

Sociocultural Correlates of Contraceptive Method Use Among Partnered U.S. Women: Findings from NCHAT

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Abstract

This study examined sociocultural correlates of contraceptive method use among partnered U.S. women using 2020–2021 National Couples' Health and Time Study data (N = 775; sterilized women excluded). Multinomial logistic regression assessed associations between method used at last sex—long-acting reversible contraception (LARC; e.g., IUD, implant), short-acting reversible contraception (SARC; e.g., pill, patch, ring, shot), other methods, or none—and religious affiliation, nativity (U.S.-born vs. foreign-born), race/ethnicity, education, insurance status, and age. Education and age were significantly associated with method choice. Graduate-level education was associated with higher odds of LARC use versus none (aOR = 4.96, 95% CI: 1.89–13.03). Women aged 18–34 had lower odds of LARC (aOR = 0.29, 95% CI: 0.13–0.65) and SARC (aOR = 0.27, 95% CI: 0.12–0.60) compared to women aged 35–50. Religious affiliation was not significant overall, though atheist identification was associated with higher SARC use (aOR = 5.05, 95% CI: 1.28–19.90). Nativity, race/ethnicity, and insurance status were not significantly associated with method choice. Findings underscore the role of education and life stage in contraceptive decision-making.

Key Words: Contraception, Cultural Characteristics, Immigrants, Religion, Pregnancy, Sexual & Reproductive Health

Introduction

Contraceptive method choice remains an important determinant of reproductive autonomy and health outcomes in the United States (U.S.). Although a wide range of effective contraceptive options is available, patterns of method use vary across sociodemographic groups. The causes extend beyond access to care; with sociocultural influences such as religion, immigration, and race or ethnicity constantly shaping contraceptive attitudes and decisions (Dehlendorf et al., 2017).

Religious tenets deeply affect attitudes towards contraception, guiding the choices of many individuals in the U.S. Although official doctrines in some faiths restrict contraception, most religiously affiliated Americans have used some form of birth control (*Contraceptive Use in the United States by Demographics*, 2022). Studies show that religion can affect not only whether contraception is used but also which methods are chosen. For example, Hispanic women in Texas who reported strong religious beliefs were more likely to select less effective postpartum methods (Roncancio et al., 2012), while cross-national analyses have shown

that religious affiliation influences preference for non-invasive or natural approaches (Boadu, 2022). Yet, ethnic and religious minority women remain understudied in reproductive health research (Krull et al., 2020). This knowledge gap may stem from religious identification not being routinely collected in health science studies, as well as fear of judgment within religious communities if women speak openly about their sexual and reproductive health (Patton et al., 2015).

Immigration status introduces another layer of complexity. Approximately 14% of U.S. women are immigrants (Shepperson, 2023). For immigrant women, cultural norms often influence comfort with family-planning services and the perceived acceptability of contraception (Srikanthan & Reid, 2008). A study done in Sweden demonstrated that targeted postpartum counseling increased immigrant women's use of long- and short-acting reversible contraception (LARC and SARC) (Kilander et al., 2022). In the U.S., immigrant women remain less likely than their U.S.-born counterparts to access preventive or contraceptive services, relying more heavily on publicly funded family-planning centers (Hasstedt et al., 2018). Immigration status and nativity can further compound these barriers, as immigrants may face additional challenges in accessing healthcare services due to factors such as language barriers, lack of health insurance, fear of discrimination, or cultural and religious stigma (Hacker et al., 2015).

Racial and ethnic disparities in unintended pregnancy rates are evident with Black and Hispanic women having a greater likelihood of unintended pregnancies compared to White women (Kim et al., 2016). Although racial differences in knowledge and attitudes toward contraception exist, they do not fully explain disparities in method use. Systemic influences such as healthcare access, provider bias, and historical mistrust of

medical institutions likely contribute (Rocca & Harper, 2012). Education, insurance, and nativity also interact with race to shape contraceptive behavior (Kim et al., 2016).

Understanding how these factors intersect is essential for improving equitable reproductive-health outcomes. Prior studies often examine religion, immigration, or race in isolation; few explore their combined impact on contraceptive choice within a nationally representative framework. This study addresses that gap by analyzing the relationships between country of birth, religious affiliation, and other sociocultural factors and the type of contraception used at the most recent sexual encounter among coupled or cohabiting women in the U.S., 2020–2021. The purpose of this study was to examine whether religious affiliation, nativity, race/ethnicity, education, insurance status, and age are associated with type of contraceptive method used at last sexual encounter among partnered U.S. women. By identifying sociocultural determinants of contraceptive decision-making, the research aims to inform culturally responsive counseling and public-health strategies that better reflect the diversity of women's lived experiences.

Methods

Study Sample and Inclusion/Exclusion Criteria

This study used cross-sectional data from the 2020–2021 National Couples' Health and Time Study (NCHAT), a nationally representative online survey of married or cohabiting U.S. adults aged 20–50 drawn from probability-based Gallup panels (Dush, et al., 2023). The survey was administered online in English and Spanish between September 2020 and April 2021. Primary respondents completed the main survey and were subsequently emailed instructions to invite their partners to participate, achieving

an overall response rate of 28%. Surveys captured demographic characteristics, religious affiliation, nativity, and related factors. Data were weighted to reflect the U.S. population of married and cohabiting adults aged 20–50 (Dush, et al., 2023).

For this analysis, only female respondents aged 18–50 with complete data on all study variables were included. Male respondents were excluded, as the focus of the study was on women's contraception use; thus, the sample was restricted to female respondents. Among 1,794 eligible women aged 18–50, 263 were excluded due to sterilization, leaving 1,531 eligible for analysis. Of these, 756 participants (49.4%) were excluded due to missing data on the outcome or one or more covariates, resulting in a final analytic sample of 775 women.

Missingness was due to item nonresponse across several variables. Because the multinomial outcome and key categorical predictors contained missing data, multiple imputation would have required strong assumptions about the missing data mechanism. Therefore, complete case analysis preserved interpretability and the final model converged properly with adequate cell sizes across outcome categories.

This study utilizes secondary analysis of public use, de-identified data. Thus, the university's Institutional Review Board considered it exempt.

Measures

Choice of Contraceptive. The outcome of interest for this study was choice of contraception method used during last sexual encounter. Participants were asked: “The last time you had sex, what was/were the primary type(s) of birth control you used? (select all that apply).” Participants could select one or more options from a list of 15 items. Contraceptive use at last vaginal sex was categorized as: long-acting reversible contraception (LARC: intrauterine implant

device (IUD), implant), short-acting reversible contraception (SARC: pill, shot, patch, or ring), other contraception (condom, diaphragm/cervical cap, contraceptive sponge, spermicide, fertility awareness, withdrawal, or other method), and none. The “none” category reflects no contraceptive method reported at the last sexual encounter. This measure does not distinguish between pregnancy intention (e.g., actively trying to conceive), ambivalence toward pregnancy, lack of access to contraception, relationship dynamics, or coercion. Therefore, this category should not be interpreted as uniformly indicating unmet contraceptive need. These categories were determined using the American College of Obstetricians and Gynecologists' (ACOG) classification of the various contraceptive types from least effective to most effective (*American College of Obstetricians and Gynecologists*, n.d.) Additionally, for women who reported using more than one type of contraception, only the method with highest effectiveness was counted as the method used by that individual. Collapsing categories was also necessary to ensure adequate cell sizes and stable estimation within the survey-weighted multinomial model.

Religion. Respondents' religion was examined as a primary predictor variable in this study. Participants responded to the survey question: “What is your current religion, if any?” by selecting one of 13 response items that included Protestant, Roman Catholic, and Muslim among others. This variable is operationalized through its categorization of Monotheism, Atheism, Agnosticism, and other religions – in accordance with Brown's classifications of religious orientation (Brown, 1964). Those who reported being Protestant, Roman Catholic, Mormon, Orthodox Christian, Other Christian, Jewish, or Muslim were classified under “Monotheism”. Atheist and Agnostic responses formed their own

categories respectively. If participants responded Buddhist, Hindu, or something else they were placed in the “Other” category. “Nothing in Particular” remained its own category. These categories were used for analytic feasibility rather than to imply doctrinal equivalence across traditions. We acknowledge that substantial theological and cultural heterogeneity exists both within and across these groupings, and that affiliation does not capture religious intensity, practice, or doctrinal adherence.

Nativity. One of the primary predictor variables for this study was country of birth. Participants were asked: “What country were you born in?” They could select a country from a drop-down menu of all countries. A total of 72 distinct countries were reported. This variable was then categorized into U.S.-born and Foreign-born, where all other countries of birth except the U.S. were encompassed in the Foreign-born category.

Confounding Variables. Demographic variables were age, insurance status, education, and race. Age groups included were ages 18-50, which were categorized into two groups: 18-34 years old, and 35-50 years old. Current insurance was categorized as private insurance, government or state insurance, and single service or not covered. Education was categorized as no college degree, associate’s/bachelor’s degree, and graduate-level college degree. Race/ethnicity was categorized as Hispanic, Black, White, and other, in compliance with the 1997 Office of Management and Budget Guidelines for the presentation of race and Hispanic origin data in federal statistics (Executive Office of the President, Office of Management and Budget, 1997).

Statistical Analysis. Descriptive statistics were calculated to determine the frequency of each contraceptive type. Bivariate analyses, including chi-square tests, were performed to assess the association between contraceptive

use and predictors. A p-value of less than 0.05 was considered statistically significant. Multivariable multinomial logistic regression was conducted to examine the association between contraceptive use and predictor variables while simultaneously adjusting for potential confounders, with the reference group being those who reported using “None” for contraceptive choice. The predictor variables included in the model were religion, nativity, race, education, insurance, age. The adjusted odds ratios (aORs) and 95% confidence intervals (CI) were estimated to assess the association between contraceptive use and each predictor. All analysis was weighted to be nationally representative and conducted using SAS version 9.4.

The multinomial logistic regression model employed in this study satisfies several critical assumptions ensuring its validity. First, the assumption of independence of observations is upheld, ensuring that the values of the outcome variable for one observation do not impact those of others. The linearity in the logits is also met, signifying that the relationship between predictor variables and the natural logarithms of the odds ratios is linear. The absence of multicollinearity, verified through Variance Inflation Factors, confirms that no predictor variable can be precisely predicted from others. Moreover, the large sample size employed in the analysis adheres to the requirement for multinomial logistic regression. The data were carefully screened for outliers and influential cases, and their absence ensures that the results are not significantly influenced. Additionally, the assumptions associated with chi-squared tests, such as the minimum cell size criterion ($N=5$) and independence of observations, have been addressed and satisfied. This methodological rigor fortifies the reliability of the model's parameter estimates and supports the validity of the study's conclusions.

Results

Sample Description

In this study, 775 individuals who participated in the survey were identified as meeting the inclusion criteria and had complete data for analysis. Descriptive analysis found that 30.6% (n=237) of participants did not use any method of contraception during their last sexual encounter (Table 1). A low number of participants used LARC and SARC methods with 18.3% (n=142) and 13.0% (n=101), respectively. Moreover, 38.1% of participants used other methods (n=295).

The majority of participants reported practicing Monotheistic religions (n=272, 35.1%), followed by Nothing in Particular (n=168, 21.7%), Agnostic (n=120, 15.5%), Atheist (n=116, 15.0%), and Other religions (n=99, 12.8%). Most participants were born in the U.S. (n=703, 90.7%), with 72 (9.3%) identifying as foreign-born. The sample included 583 (75.2%) identifying as White, 74 (9.6%) identifying as Black or African American, 47 (6.1%) as Multiracial, and 71 (9.2%) identifying with other races. Educational attainment varied, with 319 (41.2%) reporting no college degree, 282 (36.4%) holding an associate's or bachelor's degree, and 174 (22.5%) having a graduate-level degree. A substantial majority reported having some form of insurance (n=723, 93.3%), with 52 (6.7%) uninsured. In terms of age, 272 (35.1%) were 18–34 years old and 503 (64.9%) were 35–50 years old. Type of contraception used was significantly associated with education ($p<0.05$) and age ($p<.0001$), but not significantly associated with religion ($p=0.51$), nativity ($p=0.99$), race ($p=0.49$), and insurance status ($p=0.50$).

Patterns of Association in the Multivariable Multinomial Model

Females who do not use any type of contraception were compared to those who

use long-acting reversible contraception (LARC), short-acting reversible contraception (SARC), and other types of contraception. In the multivariable model (Table 2), education and age were the only characteristics that demonstrated statistically significant associations with contraceptive use.

Specifically, women with a graduate-level education had significantly higher odds of using LARC compared to no method relative to women with an associate's or bachelor's degree (aOR: 4.96, 95% CI: 1.89, 13.03). Women aged 18–34 years had lower odds of using LARC (aOR: 0.29, 95% CI: 0.13, 0.65) and SARC (aOR: 0.27, 95% CI: 0.12, 0.60) compared to women aged 35–50 years.

Although religion was not statistically significant at the global level, women identifying as Atheist had higher odds of SARC use compared to women who reported practicing “Nothing in Particular” (aOR: 5.05, 95% CI: 1.28, 19.90). No significant associations were observed for nativity, race, or insurance status in the adjusted model.

Discussion

Using nationally representative data from the National Couples' Health and Time Study (NCHAT), this analysis examined how sociocultural factors influence contraceptive decision-making among partnered women in the U.S. Educational attainment and age emerged as primary predictors of contraceptive use, underscoring the importance of sociocultural contexts in shaping reproductive behavior.

Although religion was not statistically significant at the global level in the adjusted model, some subgroup differences were observed. For example, women identifying as Atheist had higher odds of SARC use compared to women reporting “Nothing in Particular.” The absence of broader statistically significant associations across

Table 1.

Descriptive characteristics of females aged 18-50 who were either married or cohabiting in the U.S. from 2020-2021 from the NCHAT by type of contraception used (N=775).

	Total (n=775)	LARC (n=142, 18.3%)	SARC (n=101, 13.0%)	Other (n=295, 38.1%)	None (n=237, 30.6%)	P-Value
<i>Religion</i>						0.51
Monotheistic	272 (35.1)	38 (26.76)	37 (36.6)	98 (33.2)	99 (41.8)	
Agnostic	120 (15.5)	30 (21.1)	18 (17.8)	47 (15.9)	25 (10.6)	
Atheist	116 (15.0)	27 (19.0)	21 (20.8)	50 (17.0)	18 (7.6)	
Nothing in Particular	168 (21.68)	29 (20.4)	18 (17.8)	62 (21.0)	59 (24.9)	
Other	99 (12.8)	18 (23.7)	7 (6.9)	38 (12.9)	36 (15.1)	
<i>Nativity</i>						0.99
U.S.-born	703 (90.7)	133 (93.7)	89 (88.1)	267 (90.5)	214 (90.3)	
Foreign-born	72 (9.3)	9 (6.3)	12 (11.9)	28 (9.5)	23 (9.7)	
<i>Race</i>						0.49
White	583 (75.2)	103 (72.5)	74 (73.3)	225 (76.3)	181 (76.7)	
Black or African American	74 (9.6)	20 (14.1)	8 (7.9)	18 (6.1)	28 (11.8)	
Multiracial	47 (6.1)	10 (7.0)	5 (5.0)	19 (6.4)	13 (5.5)	
Other	71 (9.2)	9 (6.3)	14 (13.9)	33 (11.2)	15 (6.3)	
<i>Education</i>						< 0.05
Associate's/ Bachelor's Degree	282 (36.4)	60 (42.3)	31 (30.7)	111 (37.6)	80 (33.8)	
Graduate-Level College Degree	174 (22.5)	38 (26.8)	18 (17.8)	65 (22.0)	53 (22.4)	
No College Degree	319 (41.2)	44 (30.2)	52 (51.5)	119 (40.3)	104 (43.9)	
<i>Insurance</i>						0.50
Has Some Form of Insurance	723 (93.3)	133 (93.7)	97 (96.0)	274 (92.9)	219 (92.4)	
No Insurance/ Uninsured	52 (6.7)	9 (6.3)	4 (4.0)	21 (7.1)	18 (7.6)	
<i>Age</i>						< 0.05
18-34 years old	272 (35.1)	65 (45.8)	49 (48.5)	99 (33.46)	59 (24.9)	
35-50 years old	503 (64.9)	77 (54.2)	52 (51.5)	196 (66.4)	178 (75.1)	

Table 2.

Multinomial logistic regression modeling of the contraception type use and covariates for females in the NCHAT data set (N= 775).

Characteristic	LARC vs None, OR (95% CI)	SARC vs None, OR (95% CI)	Other vs None, OR (95% CI)
<i>Religion</i>			
Nothing in Particular	Reference	Reference	Reference
Monotheistic	0.64 (0.25, 1.60)	1.62 (0.61, 4.30)	0.97 (0.46, 2.05)
Agnostic	1.46 (0.44, 4.78)	2.64 (0.69, 10.09)	1.35 (0.48, 3.78)
Atheist	2.88 (0.73, 11.38)	5.05 (1.28, 19.90)	2.27 (0.71, 7.27)
Other	0.69 (0.21, 2.30)	1.03 (0.25, 4.28)	1.30 (0.49, 3.46)
<i>Nativity</i>			
U.S.-born	Reference	Reference	Reference
Foreign-born	0.83 (0.23, 2.96)	1.03 (0.32, 3.33)	1.00 (0.44, 2.26)
<i>Race</i>			
White	Reference	Reference	Reference
Black or African American	1.11 (0.47, 2.64)	0.64 (0.22, 1.82)	0.47 (0.22, 1.02)
Multiracial	1.33 (0.39, 4.48)	1.52 (0.38, 6.09)	0.94 (0.31, 2.87)
Other	0.82 (0.24, 2.84)	2.08 (0.64, 6.79)	0.99 (0.42, 2.32)
<i>Education</i>			
Associate's/Bachelor's Degree	Reference	Reference	Reference
No College Degree	0.68 (0.30, 1.52)	1.89 (0.80, 4.43)	0.59 (0.33, 1.06)
Graduate-Level College Degree	4.96 (1.89, 13.03)	3.14 (1.00, 9.91)	1.90 (0.83, 4.35)
<i>Insurance</i>			
No Insurance/Uninsured	Reference	Reference	Reference
Has Some Form of Insurance	1.33 (0.29, 6.14)	2.73 (0.52, 14.31)	0.86 (0.29, 2.49)
<i>Age</i>			
35-50 years old	Reference	Reference	Reference
18-34 years old	0.29 (0.13, 0.65)	0.27 (0.12, 0.60)	0.55 (0.28, 1.10)

Bold values = statistically significant

religious groups suggests that religious impacts on contraceptive choice may be more nuanced than previously assumed and potentially mediated by sociocultural factors such as education and access. Prior research indicates that religious teachings and community norms can shape reproductive health decisions. For instance, a study focusing on Muslim women in Saudi Arabia revealed generally positive attitudes toward

contraceptive use, with women valuing fertility control for physical, emotional, and financial well-being (Alomair et al., 2023). Within Christian denominations, some traditions favor natural family planning over hormonal methods (Pinter et al., 2016). However, the limited associations observed in this study suggest that religious identity alone may not independently drive contraceptive method choice once

sociodemographic characteristics are accounted for.

Educational level surfaced as a notable correlate of contraception use; women with graduate-level education had significantly higher odds of using LARC compared to no method relative to women with an associate's or bachelor's degree. This observation underscores the role of health literacy as a notable mediator in this relationship. Health literacy extends beyond basic reading skills, encompassing the ability to navigate healthcare systems, understand health information, and make informed health decisions. Consequently, women with higher education levels often possess better health literacy, which empowers them to make informed choices about their sexual and reproductive health such as the utilization of effective contraceptive methods like LARC. Moreover, the interplay between educational attainment and access to contraception is significant. Enhanced access to contraceptive options permits women to delay childbirth, thereby investing more time in their educational and career pursuits (Pazol et al., 2015). This dynamic not only reflects the empowerment provided by educational attainment but also highlights the critical role of comprehensive health education in enabling women to access and utilize contraception effectively, as seen in the increased use of LARC among educated women (Ewerling et al., 2021).

Age also demonstrated a significant association with contraceptive method choice. Women aged 18–34 had lower odds of using LARC and SARC compared to women aged 35–50 when no method was used as the reference category. This pattern may reflect life course differences in fertility intentions, completed childbearing, or perceived pregnancy risk, suggesting that contraceptive decision-making is shaped not only by sociocultural resources but also by stage of life.

Contrary to expectations, nativity and racial background were not significantly associated with contraceptive method choice. This finding may reflect assimilation processes that narrow behavioral differences between U.S.-born and immigrant women (Lopez-Class et al., 2011). There is a need for nuanced measures of acculturation in health research, acknowledging that the process of acculturation can lead to both positive and negative health outcomes, depending on the context and the individual (Payne & Fanarjian, 2014). Another aspect to consider is the role of perceived discrimination in contraceptive choice, especially among women of color who historically have faced coercive reproductive health practices (Loder et al., 2021). Such experiences of discrimination could lead to mistrust in medical institutions and affect contraceptive choices (Kossler et al., 2011).

Another possibility is that the U.S. healthcare system's general approach may mask unique cultural practices through a standardizing effect. This refers to the tendency to apply uniform procedures and policies without fully accounting for cultural differences, potentially minimizing observable variation across groups. Research suggests that disparities in contraceptive use across racial and ethnic groups may be driven more by sociocultural factors such as insurance coverage, access to care, and educational differences than by cultural norms alone (Troutman et al., 2020). Addressing disparities therefore requires attention to multifaceted barriers, including access, culturally responsive care, and patient education (Kossler et al., 2011). Insurance status was not significantly associated with contraceptive method use in the adjusted model, suggesting that sociocultural factors related to education and life stage may play a more central role in this sample.

Limitations

This cross-sectional study cannot infer causality, and reliance on self-reported data introduces potential reporting bias. Because the sample included only partnered women aged 18–50 with complete data, findings may not generalize to single, non-cohabiting, or sterilized women, nor to respondents with missing survey information. The use of complete case analysis reduced the analytic sample size, which may have limited power to detect subgroup-specific associations, particularly among racial, religious, and immigrant groups. Additionally, the measure of no contraceptive use at last sex represents a heterogeneous category. Reporting “none” does not necessarily reflect lack of access or disengagement from family planning; women in this category may have been actively attempting pregnancy, ambivalent about pregnancy, or influenced by relational or contextual factors not captured in the dataset. These circumstances cannot be disentangled in this cross-sectional analysis. Furthermore, the measures used may not fully capture nuances of acculturation or the depth of religious engagement. Lastly, the dataset did not include psychosocial constructs commonly used in health behavior theories. As a result, this study could not directly evaluate theoretical mechanisms such as those proposed in the Theory of Planned Behavior or Health Belief Model. Future research should incorporate theory-driven measures to examine how psychosocial beliefs related to religion, nativity, and cultural context influence contraceptive decision-making. Further research should consider longitudinal and mixed-method approaches to better understand how sociocultural factors, cultural identity, fertility intentions, and life course transitions shape contraceptive decision-making over time.

Strengths

Despite these limitations, the study’s strengths include its use of nationally representative data and its examination of sociocultural and sociocultural correlates of contraceptive method choice. The findings reinforce the importance of integrating educational attainment and life course considerations into contraceptive counseling and public-health interventions. Strengthening health education and ensuring culturally responsive counseling may help reduce unintended pregnancies and promote reproductive autonomy.

Overall, these findings contribute to sexual and reproductive health strategies that account for sociocultural determinants of contraceptive behavior. While religious affiliation was not independently associated with method choice at the global level, patient-centered and culturally responsive care remains essential. Consistent with American College of Obstetricians and Gynecologists (ACOG) guidance, contraceptive counseling should be individualized and aligned with patients’ educational background, life stage, beliefs, and circumstances to advance equity and improve reproductive health outcomes across diverse U.S. populations.

Implications for Health Behavior Research

This study advances health behavior research by showing that sociocultural factors (particularly education and age) are more strongly associated with contraceptive method choice than religious affiliation, immigration status, or race among partnered women in the U.S. These findings highlight the need to move beyond identity-based explanations of contraceptive use and instead emphasize socioeconomic position, health literacy, and access to care as central determinants of reproductive behavior. Although religion was not significant at the

global level, isolated subgroup differences suggest belief systems may still influence attitudes in specific contexts. For researchers, this underscores the importance of clearly distinguishing sociocultural from cultural predictors in models of preventive health behavior. Practitioners and policymakers should prioritize efforts that reduce sociocultural barriers to effective contraception, especially those linked to educational attainment and life stage. By clarifying the relative influence of these factors, this study contributes to a more precise understanding of contraceptive decision-making and strengthens theoretical approaches to reproductive health behavior.

Discussion Questions

How can health behavior researchers better integrate sociocultural constructs—such as religious norms, acculturation, and health literacy—into existing behavioral models to more accurately predict contraceptive decision-making among diverse populations?

Given the influence of religion and immigration status on contraceptive choices, what strategies can public health practitioners and policymakers use to design culturally competent reproductive health interventions that both respect belief systems and promote equitable access to care?

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