

Demographics of Contraceptive Method Use in California, 2020

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INTRODUCTION

An estimated three-quarters of California women—approximately 2.8 million in 2020—who are sexually active and wish to avoid pregnancy are using contraception.¹ While contraceptive use demographic data is readily available at the national level, less information is available on the demographics of contraceptive use at the state level in California. California did not ask the contraception-related questions in the 2019 national Behavioral Risk Factor Surveillance System (BRFSS) survey, which provides the most recent estimates of state-level demographic data on contraceptive use.² To the extent that significant demographic differences among California contraceptive users exist, identifying and understanding those differences can inform future research, policy, public education, and outreach about contraception use.

Contraceptive method choice may be influenced by a variety of factors. Commonly-reported factors are both physiological (e.g., menstrual regulation or symptom relief, acne treatment, weighing/avoiding common side effects, and popular misconceptions about side effects) and financial/logistical (e.g., cost, convenience, and practical barriers associated with scheduling appointments and obtaining and picking up a prescription, which may involve taking time off work and traveling). Perceived benefits and barriers may also be weighed within the context of perceived need for contraception, (e.g., frequency of sexual intercourse).³ Furthermore, some women may prioritize control over the

¹ Cohen, C., Conron, K.J., Guardado, R., Serpico, J. (alphabetical author order). (2023). Contraceptive Utilization and Access Among Cisgender Heterosexual and Bisexual California Women. The Center on Reproductive Health, Law, and Policy, UCLA School of Law.

² Douglas-Hall A, Li N, and Kavanaugh ML. State-Level Estimates of Contraceptive Use in the United States, 2019. Guttmacher Institute, December 2020. <https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-in-us-2019>.

³ Dehlendorf, C., Rodriguez, M. I., Levy, K., Borrero, S., & Steinauer, J. (2010, March). *Disparities in family planning*. American

administration and use of the contraceptive method they choose. These concerns are especially common among women whose communities have a history of reproductive coercion, control, and abuse including forced sterilization, primarily of women with disabilities and Black, Indigenous and other women of color.⁴ Nationally, an estimated one-quarter of women using contraception are not using the method they would prefer.⁵ We hope that the data presented here will aid efforts to increase Californians' ability to use their contraceptive method of choice.

We examined sociodemographic variability in the main method of birth control reported by sexually active cisgender heterosexual and bisexual women. We found both demographic differences among California users and differences between California data and national data. Researchers, advocates, providers, and others concerned with contraceptive method choice should take these differences

journal of obstetrics and gynecology. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835625/>; Dehlendorf, C., Foster, D. G., de Bocanegra, H. T., Brindis, C., Bradsberry, M., & Darney, P. (2011). Race, ethnicity and differences in contraception among low-income women: Methods received by Family Pact clients, California, 2001-2007. *Perspectives on Sexual and Reproductive Health*, 43(3), 181–187. <https://doi.org/10.1363/4318111>; Jackson, A. V., Karasek, D., Dehlendorf, C., & Foster, D. G. (2016). Racial and ethnic differences in women's preferences for features of contraceptive methods. *Contraception*, 93(5), 406–411. <https://doi.org/10.1016/j.contraception.2015.12.010>; Le Guen, M., Schantz, C., Régnier-Loilier, A., & de La Rochebrochard, E. (2021). Reasons for rejecting hormonal contraception in western countries: A systematic review. *Social Science & Medicine*, 284, 114247. <https://doi.org/10.1016/j.socscimed.2021.114247>; Jones RK. (2011) Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills. New York: Guttmacher Institute.; Hirth, J. M., Dinehart, E. E., Lin, Y.-L., Kuo, Y.-F., & Patel, P. R. (2021). Reasons why young women in the United States choose their contraceptive method. *Journal of Women's Health*, 30(1), 64–72. <https://doi.org/10.1089/jwh.2019.8182>; Dennis, A., & Grossman, D. (2012). Barriers to contraception and interest in over-the-counter access among low-income women: A qualitative study. *Perspectives on Sexual and Reproductive Health*, 44(2), 84–91. <https://doi.org/10.1363/4408412>. Barber, J. S., Ela, E., Gatny, H., Kusunoki, Y., Fakhri, S., Batra, P., & Farris, K. (2019). Contraceptive desert? black-white differences in characteristics of nearby pharmacies. *Journal of Racial and Ethnic Health Disparities*, 6(4), 719–732. <https://doi.org/10.1007/s40615-019-00570-3>. Frost, J. J., & Darroch, J. E. (2008). Factors associated with contraceptive choice and inconsistent method use, United States, 2004. *Perspectives on Sexual and Reproductive Health*, 40(2), 94–104. <https://doi.org/10.1363/4009408>. Burke, K. L., Potter, J. E., & White, K. (2020). Unsatisfied contraceptive preferences due to cost among women in the United States. *Contraception: X*, 2, 100032. <https://doi.org/10.1016/j.conx.2020.100032>; Brittini Frederiksen, U. R., & 2022, N. (2022, November 18). *Contraception in the United States: A closer look at experiences, preferences, and coverage*. KFF. <https://www.kff.org/womens-health-policy/report/contraception-in-the-united-states-a-closer-look-at-experiences-preferences-and-coverage/>;

⁴ Dehlendorf, C., Rodriguez, M. I., Levy, K., Borrero, S., & Steinauer, J. (2010, March). *Disparities in family planning*. American journal of obstetrics and gynecology. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835625/>; Dehlendorf, C., Foster, D. G., de Bocanegra, H. T., Brindis, C., Bradsberry, M., & Darney, P. (2011). Race, ethnicity and differences in contraception among low-income women: Methods received by Family Pact clients, California, 2001-2007. *Perspectives on Sexual and Reproductive Health*, 43(3), 181–187. <https://doi.org/10.1363/4318111>; Jackson, A. V., Karasek, D., Dehlendorf, C., & Foster, D. G. (2016). Racial and ethnic differences in women's preferences for features of contraceptive methods. *Contraception*, 93(5), 406–411. <https://doi.org/10.1016/j.contraception.2015.12.010>; Kessler, K., Kuroki, L. M., Allsworth, J. E., Secura, G. M., Roehl, K. A., & Peipert, J. F. (2011). Perceived racial, socioeconomic and gender discrimination and its impact on contraceptive choice. *Contraception*, 84(3), 273–279. <https://doi.org/10.1016/j.contraception.2011.01.004>.

⁵ Frederiksen, B., Ranji, U., Long, M., Diep, K., & Salganicoff, A. (2022, November 3). *Contraception in the United States: A closer look at experiences, preferences, and coverage*. KFF. <https://www.kff.org/womens-health-policy/report/contraception-in-the-united-states-a-closer-look-at-experiences-preferences-and-coverage/>

into account and engage in further study to understand the driving factors behind the differences and better determine how to best support access and preferences.

METHODS

We analyzed 2020 California Health Interview Survey (CHIS) data. CHIS is a health survey managed by the UCLA Center for Health Policy Research. CHIS data are collected via an annual survey from a representative household sample of about 20,000 adults ages 18 and up on a range of health-related topics including reproductive health and birth control utilization. Households were randomly selected using address-based sampling and were mailed an invitation to complete the CHIS survey online. We limited our analytic sample to women ages 18-44 who were assigned female at birth, identified as straight/heterosexual or bisexual, did not indicate that they were unable to get pregnant, and did not intend to get pregnant in the next 12 months. Respondents were classified by their birth control method used into one of four contraception groups: “Sterilization (tubal ligation, vasectomy),” “Long-Acting Reversible Contraception (LARC) (IUD, implant),” “The pill or other hormonal methods (oral contraceptive pills, injection/Depo-Provera, patch, vaginal ring/Nuva Ring),” and “Condoms or other.”

We performed descriptive analyses using design-based F-tests (Rao-Scott Chi-square tests) of differences in proportions to assess whether sociodemographic and health characteristics varied across contraception groups at an alpha of 0.05. Confidence intervals (95% CI) were included to communicate the degree of uncertainty around an estimate due to sampling error. Non-overlapping confidence intervals were deemed indicative of statistically significant differences in two proportions at an alpha of 0.05. All analyses were conducted using Stata v17.1 and weighted using person-level weights provided by the UCLA Center for Health Policy Research. All sample sizes (n) are unweighted.

FINDINGS IN CONTEXT

Below, we present data on contraceptive method choice by demographic groups in California (Table 1).⁶ Our findings are presented in the bullets below, followed by relevant data from the wider literature to provide context for the patterns that emerge from the CHIS data.

Age

Our data reveal differences in method choice over the reproductive lifespan of women in California. Particularly notable differences arise in rates of sterilization and oral contraceptive pill usage.

- Permanent methods are more common among older women: between 5-6% of respondents ages 18-29 report sterilization, rising to 13.8% of those ages 30-34, and peaking between 28-29% for those over age 35.
 - The relative increase in sterilization with age may be a natural consequence of women

⁶ Age and marital status, age and urbanicity, and race-ethnicity, language spoken at home, and citizenship status are likely correlated; therefore, there may be similarities across contraceptive usage across these groups.

opting for permanent contraception once they have completed childbearing.⁷ However, younger women, especially those without children, have reported barriers to accessing desired sterilization procedures, including federal Medicaid age requirements and refusal from individual providers.⁸

- On the other end of the spectrum, pill users skew disproportionately young, making up the largest share of 18-29-year-olds at 42.5-7%. Pill use consistently declines as age increases, with only 18.5% of 40–44-year-olds reporting the method.
 - The high reliance of young women on the pill suggests future over-the-counter access may have positive impacts for young people. On July 13, 2023, FDA approved Opill—a progestin-only oral contraceptive—for over-the-counter sale; it is expected to be available on shelves in 2024.
 - Our data indicates that the availability of over-the-counter oral contraceptives is likely to impact young people, who are more likely to rely on this method. Young people often have difficulty accessing contraception due to cost, lack of insurance coverage, or unawareness of health plan benefits. Opill’s availability over the counter may increase access by addressing these barriers.⁹
 - Insurance coverage allows contraception to be affordable for many Americans, and if oral contraceptives are made available over the counter without policy action to ensure continued insurance coverage, their impact on access will be diminished.
 - California lawmakers have already demonstrated responsiveness to this issue by passing SB 523, which was signed into law by Governor Gavin Newsom in September 2022 and guarantees insurance coverage for all over-the-counter methods of contraception, including emergency contraception.¹⁰ Five other states have also enacted similar laws requiring private insurance coverage requirements for over-the-counter contraception.¹¹ Members of Congress in both the United States House and Senate have introduced the Affordability is Access Act, which would similarly guarantee insurance coverage for over-the-counter contraception without cost sharing at the federal level.¹²

⁷ Dehlendorf, C., Park, S. Y., Emeremni, C., Comer, D., & Borrero, S. (2013). Racial/ethnic disparities in contraceptive use: Variation by age and women’s reproductive experiences. *Contraception*, 88(3), 466–467. <https://doi.org/10.1016/j.contraception.2013.05.137>

⁸ Richie, C. (2013). Voluntary sterilization for childfree women. *Hastings Center Report*, 43(6), 36–44. <https://doi.org/10.1002/hast.216>

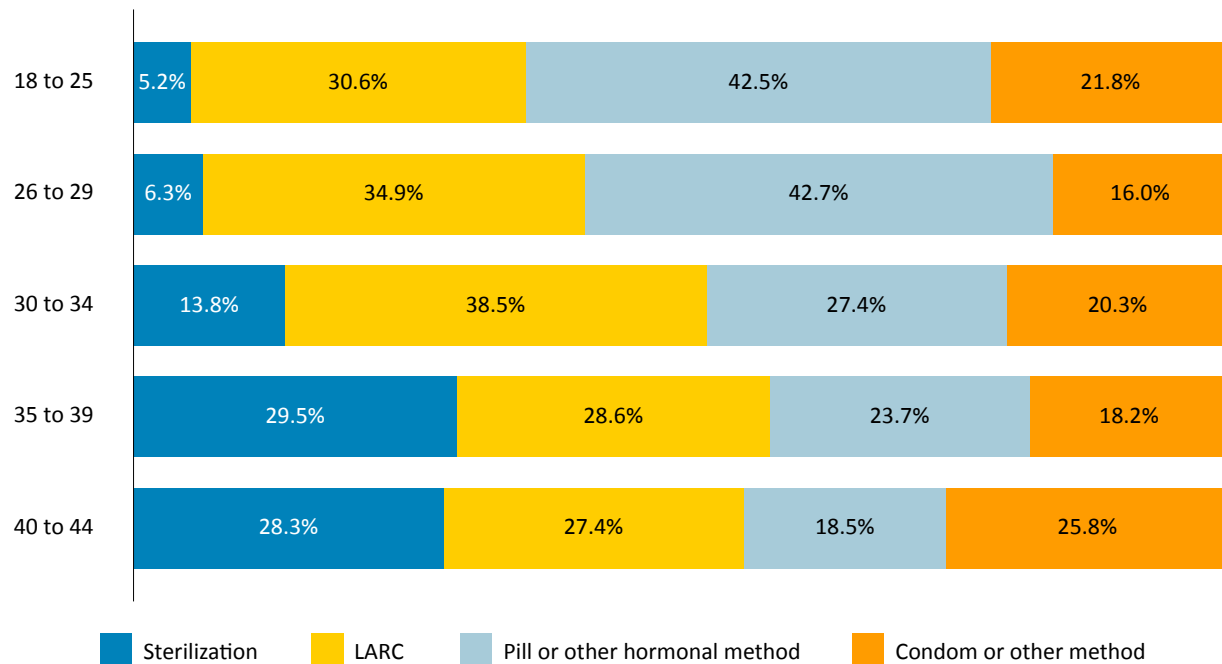
⁹ Tak, C. R., Kessler, L. T., Scott, M. A., & Gunning, K. M. (2019). Pharmacist-prescribed hormonal contraception: A review of the current landscape. *Journal of the American Pharmacists Association*, 59(5), 633–641. <https://doi.org/10.1016/j.japh.2019.05.015>

¹⁰ CA. Legis. S. SB-523 Reg. Sess. 2021-2022 (2022) <https://legiscan.com/CA/text/SB523/id/2609428>

¹¹ Long, M., Diep, K., Sobel, L., & Salganicoff, A. (2023, September 14). *Insurance coverage of OTC oral contraceptives: Lessons from the field*. KFF. <https://www.kff.org/womens-health-policy/report/insurance-coverage-of-otc-oral-contraceptives-lessons-from-the-field/>

¹² Eldahshoury, M. (2023, May 18). *Pressley, Murray, Bera, Ocasio Cortez re-introduce affordability is access act, advocate for free over-*

Figure 1. Contraceptive method used among California women ages 18-44 who do not intend to get pregnant in the next 12 months (N=1,767) by age, 2020 California Health Interview Survey



Race and Language Spoken at Home

Our data reveals some differences with respect to condom usage and sterilization amongst different racial and linguistic groups and, with respect to sterilization, some significant differences between California versus national data.

- Non-Hispanic Asian and non-Hispanic Black women used condoms at higher rates than any other racial-ethnic group—36.2% and 33.3%, respectively, compared to 18.3% of white women, 17.1% of Hispanic women, and 8.8% of women identifying as multi-racial or any other race.
 - Past research has found that Black and Asian women were more likely to have preferences for contraceptive method features associated with condoms, such as being able to stop use at any time, being able to use a method only during intercourse, or using a method that will not have an effect on the menstrual cycle.¹³

the-counter birth control. Ayanna Pressley. <https://pressley.house.gov/2023/05/18/pressley-murray-bera-ocasio-cortez-re-introduce-affordability-is-access-act-advocate-for-free-over-the-counter-birth-control/>

¹³ Jackson, A. V., Karasek, D., Dehlendorf, C., & Foster, D. G. (2016). Racial and ethnic differences in women's preferences for features of contraceptive methods. *Contraception*, 93(5), 406–411. <https://doi.org/10.1016/j.contraception.2015.12.010>.

- Black women were also much less likely to report sterilization than women of any other group (1% compared to 12.0%-19.3% for all other groups).
 - The low rate of sterilization among Black women in our sample notably differs from national trends as, non-Hispanic Black women have previously reported the highest rates of female sterilization compared to other racial groups.¹⁴
- Although Latina/Hispanic women did not report higher rates of sterilization than other racial-ethnic groups, women who primarily speak Spanish in the home reported the highest rates of sterilization. Notably, the lowest rates of sterilization were reported by women who primarily speak both Spanish and English at home.
 - These respondents likely represent a subset of the overall Latina/Hispanic population in our sample, a subset which likely comprises more monolingual families and immigrant households. These findings are consistent with prior data showing that sterilization is the most common form of contraception in Latin America and the Caribbean.¹⁵
- Women who primarily speak Spanish at home also reported the lowest rates of condom use: 5.9% compared with 17.6% for those who speak English at home, 22.4% for women who speak both English and Spanish, 31.3% for other languages, and 36.5% for women who speak English and Asian languages at home. While the finding that women who speak English and Asian languages at home use condoms at the highest rates among language groups tracks the finding that Asian women use condoms at the highest rates among racial groups (36.5% and 36.2%, respectively), the reverse did not hold true for Spanish speakers (5.9%) and Latina/Hispanic women (17.1%).
 - Women who speak Spanish at home are likely a subset of our sample that is comprised of monolingual and immigrant households. These findings may reflect past research that has found that acculturation among Latina/Hispanic women living in the United States is associated with increased condom use.¹⁶ Adoption of the dominant culture's language, in this case English, is associated with higher levels of acculturation.¹⁷

¹⁴ Daniels K, Abma JC. Current contraceptive status among women aged 15–49: United States, 2015–2017. (2018). NCHS Data Brief, no 327. Hyattsville, MD: National Center for Health <https://www.cdc.gov/nchs/products/databriefs/db327.htm>.

¹⁵ United Nations, Department of Economic and Social Affairs, Population Division (2019). Contraceptive Use by Method 2019: Data Booklet (ST/ESA/SER.A/435). https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2020/Jan/un_2019_contraceptiveusebymethod_databooklet.pdf

¹⁶ McDonald, J. A., Manlove, J., & Ikramullah, E. N. (2009). Immigration measures and reproductive health among Hispanic youth: Findings from the National Longitudinal Survey of Youth, 1997–2003. *Journal of Adolescent Health*, 44(1), 14–24. <https://doi.org/10.1016/j.jadohealth.2008.08.001>

¹⁷ Roncancio, A. M., Ward, K. K., & Berenson, A. B. (2012). The use of effective contraception among young Hispanic women: The role of acculturation. *Journal of Pediatric and Adolescent Gynecology*, 25(1), 35–38. <https://doi.org/10.1016/j.jpag.2011.08.008>

Figure 2. Contraceptive method used among California women ages 18-44 who do not intend to get pregnant in the next 12 months (N=1,767) by race-ethnicity, 2020 California Health Interview Survey

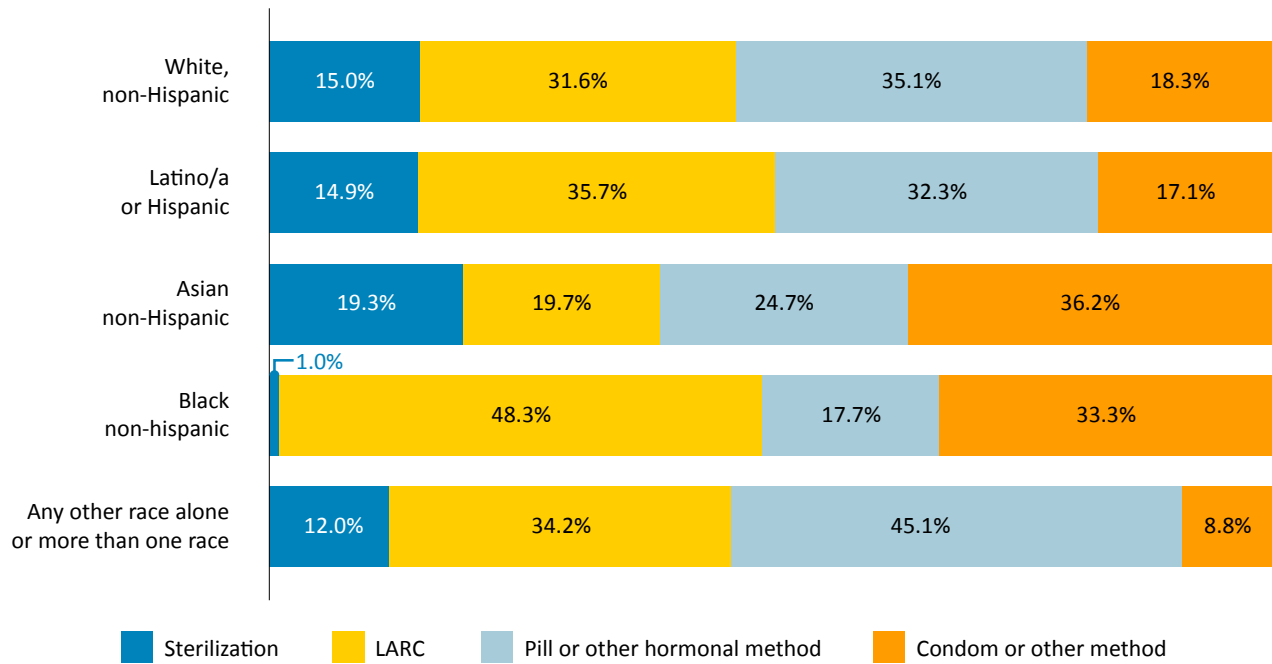
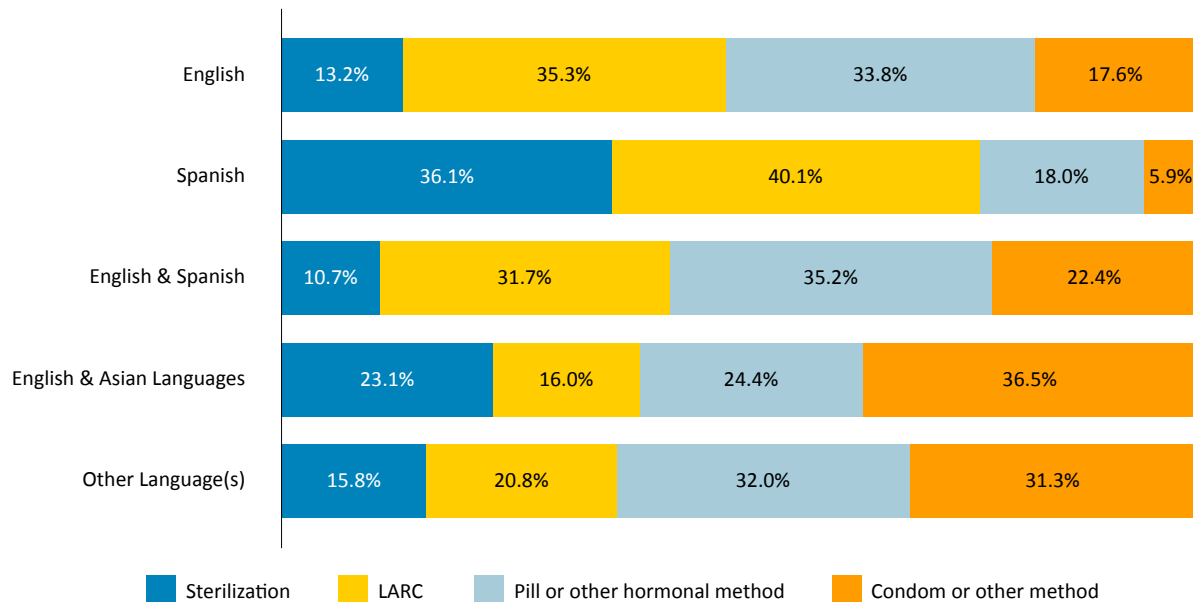


Figure 3. Contraceptive method used among California women ages 18-44 who do not intend to get pregnant in the next 12 months (N=1,767) by language spoken at home, 2020 California Health Interview Survey



Insurance Type and Usual Source of Care

Our data revealed that uninsured women more frequently relied on condoms. In California, the group most likely to use LARCs was those insured through Medi-Cal (compared to women on other forms of insurance or those uninsured), distinguishing California from national use patterns for women on Medicaid.

- In our sample, uninsured women reported relying on condoms more than other groups, with 43.5% reporting condoms as their primary method, compared to 20.5% of those with employment-based insurance, 10.8% of Medicaid (Medi-Cal) recipients, and 28.4% of those reporting another form of insurance.
 - This finding is consistent with data showing that people without health insurance are less likely to use prescription forms of birth control, due to the high cost.¹⁸ Many women cite cost as the reason why they are not using their preferred method, especially among women who are uninsured, low-income, or using condoms or withdrawal.¹⁹
- Women on Medi-Cal reported higher LARC usage than other groups (43.1%, compared to 30.5% of those with employment-based insurance, 17.2% of uninsured, and 27.7% other insurance).
 - Nationally, only 12% of Medicaid enrollees of childbearing age use LARC.²⁰
 - Various administrative, logistical, and implementation barriers have made it difficult to increase LARC utilization among Medicaid enrollees.²¹ Some of these barriers include global maternity fees, high cost of stocking LARCs, and covering LARC placement and removal only in certain health care settings.²²

¹⁸ Barber, J. S., Ela, E., Gatny, H., Kusunoki, Y., Fakhri, S., Batra, P., & Farris, K. (2019). Contraceptive desert? black-white differences in characteristics of nearby pharmacies. *Journal of Racial and Ethnic Health Disparities*, 6(4), 719–732. <https://doi.org/10.1007/s40615-019-00570-3>; Dehlendorf, C., Rodriguez, M. I., Levy, K., Borrero, S., & Steinauer, J. (2010, March). *Disparities in family planning*. American journal of obstetrics and gynecology. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835625/>

¹⁹ Burke, K. L., Potter, J. E., & White, K. (2020). Unsatisfied contraceptive preferences due to cost among women in the United States. *Contraception: X*, 2, 100032. <https://doi.org/10.1016/j.conx.2020.100032>; Brittini Frederiksen, U. R., & 2022, N. (2022, November 18). *Contraception in the United States: A closer look at experiences, preferences, and coverage*. KFF. <https://www.kff.org/womens-health-policy/report/contraception-in-the-united-states-a-closer-look-at-experiences-preferences-and-coverage/>; Dehlendorf, C., Rodriguez, M. I., Levy, K., Borrero, S., & Steinauer, J. (2010, March). *Disparities in family planning*. American journal of obstetrics and gynecology. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835625/>; Frost, J. J., & Darroch, J. E. (2008). Factors associated with contraceptive choice and inconsistent method use, United States, 2004. *Perspectives on Sexual and Reproductive Health*, 40(2), 94–104. <https://doi.org/10.1363/4009408>; Dennis, A., & Grossman, D. (2012). Barriers to contraception and interest in over-the-counter access among low-income women: A qualitative study. *Perspectives on Sexual and Reproductive Health*, 44(2), 84–91. <https://doi.org/10.1363/4408412>

²⁰ Fuerst, M., & George, K. (2020). (rep.). *Advancing Person-Centered LARC Access among the Medicaid Population* (pp. 1–22). Institute for Medication Innovation.

²¹ Id.

²² Ranji, U., Gomez, I., Salganicoff, A., Rosenzweig, C., Kellenberg, R., & Gifford, K. (2023, March 6). State Medicaid Strategies to

- However, in California, the Department of Healthcare Services uses a portion of revenue created by a tobacco tax to improve access to family planning services including LARC.²³ The allocation of funds helps pay for LARC devices, insertion, and removal, making it easier for women on Medi-Cal to access LARC.²⁴

Figure 4. Contraceptive method used among California women ages 18-44 who do not intend to get pregnant in the next 12 months (N=1,767) by health insurance type, 2020 California Health Interview Survey

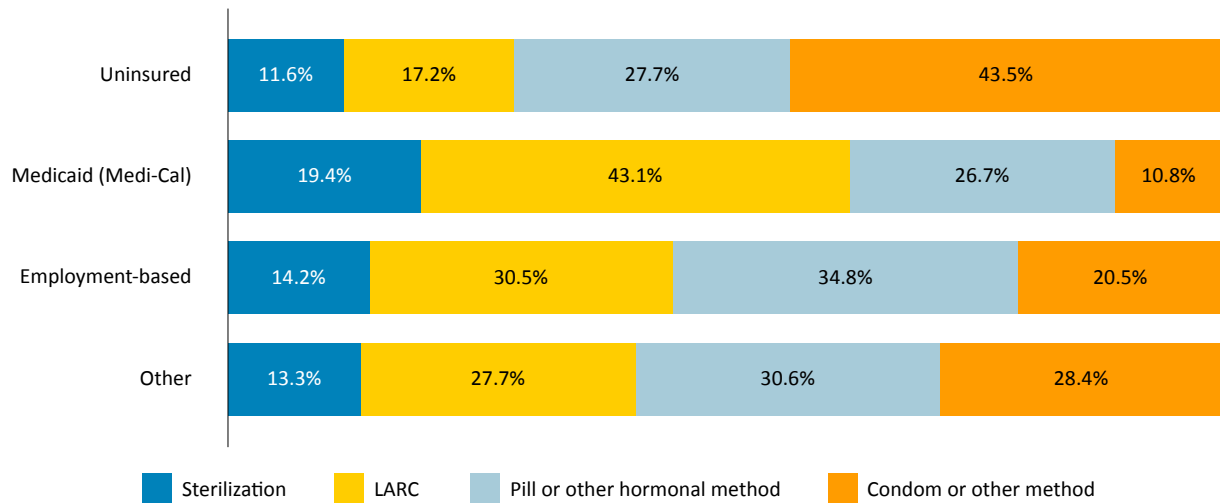
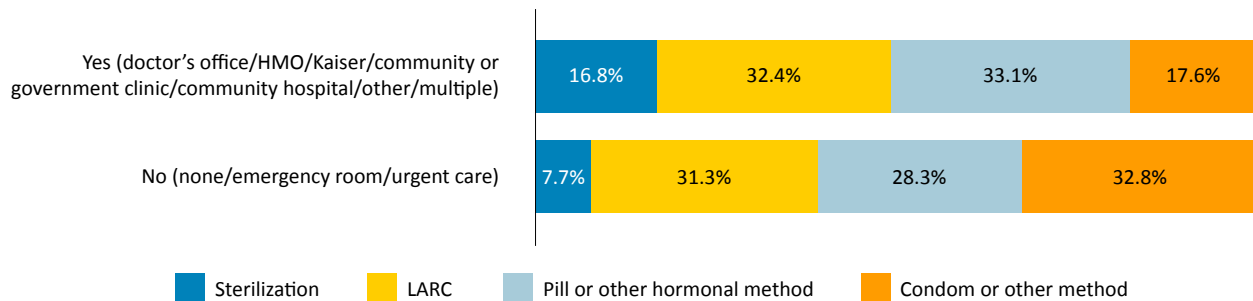


Figure 5. Contraceptive method used among California women ages 18-44 who do not intend to get pregnant in the next 12 months (N=1,767) by usual source of care, 2020 California Health Interview Survey



²³ Id.

²⁴ Id.

RECOMMENDATIONS FOR FUTURE RESEARCH

- Increase contraceptive research among all demographic groups to further understand what factors influence their choice of contraception. Further research is particularly needed regarding the following:
 - Potential factors driving racial differences in method choice
 - Experiences of immigrant women seeking contraceptive care, including facilitators and barriers to accessing preferred methods
 - Access to preferred contraceptive method among uninsured women

APPENDICES

APPENDIX A: TABLES

Table 1. Use of specific contraceptive method* within sociodemographic and health-related characteristic groups of cisgender heterosexual and bisexual California women ages 18-44 who do not wish to get pregnant and who are using contraceptives (N=1,767), 2020 California Health Interview Survey

	Sterilization n=386		LARC n=506		The pill or other hormonal methods n=530		Condoms or other* n=345	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Pregnancy intention (n=1,907)								
Do not plan to get pregnant within next 12 months	15.1	13.1, 17.4	32.2	29.1, 35.5	32.2	29.2, 35.5	20.4	17.8, 23.3
Planning to get pregnant within next 12 months	6.3	2.7, 13.7	24.6	16.3, 35.2	38.2	27.6, 50.1	31.0	18.8, 46.5
Age								
18-25	5.2	2.1, 12.0	30.6	25.0, 36.8	42.5	36.4, 48.7	21.8	16.5, 28.2
26-29	6.3	3.5, 10.9	34.9	27.1, 43.7	42.7	34.8, 51.1	16.0	11.0, 22.9
30-34	13.8	9.1, 20.5	38.5	30.9, 46.8	27.4	20.5, 35.5	20.3	14.6, 27.4
35-39	29.5	24.1, 35.5	28.6	21.8, 36.5	23.7	17.9, 30.7	18.2	13.5, 24.1
40-44	28.3	23.0, 34.2	27.4	22.1, 33.5	18.5	13.4, 25.1	25.8	19.5, 33.3
Marital status								
Married	26.4	23.3, 29.9	30.2	26.7, 34.0	21.8	17.8, 26.4	21.5	17.4, 26.2
Living w/ partner	9.6	5.3, 16.9	38.3	30.1, 47.3	33.8	26.6, 41.8	18.3	12.7, 25.6
Widow/separated/divorced	11.5	6.0, 20.7	39.7	28.1, 52.6	25.9	16.8, 37.7	22.9	14.7, 34.0
Never married	5.7	3.0, 10.7	29.8	24.3, 35.9	44.3	38.6, 50.1	20.2	15.8, 25.5
Sexual orientation								
Straight/heterosexual,	16.1	13.9, 18.5	30.9	27.4, 34.6	32.2	29.0, 35.6	20.8	18.0, 24.0
Bisexual	6.8	2.9, 14.9	44.2	36.3, 52.3	32.5	24.1, 42.2	16.5	10.3, 25.5
Race-ethnicity								
White, non-Hispanic	15.0	12.9, 17.5	31.6	27.8, 35.6	35.1	30.8, 39.5	18.3	15.6, 21.4
Latino/a or Hispanic	14.9	11.3, 19.6	35.7	30.2, 41.6	32.3	27.2, 37.8	17.1	13.4, 21.7
Asian, non-Hispanic	19.3	12.7, 28.3	19.7	15.1, 25.4	24.7	18.9, 31.7	36.2	27.4, 46.1
Black, non-Hispanic	1.0	0.2, 5.4	48.3	24.6, 72.7	17.7	7.4, 36.8	33.0	18.1, 52.3
Any other race alone, or more than one race	12.0	6.5, 21.2	34.2	21.4, 49.8	45.1	30.2, 60.8	8.8	3.5, 20.2
Race-ethnicity								
White, non-Hispanic	15.0	12.9, 17.5	31.6	27.8, 35.6	35.1	30.8, 39.5	18.3	15.6, 21.4

	Sterilization n=386		LARC n=506		The pill or other hormonal methods n=530		Condoms or other* n=345	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
All other racial-ethnic groups	15.2	12.3, 18.7	32.5	28.3, 37.0	30.8	27.0, 34.8	21.5	17.9, 25.6
Language spoken at home								
English	13.2	11.4, 15.3	35.3	32.2, 38.6	33.8	30.0, 37.8	17.6	14.9, 20.7
Spanish	36.1	20.0, 56.0	40.1	20.9, 62.8	18.0	6.1, 42.5	5.9	2.5, 13.4
English & Spanish	10.7	7.0, 16.0	31.7	25.5, 38.7	35.2	28.3, 42.8	22.4	16.1, 30.1
English & Asian languages	23.1	10.7, 43.1	16.0	10.0, 24.7	24.4	16.6, 34.3	36.5	23.0, 52.5
Other language(s)	15.8	11.0, 22.2	20.8	15.6, 27.1	32.0	22.7, 43.1	31.3	22.0, 42.4
Citizenship status								
US-born	13.0	11.1, 15.2	33.3	29.9, 36.9	34.9	31.3, 38.6	18.7	15.9, 22.0
Naturalized	21.7	13.4, 33.2	24.7	16.3, 35.7	21.7	15.7, 29.3	31.8	21.5, 44.3
Non-citizen	20.5	14.2, 28.7	31.9	22.4, 43.2	27.0	18.5, 37.6	20.6	13.7, 29.8
Urbanicity								
Urban	14.2	12.0, 16.6	31.8	28.4, 35.4	32.8	29.5, 36.3	21.2	18.4, 24.4
Rural	24.8	16.2, 35.9	36.3	23.7, 51.1	26.5	18.3, 36.8	12.4	7.6, 19.5
Education								
High school or less	16.9	10.9, 25.4	43.0	33.7, 52.9	22.7	15.8, 31.4	17.4	11.2, 25.9
Associates or some college	18.8	14.4, 24.0	27.8	22.1, 34.5	38.9	32.3, 45.9	14.5	10.6, 19.5
Bachelors or more	12.9	11.1, 14.9	29.0	25.9, 32.3	34.0	30.4, 37.8	24.1	21.1, 27.4
Poverty								
<100% federal poverty level (FPL)	17.1	9.7, 28.2	39.0	28.1, 51.1	29.3	19.2, 42.1	14.6	8.4, 24.2
100%-199% FPL	11.9	7.4, 18.8	38.8	29.6, 49.0	32.5	24.4, 41.9	16.7	10.4, 25.7
200%-299% FPL	19.9	12.4, 30.4	29.6	19.8, 41.8	25.6	17.2, 36.3	24.9	17.7, 33.8
300%-399% FPL	18.6	12.6, 26.6	25.3	19.0, 32.8	40.4	31.5, 50.0	15.7	9.7, 24.3
≥ 400% FPL	13.4	11.5, 15.5	30.6	27.1, 34.4	32.6	29.0, 36.4	23.4	19.6, 27.7
Health & Health Service Characteristics								
Health insurance type								
Uninsured	11.6	5.3, 23.5	17.2	9.5, 29.0	27.7	19.6, 37.5	43.5	30.5, 57.5
Medicaid (Medi-Cal)	19.4	13.3, 27.4	43.1	34.8, 51.8	26.7	19.9, 35.0	10.8	7.7, 14.9
Employment-based	14.2	12.4, 16.3	30.5	27.2, 34.0	34.8	31.2, 38.6	20.5	17.3, 24.1
Other	13.3	7.9, 21.5	27.7	18.8, 38.9	30.6	20.1, 43.6	28.4	18.6, 40.8
Self-reported health								
Poor/fair	18.6	11.4, 29.0	29.1	16.6, 45.9	24.6	15.8, 36.0	27.7	15.1, 45.2
Good/very good/excellent	14.8	12.7, 17.2	32.5	29.5, 35.6	33.0	29.8, 36.3	19.7	17.1, 22.6

	Sterilization n=386		LARC n=506		The pill or other hormonal methods n=530		Condoms or other* n=345	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Has usual source of health care								
Yes (doctor's office/ HMO/Kaiser/ community or government clinic/ community hospital/ other/multiple)	16.8	14.5, 19.4	32.4	29.4, 35.6	33.1	29.7, 36.8	17.6	15.1, 20.5
No (None/emergency room/urgent care)	7.7	4.5, 12.7	31.3	22.4, 41.8	28.3	22.2, 35.3	32.8	25.3, 41.3
Had trouble finding general doctor (12 mos)								
Yes	12.7	5.8, 25.6	27.3	14.6, 45.1	35.1	25.3, 46.3	24.9	15.4, 37.7
No	15.4	13.3, 17.7	32.6	29.6, 35.9	32.0	28.9, 35.3	20.0	17.3, 23.1
Delay or never obtain needed medical care (12 mos)								
Yes	11.0	7.2, 16.3	33.8	27.4, 40.9	33.6	27.6, 40.1	21.6	16.4, 28.0
No	16.3	13.9, 18.9	31.8	28.5, 35.2	31.9	28.5, 35.5	20.1	17.0, 23.6
Delay or never obtained needed prescription (12 mos)								
Yes	13.1	7.4, 22.2	36.8	27.2, 47.5	32.0	24.7, 40.4	18.1	12.1, 26.2
No	15.4	13.2, 17.8	31.7	28.5, 35.1	32.3	29.0, 35.8	20.7	17.8, 23.9
Received birth control counseling in past 12 months								
Yes	9.5	6.3, 14.1	32.5	27.6, 37.8	41.4	36.6, 46.8	16.6	12.5, 21.7
No	18.8	16.2, 21.7	32.0	28.0, 36.3	26.3	22.5, 30.4	22.9	19.8, 26.3
Any condom use								
Yes	4.3	2.3, 7.8	5.9	3.9, 8.9	21.8	17.4, 27.0	68.0	62.4, 73.1
No	19.6	16.9, 22.5	42.9	39.1, 46.8	36.5	32.8, 40.3	1.0	0.6, 1.8

* Row percentages total 100%

CI: Confidence Interval

APPENDIX B: DETAILED STUDY METHODS

Following the initial invitation, a reminder postcard and a second letter were sent to the household encouraging their participation. If a household did not complete the survey online, and received all three letters, interviewers attempted to complete the interview over the telephone. Households could also opt to complete the survey over the phone. Both online and phone surveys were available in English, Spanish, Cantonese, Korean, and Vietnamese. Phone surveys could also be completed in Tagalog. The mailings sent to each address were customized to include messages in multiple languages, based on languages spoken in a potential volunteer's neighborhood. Survey participants responded to a series of questions about reproductive health and birth control utilization. Questions about current pregnancy status (To your knowledge, are you now pregnant?) and intention (Which of the following statements best describes your pregnancy plans?) were first asked. Responses for current pregnancy status were "Yes", "No", and "Not Applicable." Responses for pregnancy intention were "I do not plan to get pregnant within the next 12 months", "I am not sexually active", "I am planning to get pregnant within the next 12 months", "I am currently pregnant", and "I am not able to get pregnant". If respondents did not report being pregnant, were not gay, lesbian, or homosexual, were not unable to get pregnant, did not indicate that they were not sexually active, they were then asked about general birth control use ("Are you or your male sex partner currently using a birth control method to prevent pregnancy?). Responses for this question were "Yes", "No", and "No male sexual partner." If respondents answered "Yes", they were asked about birth control methods used ("Which birth control method or methods are you using?"). Response options included "Tubal ligation (tubes tied cut)," "Vasectomy (male sterilization)," "IUD (Mirena®, Paragard®, Skyla®, Kyleena®, Liletta®, etc.)," "Implant (Implanon®, Nexplanon®, etc.)," "Birth control pills", "Other hormonal methods (Injection/ Depo-Provera, patch, vaginal ring/NuvaRing®)," "Condoms (male)," "Other(Specify:____)."

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ABOUT THE CENTER ON REPRODUCTIVE HEALTH, LAW, AND POLICY (CRHLP)

Founded in 2021 through a budget allocation from the state of California, CRHLP is an interdisciplinary, national academic research center dedicated to training the next generation of reproductive health and rights leaders, while producing research-informed strategies to transform current debates. CRHLP amplifies UCLA Law's current work on reproductive health, law, and policy and builds capacity by attracting new leaders, scholars, and students. CRHLP is committed to the highest standards of independent inquiry, academic excellence, and rigor. Research findings and conclusions are never altered to accommodate other interests, including those of funders, other organizations, or government bodies and officials.

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