians and Gynecologists endorse universal pregnancy intention screening to identify patients in need of contraceptive care [33,34]. Strategies including One Key Question®, whereby contraceptive and preconception counseling is guided by asking “Would you like to become pregnant in the next year?” are being increasingly implemented in health systems [35]. Reliance on this strategy alone may miss patients who would like to use contraception. To better meet patient needs, contraceptive counseling should allow women to express a range of feelings about pregnancy across different 236 domains of pregnancy preferences and consider each woman’s interest in obtaining contraceptive information [36].

This research has limitations. The study was cross-sectional and assessed contraceptive use over the prior 30 days; it is possible that participants’ pregnancy preferences changed after the time of contraceptive use. Future longitudinal research should examine the relationship between pregnancy preferences and subsequent contraceptive use. The study also relied on participant-reported estimates of consistency of contraceptive use, which may not be uniformly applicable across method types. In addition, restrictions on access to contraceptives could have modified the pregnancy preferences-contraceptive use relationships; however, restricted access is less likely at play because participants were recruited from healthcare settings that provided contraceptive care. Still, results may not be generalizable to women who do not have access to health care. The study also did not account for partners’ preferences, which may modify the relationship between women’s preferences and contraceptive use [3,31]. Strengths of the study include the use of a rigorously developed and evaluated measure of pregnancy preferences in a racially/ethnically and geographically diverse sample.

Women’s multifaceted preferences about pregnancy contribute significantly to their willingness to use contraception. However, women may use contraception despite being open to a possible pregnancy. Healthcare providers and researchers should not assume that pregnancy preferences are the sole motivation for contraceptive use. More likely, the particular circumstances of women’s lives simultaneously shape women’s pregnancy preferences and whether they use contraceptives in accordance with those preferences.

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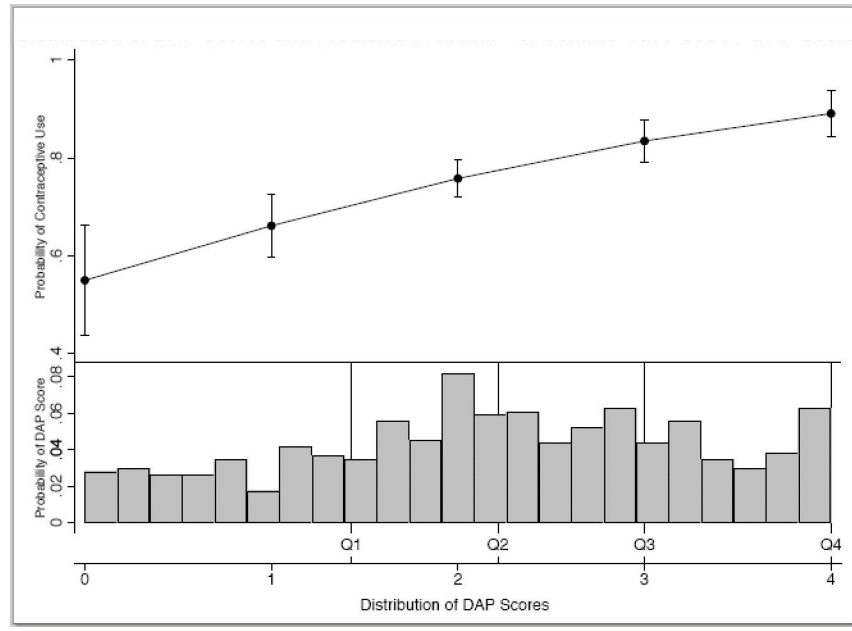


Fig. 1. Distribution of DAP Scores and Predicted Probability of Contraceptive Use by DAP Score.

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Table 1.

Sociodemographic Characteristics and Contraceptive Use among Participants (N=575)

Key Variables	N	%
Age (Range: 15 – 45)		
Mean years (SD)	27.2	(7.4)
Age Group		
15 – 24	239	41.4
25 – 45	336	58.6
Race/Ethnicity (N=572)		
Latina	273	47.7
Non-Latina Black	155	27.1
Non-Latina White	92	16.1
Multiracial/other	52	9.1
Relationship Status (N=570)		
Main Partner & Cohabiting	285	50.0
Main Partner & Not Cohabiting	203	35.6
No Main Partner	82	14.4
Parity (N=542)		
0	206	38.0
1	116	21.4
2	106	19.6
3+	114	21.0
Education (N=556)		
Less than high school	83	14.9
High school or GED	341	61.3
Some Community College/Tech	75	13.5
College Degree or More	57	10.3
Receives Public Assistance (N=573)	258	45.0
Poverty (N=572)		
Above 100% FPL	238	41.7
Below 100% FPL	245	42.8
Missing	89	15.6
State of Recruitment (N=573)		
Texas	309	53.9
New Mexico/Arizona	88	15.4
South Carolina	116	20.2
New Jersey	60	10.5
Contraceptive Use		
Any Contraceptive Method	388	76.2
Long-acting reversible	97	16.9
Short-acting hormonal	175	30.5
Male condom	116	20.1

Key Variables	N	%
No Method	121	21.0
No sex with male in last 30 days	66	11.5
Consistency of Contraceptive Use (N=505)		
Mean percent of sex acts in last 30 days (SD)	65.9	(43.6)

Note: Consistency of contraceptive use is the percentage of acts of sexual intercourse in the last 30 days in which contraception was used among participants who had sex with a male in the last 30 days.

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Table 2.

Desire to Avoid Pregnancy (DAP) Scores by Participant Characteristics and Bivariable Linear Regression Models for DAP Scores

	DAP Score		Bivariable Models	
	Mean	SD	β	95% CI
Age (years) (N=575)	–	–	–0.02	[–0.03, –0.01]
Race/Ethnicity (N=572)				
Latina	2.16	1.03	Ref.	
Non-Latina Black	2.18	1.03	0.01	[–0.20, 0.22]
Non-Latina White	2.29	1.20	0.13	[–0.12, 0.38]
Multiracial/other	2.20	1.05	0.03	[–0.28, 0.35]
Relationship Status (N=570)				
Main Partner & Cohabiting	1.86	1.03	Ref.	
Main Partner & Not Cohabiting	2.50	1.01	0.64	[0.45, 0.82]
No Main Partner	2.54	0.93	0.67	[0.43, 0.92]
Parity (N=542)				
Nulliparous	2.28	1.12	Ref.	
Parous	2.09	1.00	–0.19	[–0.37, –0.01]
Education (N=556)				
Less than high school	2.29	1.01	Ref.	
High school or GED	2.11	1.05	–0.18	[–0.43, 0.08]
Some Community College/Tech	2.22	1.13	–0.07	[–0.40, 0.26]
College Degree or More	2.39	1.12	0.10	[–0.26, 0.46]
Poverty (N=572)				
Above 100% FPL	2.31	1.10	Ref.	
Below 100% FPL	2.02	1.04	–0.28	[–0.47, –0.10]
Missing	2.36	0.94	0.06	[–0.20, 0.32]
Receives Public Assistance (N=573)				
No	2.16	1.06	Ref.	
Yes	2.21	1.06	–0.05	[–0.23, 0.12]
State (N=573)				
Texas	2.23	1.04	Ref.	
New Mexico/Arizona	2.02	1.18	–0.20	[–0.45, 0.05]
South Carolina	2.19	1.05	–0.04	[–0.26, 0.19]
New Jersey	2.25	0.98	0.03	[–0.26, 0.32]

Table 3.

Logistic Regression Models for Any Contraceptive Use among All Sexually Active Women (N = 509)

	<u>Bivariable Model</u>		<u>Multivariable Model</u>	
	OR	95% CI	aOR	95% CI
DAP Score	1.64	[1.35, 2.00]	1.63	[1.31, 2.04]
Age (years)	-	--	1.01	[0.97, 1.05]
Race/Ethnicity				
Latina	-	--	Ref.	
Non-Latina Black	-	--	0.59	[0.26, 1.33]
Non-Latina White	-	--	0.54	[0.28, 1.04]
Multiracial/other	-	--	0.32	[0.14, 0.69]
Relationship Status				
Main Partner & Cohabiting	-	--	Ref.	
Main Partner & Not Cohabiting	-	--	1.40	[0.80, 2.36]
No Main Partner	-	--	0.83	[0.39, 1.78]
Nulliparous	-	--	1.28	[0.80, 2.35]
Education				
Less than high school	-	--	Ref.	
High school or GED	-	--	0.55	[0.27, 1.18]
Some Community College/Tech	-	--	0.80	[0.33, 2.21]
College Degree or More	-	--	0.71	[0.26, 2.08]
Poverty				
Above 100% FPL	-	--	Ref.	
Below 100% FPL	-	--	1.29	[0.78, 2.19]
Missing	-	--	1.06	[0.51, 2.23]
Receives Public Assistance	-	--	1.19	[0.71, 2.01]
State				
Texas	-	--	Ref.	
New Mexico/Arizona	-	--	1.01	[0.51, 2.00]
South Carolina	-	--	1.42	[0.63, 3.20]
New Jersey	-	--	1.81	[0.71 4.59]

Notes: aOR = adjusted Odds Ratio

Table 4.

Multivariable Multinomial Logit Model of DAP and Contraceptive Method Use (N = 509)

	<u>LARC vs. None</u>		<u>SARC vs. None</u>		<u>Condoms vs. None</u>	
	aRR	95% CI	aRR	95% CI	aRR	95% CI
DAP Score	1.73	[1.30, 2.30]	1.68	[1.30, 2.16]	1.55	[1.18, 2.04]

Notes: aRR = adjusted Risk Ratios; No significant differences between method types

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Table 5.

Multivariable Linear Regression Models for Consistency of Contraceptive Use

	All Sexually Active Women (N = 509)		Women Using SARC or Condoms (N = 291)	
	a β	95% CI	a β	95% CI
DAP Score	8.9	[5.2, 8.9]	2.2	[-1.6, 6.1]
Age (years)	-0.1	[-0.7, -0.1]	-0.1	[-0.7, 0.6]
Race/Ethnicity				
Latina	Ref.	Ref.	Ref.	
Non-Latina Black	-12.2	[-26.0, -12.2]	-5.9	[-18.9, 7.2]
Non-Latina White	-8.2	[-19.8, -8.2]	2.4	[-9.9, 14.6]
Multiracial/other	-19.6	[-34.4, -19.6]	-4.4	[-20.3, 11.5]
Relationship Status				
Main Partner & Cohabiting	Ref.		Ref.	
Main Partner & Not Cohabiting	3.4	[-5.8, 12.7]	-1.2	[-9.9, 7.5]
No Main Partner	-7.8	[-21.2, 5.6]	-7.8	[-20.6, 4.9]
Nulliparous	13.3	[2.8, 23.8]	10.8	[0.7, 20.8]
Education				
Less than high school	Ref.		Ref.	
High school or GED	-2.7	[-13.7, 8.3]	3.7	[-6.2, 13.7]
Some Community College/Tech	4.0	[-10.9, 18.8]	7.9	[-5.5, 21.3]
College Degree or More	6.8	[-9.7, 23.2]	13.5	[-2.1, 29.1]
Poverty				
Above 100% FPL	Ref.		Ref.	
Below 100% FPL	0.7	[-8.6, 10.1]	-5.5	[-14.6, 3.7]
Missing	4.7	[-8.3, 17.7]	4.4	[-7.9, 16.7]
Receives Public Assistance	0.3	[-9.2, 9.80]	0.5	[-8.5, 9.5]
State of Residence				
Texas	Ref.		Ref.	
New Mexico/Arizona	4.6	[-7.8, 17.0]	9.0	[-3.9, 21.9]
South Carolina	6.4	[-8.0, 20.8]	5.2	[-8.8, 19.1]
New Jersey	9.4	[-5.8, 24.7]	6.2	[-7.8, 20.2]

Notes: a β = adjusted β ; Consistency of contraceptive use = the percentage of acts of sexual intercourse in the last 30 days in which contraception was used, as reported by the participant.

Table 6.

Multivariable Logistic Regression Models for Any Contraceptive Use for Participants in the Lowest Quartile of DAP Scores; N = 138

	aOR	95% CI
Age (years)	1.00	[0.94, 1.08]
Race/Ethnicity		
Latina	Ref.	
Non-Latina Black	0.26	[0.05, 1.39]
Non-Latina White	0.68	[0.20, 2.28]
Multiracial/other	0.05	[0.01, 0.45]
Relationship Status		
Main Partner & Cohabiting	Ref.	
Main Partner & Not Cohabiting	2.40	[0.83, 6.97]
No Main Partner	0.68	[0.12, 3.95]
Nulliparous	3.09	[1.13, 8.46]
Education		
Less than high school	Ref.	
High school or GED	0.67	[0.16, 2.75]
Some Community College/Tech	0.99	[0.16, 6.31]
College Degree or More	0.57	[0.09, 3.65]
Poverty		
Above 100% FPL	Ref.	
Below 100% FPL	2.56	[1.02, 6.41]
Missing	4.18	[0.79, 22.01]
State of Residence		
Texas	Ref.	
New Mexico/Arizona	1.12	[0.32, 3.93]
South Carolina	3.94	[0.62, 24.90]
New Jersey	6.09	[0.77, 48.08]

Notes: aOR = adjusted Odds Ratio; Low DAP Score includes first quartile of DAP Scores and any contraceptive use includes long-acting reversible contraception, short-acting reversible contraception, and condoms.