# Contraceptive Service Use among Hispanics in the U.S.

Elizabeth Wildsmith

Kate Welti

Jennifer Manlove

Child Trends

## Abstract

A better understanding of factors linked to contraceptive service use among Hispanic women is central to efforts to promote sexual and reproductive health in general among Hispanics, a group with high rates of unintended pregnancy. We use data from two waves of the NSFG to identify factors linked to contraceptive service use *among* Hispanics. Notably, we focus on heterogeneity within the Hispanic population, examining differences in service use by level of "acculturation" – a combined measure of nativity, length of time in the U.S., and language use at home. Our findings show that, in this sample, contraceptive services, particularly at clinics, are fairly accessible to the foreign-born population. Instead, it seems to be the least acculturated of the native-born/1.5 generation population—the Spanish speakers—that receive the fewest contraceptive services, at either a clinic or non-clinic location.

# Family Planning Service Use among Hispanics in the U.S.

## Introduction and Background

Rates of unintended pregnancy are high in the U.S. The high rates of teen and unintended pregnancy as well as the low rates of contraceptive use among Hispanics, particularly among the immigrant population, are notable because Hispanics are the largest minority group and are one of the fastest growing populations in the U.S (Martin et al. 2007; Ryan et al. 2005). These patterns have raised concern. In fact, in 2004, an expert meeting of health professionals, community leaders, and researchers concluded that: "There is an urgent need to address the knowledge gaps that stand in the way of the design and implementation of effective programs and policies for Latina sexual and reproductive health" (Foulkes et al. 2007).

The nation's federally funded Title X programs are designed to provide services to help individuals and couples avoid unintended pregnancy. However, the high unmet need for family planning and contraceptive services suggests that some of those in greatest need of services are not utilizing family planning clinics or programs. One continued challenge among family planning programs is getting at-risk populations to come to clinics, as well as ensuring that those who have come in the past continue to receive services. These concerns seem to be particularly relevant for Hispanics. For example, a recent survey found that less than 20 percent of Hispanic women in Miami and Atlanta reported that Hispanics in their community had adequate health services (Asamoa et al. 2004). Additionally, Hispanic women are less likely than whites or blacks to report having a positive experience at their last visit to a family planning clinic (Forrest and Frost 1996). A better understanding of factors linked to contraceptive service use among Hispanic women is central to efforts to promote sexual and reproductive health in general among Hispanics.

Although existing research links age, marital status, socioeconomic status, race/ethnicity, and insurance status to the use of family planning and contraceptive services among all women (Frost 2001; Hock-Long et al. 2003), very limited research—particularly multivariate research—examines these association among Hispanics (see Solorio et al. 2004 for work on adolescents). Additionally, no quantitative research of which we are aware has focused on heterogeneity in family planning or contraceptive service use within the Hispanic population. However, other research finds that measures of acculturation—e.g., immigrant status, length of time in the U.S., and language use—as well as country of origin are linked to sexual initiation and contraceptive use (Afable-Munsuz and Brindis 2006), such that more acculturated youth tend to increased contraceptive use, although there remains debate over the strength and nature of these associations (Driscoll et al 2001). Additionally, qualitative research suggests that there is substantial variation within the Hispanic population, such that access to and use of family planning services are likely to be influenced by cultural issues (e.g., traditional gender roles) as well as by some of the common indicators of acculturation, such as language use and length of time in the U.S. (Sable et al. 2009). Together, this suggests that research focused specifically on

Hispanics needs to pay particular attention to the ways in which family planning and contraceptive service use might vary by important individual indicators of acculturation as well as by country of origin (Driscoll et al. 2001).

Thus, building on prior research examining factors associated with family planning and contraceptive service use among all women, our study will use a variety of descriptive and multivariate analytic techniques to identify factors associated with contraceptive service use *among* Hispanics. As in prior research, we will examine the role of important individual and family covariates such as: age, marital status, sexual activity, educational attainment, type of health insurance, and family background (specifically, parental education, family structure, and religiosity). However, we will expand on previous analyses by including additional individual and family level covariates, including measures of acculturation—such as generation, time spent in the US, and language use—as well as other potentially important measures—such as sexual behavior history and attitudes towards childbearing and gender roles.

## Data and Methods

*Data.*

Data for these analyses come from the 2002 and 2006-2008 National Survey of Family Growth (NSFG). The NSFG, conducted by the National Center for Health Statistics (NCHS), is a nationally representative survey designed to gather information on family life, pregnancy, infertility, use of contraception, and the health of women aged 15 to 44. The NSFG, therefore, is explicitly suited to examine the associations between personal and family characteristics and the receipt of contraceptive services among Hispanic women. The 2002 survey included 7,643 females and the 2006-08 included 7,356 females. Hispanics were oversampled in both surveys.

*Sample.*

Our sample was limited to Hispanic women who were aged 18-29[1] at the time of the survey and who had been sexually active in the past year; these restrictions resulted in a total of N=999 women (507 from the 2002 survey and 492 from the 2006-08 survey). A woman was identified as sexually active in the past year if she had sexual intercourse with at least one male partner in the 12 months prior to the interview.

*Measures.*

We examined two dependent variables: 1) a binary measure of the use of any contraceptive services in the past year; and 2) and a three-level measure further identifying where contraceptive services were received (no services, at a clinic, or at a non-clinic location).

[1] We are simultaneously working on a qualitative study of family planning service use among Hispanic women, which is limited to women aged 18-29. We restricted the quantitative analyses to women aged 18-29 to be consistent with the age range in the qualitative research.

A respondent was considered to have received any contraceptive services in the past year if she visited a medical provider for one of the following services: to obtain a birth control method or prescription, a birth control-related check-up, birth control counseling, sterilization counseling or a sterilization operation. A respondent was also considered to have received contraceptive services if she had used a birth control method in the month prior to the interview and obtained that method (or a prescription for that method) from a medical source—specifically a clinic, hospital, private doctor's office or HMO facility. A respondent was considered to have received *clinic services* if she reported using a clinic (including: a community health clinic, community clinic, public health clinic, family planning or Planned Parenthood clinic) for any of her contraceptive services; otherwise, if she received contraceptive services elsewhere (a private doctor's office, HMO facility, hospital, employer or school clinic, or urgent care center) she was considered to have used *non-clinic services*.

Our main independent variables of interest measured the respondent's level of acculturation and country of origin (Mexican origin vs. all others). There are many possible measures of acculturation, depending in part of the level of detail available in the data set being examined. Based on exploratory analyses of the NSFG, we chose to create one three-level variable that combined generation status, length of time in the U.S., and language status. Specifically, we identified respondents who: 1) were native-born or came to the U.S. before age 12 (i.e., 1.5 generation) and spoke primarily English; 2) were native-born or came to the U.S. before age 12 and spoke primarily Spanish; and 3) were foreign-born and came to the U.S. at age of 12 or older (referred to as "foreign-born" from here on out). We chose to combine the 1.5-generation Hispanics with native-born Hispanics (as opposed to the foreign born) because exploratory analyses demonstrated that the use of contraceptive services were virtually the same in both groups. Additionally, this is consistent with previous research suggesting that the "1.5 generation" are more similar to the U.S.-born population than the foreign born as they have spent a large part of their youth in the U.S. educational system and within U.S. communities (Rumbaut 1996). We will refer to this group throughout the paper as the "native-born/1.5 generation". Additionally, we further divided the native-born/1.5 generation by language status as speaking predominantly Spanish or English in the household was linked to contraceptive service receipt for this group (although not for the foreign born).

Other independent variables included personal and family background characteristics. These were: a continuous measure of the respondent's age at interview, respondent's poverty status (<100%, 100-249%, 250%+ of the federal poverty guideline), whether the respondent lived with both biological parents at age 14, whether the respondent had at least one parent that completed some college, whether the respondent was currently enrolled in school, whether the respondent lived with at least one parental figure at the time of interview, young age at first sex (less than 15), marital/cohabiting status (married, cohabiting, neither), respondent had at least one child, respondent had two of more partners in the past year, and two measures of traditional gender attitudes. These attitude measures indicated how much the respondent agreed with the

following statements "A working mother can establish just as warm and secure a relationship with her children as a mother who does not work" and "It is much better for everyone if the man earns the main living and the woman takes care of the home and family." Responses were recorded on a scale of one to five where one was "strongly agree" and five was "strongly disagree." For the purposes of our analyses, both measures were coded such that a higher score indicated a more traditional gender view.[2]

*Methods.*

We began with descriptive analyses of the full sample. Bivariate analyses were then conducted using t-tests and chi-square analyses to test whether receipt of any contraceptive services and where services were received differed by generation and language status, Mexican origin, and family and individual characteristics. Multivariate analyses tested for associations between independent and the dependent variables net of potentially confounding factors. Logistic regression was used to predict the overall receipt of contraceptive services and multinomial logistic regression was used to predict where services were received, comparing the receipt of clinic services and non-clinic services to no services and comparing the receipt of clinic services to non-clinic services. All analyses were weighted and used the survey design command in Stata to account for the complex sampling design of the NSFG.

**Results**

*Sample characteristics*

Over two-thirds (68%) of our sample of Hispanic women received contraceptive services in the past year. Approximately half of these women received services from a clinic and the other half from a non-clinic location. Approximately two-thirds of the sample (63%) were native-born/1.5 generation and spoke English as their primary language; 5% were native-born/1.5 generation and spoke Spanish as their primary language; the remaining approximately one-third (32%) of the sample were foreign-born women who came to the U.S. at age 12 or later. The majority of the sample (69%) was of Mexican origin.

* Table 1 about here *

Approximately 12% of the sample was 18 or 19 at the time of the interview, 41% were 20-24 and 48% were 25-29. The sample was generally disadvantaged. Approximately three-quarters of women (77%) were poor or low-income and only one-third (34%) had at least one parent with some college education. Two-thirds (66%) lived with both biological parents at age 14, one-quarter (24%) were currently enrolled in school and just over a quarter lived with at least one parental figure (27%). Related to their sexual experience and relationship and fertility status,

[2] The NSFG contains additional indicators of attitudes. We explored whether these measures (in addition to the ones included in the final analyses) could be combined into a scale that measured traditional gender attitudes; however the various measures were very loosely correlated with one another and no clear factor was identified.

13% had sex for the first time before age 15, 44% were married, 21% were cohabiting and 35% were not in a married or cohabiting relationship, approximately two-thirds (65%) had at least one child and 14% had two of more partners in the past year. Finally, women's gender attitudes were only weakly traditional. On a scale of 1-5, women averaged 2.8 on the question of whether it is better for a man to work and a woman to stay home and a 2.1 on the question of whether a working mother cannot establish as loving a bond with her child as a mother not working.

*Bivariate results*

A woman's generation and language status were associated with receiving contraceptive services; and native-born/1.5 generation Spanish-speaking women were the least likely to receive services. Almost three-quarters (72%) of foreign-born women received services compared with 68% of native-born/1.5 generation English-speaking women and less than half (46%) of native-born/1.5 generation Spanish-speaking women. Most other individual and family background characteristics were not associated with contraceptive service use with the exception of an older age at first sex, having children (marginally significant), and having only one sexual partner in the past year.

* Table 2 about here *

More of our measures of interest were associated with *where* a woman received contraceptive services (clinic versus non-clinic location). Foreign-born women were the most likely to receive services at a clinic while native-born/1.5 generation English-speaking women were the most likely to receive non-clinic services. Women who were native-born/1.5 generation but spoke primarily Spanish were the least likely to receive any services and showed a preference for clinic services if they did. Women of Mexican origin were more likely than those from other countries of origin to receive clinic services than non-clinic services.

Women below or near the poverty line or whose parents were less educated were more likely to receive services from a clinic than a non-clinic location. A higher percentage of those not enrolled in school used clinic services (34%) compared with those who were in school (27%). Cohabiting women were the most likely to use clinic services (45%) and married women were the least likely (27%). Finally, those with less traditional gender attitudes were more likely to use clinic services.

*Multivariate results*

In Table 3, we see that the association between generation and language status and receipt of any contraceptive services remained significant. As compared to foreign-born women, those who were native-born/1.5 generation and spoke primarily Spanish had lower odds of receiving any contraceptive services (OR=.32). Women who were native-born/1.5 generation and spoke primarily English did not significantly differ from foreign-born women in their receipt of services. However, they did have higher odds of service receipt than their counterparts who

spoke primarily Spanish although the difference was only marginally significant (results not shown). Few individual and family characteristics were associated with receipt of any contraceptive services. The odds of receiving services decreased with age (OR = .91) and those who had sex for the first time at a young age (<15) were less likely to receive services (OR = .65) than those who were age 15 or older at first sex. Finally, those who had at least one child had more than twice the odds of receiving services (OR = 2.13).

* Table 3 about here *

A more complete picture emerges in multinomial regression models predicting where services were received. Women who were native-born/1.5 generation (regardless of language status) had a lower relative risk of receiving clinic services versus no services (RRR = .37 for English speakers and RRR = .34 for Spanish speakers) compared to foreign-born women. Additionally, compared to foreign-born women and native-born/1.5 generation English speaking women, those who were native-born/1.5 generation and spoke primarily Spanish had a lower relative risk of receiving non-clinic services versus no services (RRR = .34 versus foreign-born women). Finally, native-born/1.5 generation English-speaking women had a lower relative risk of receiving clinic services versus non-clinic services as compared with foreign-born women (RRR=.26); they also had a lower relative risk than their native-born/1.5 generation Spanish-speaking counterparts (comparison not shown). Although Mexican origin status was not associated with receipt of services overall, it was associated with a higher likelihood of receiving clinic services (versus no services or non-clinic services).

* Table 4 about here *

Multinomial models revealed that the negative association between respondent's age at interview and young at age first sex and overall contraceptive service receipt was being driven by a lower likelihood of clinic service receipt versus no services. Better economic circumstances, being low-income (100-249% poverty) as compared to poor (<100% poverty), and having a parent who completed at least some college was associated with lower odds of receiving clinic services as compared to non-clinic services. Cohabiting women had a higher relative risk than married women of receiving clinic services (RRR = 1.81 versus no services and RRR = 2.30 versus non-clinic services). Finally, having had at least one child was associated with a higher risk of non-clinic service use compared with no services (RRR = 2.33).

**Discussion**

In this paper, we examined heterogeneity in contraceptive service use within the Hispanic population, paying particular attention to measures of acculturation. Prior research has suggested that diversity in contraceptive service use is likely a root difference between more and less acculturated Hispanic teens in use of contraceptives (Driscoll et al. 2001), and this is likely true for young adults as well.

We chose to use a multidimensional indicator of acculturation—combining nativity, language use, and time in the U.S.—as preliminary analyses indicated that Hispanic youth who immigrated to the U.S. before age 12 were more similar to native-born Hispanic youth (a la Rumbaut 1996) in use of contraceptive services and because language use strongly distinguished between the native-born/1.5 generation in service use.

This multidimensional measure of acculturation was linked to the use of any contraceptive services as well as the location of those services. Notably, we found that foreign-born Hispanics in this sample (those coming to the U.S. after age 12) were more or less equally likely to have received contraceptive services as the most acculturated group, the native-born/1.5 generation English speakers (although this difference was no longer significant in the multivariate model); it was the native-born/1.5 generation Spanish speakers who were the least likely to receive any contraceptive services. A somewhat more comprehensive story emerged in the multinomial model. Specifically, while it is true that the native-born/1.5 generation were less likely than the foreign-born to receive any contraceptive services, these two groups were equally likely to receive services in a clinic or non-clinic setting. Conversely, while the most acculturated group—the native-born/1.5 generation English speakers—were similar to foreign-born Hispanics in receipt of services, these services were much more likely to occur in a non-clinic setting, such as a private doctors office.

Although prior research among Hispanics suggests that the foreign-born population (arguably the least acculturated) face the most barriers to contraceptive service use (Driscoll et al. 2001), we actually find that they have similar levels of contraceptive service use as the native-born/1.5 generation English speakers (arguably the most acculturated). This is interesting because it is often assumed that access to services will increase linearly with level of acculturation. However, we see some evidence, at least among this sample, that clinics are fairly accessible to the foreign-born population. Instead, it seems to be the least acculturated of the native-born/1.5 generation—the Spanish speakers—that are really disadvantaged in the overall receipt of services, at any location. It is important to remember, however, that this is a small group of women. The particularly high level of contraceptive services received among the foreign-born may reflect, at lest to some extent, alternative ways of obtaining contraceptives. For example, research of Hispanic women in communities directly bordering Mexico finds that women born and educated in Mexico are the most likely to get their contraceptives from pharmacies in Mexico (Potter et al. 2010).

Our findings suggest that the link between dimensions of acculturation and the receipt of contraceptive services is complex, as is the relationship of measures of acculturation to reproductive health in general (Driscoll et al. 2001). By PAA, we plan to discuss, and tie in our findings, theories of acculturation more thoroughly. Additionally, we plan to do step-wise modeling (as opposed to just one final model) to examine how much our individual and background characteristics (including other factors tied to acculturation—such as SES, education, and gender roles) "explain" the link between our main independent variables and the

receipt of contraceptive service as well as explore possible moderating relationships (e.g., does association of gender roles with contraceptive service receipt vary by our primary IV).

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| Table 2: Associations between select characteristics and use of contraceptive services, by provider type | | | | | | |
|---|---|---|---|---|---|---|
| | Contraceptive service user | | No contraceptive Services | Clinic | Non-clinic | |
| *Acculturation and Country of Origin* | | | | | | |
| Generation/language status | | * | | | | *** |
| Native-born/came to the U.S. before age 12 and English speaking | 67.6% | | 32.6% | 24.3% | 43.1% | |
| Native-born/came to the U.S. before age 12 and Spanish speaking | 46.4% | | 53.6% | 31.4% | 15.0% | |
| Foreign-born and came to the U.S. age 12 or older | 72.3% | | 28.4% | 47.8% | 23.8% | |
| Group of origin | | ns | | | | *** |
| Not of Mexican origin | 65.5% | | 34.6% | 17.9% | 47.6% | |
| Mexican origin | 69.9% | | 31.3% | 38.4% | 30.2% | |
| | | | | | | |
| *Individual and Background Characteristics* | | | | | | |
| Age at interview | | ns | | | | ns |
| 18-19 | 72.7% | | 27.3% | 31.6% | 41.1% | |
| 20-24 | 71.7% | | 28.7% | 36.0% | 35.3% | |
| 25-29 | 63.9% | | 36.7% | 28.8% | 34.6% | |
| Poverty | | ns | | | | ** |
| <100% | 67.0% | | 33.4% | 39.5% | 27.1% | |
| 100-249% | 69.0% | | 31.7% | 30.4% | 38.0% | |
| >250% | 68.3% | | 31.7% | 22.9% | 45.4% | |
| Family structure at age 14 | | ns | | | | ns |
| Not living with both bio/adoptive parents at age 14 | 65.7% | | 34.3% | 30.5% | 35.3% | |
| Living with both bio/adoptive parents at age 14 | 69.3% | | 31.3% | 32.9% | 35.8% | |
| Parent education (combined highest) | | ns | | | | *** |
| High school/GED or less | 66.5% | | 34.1% | 38.0% | 28.0% | |
| Some college or more | 71.1% | | 29.0% | 20.8% | 50.2% | |
| Currently enrolled in school | | ns | | | | * |
| No | 66.9% | | 33.6% | 33.6% | 32.7% | |
| Yes | 71.7% | | 28.3% | 27.2% | 44.4% | |
| Lives with a parent or parental figure | | ns | | | | ns |
| No | 68.4% | | 32.0% | 33.3% | 34.8% | |
| Yes | 67.2% | | 33.4% | 28.7% | 38.0% | |
| Age at first sex | | * | | | | ns |
| <15 | 60.4% | | 31.2% | 33.2% | 35.7% | |
| 15 + | 69.2% | | 39.9% | 24.6% | 35.5% | |
| Current relationship status | | ns | | | | * |
| Married | 69.2% | | 31.6% | 27.2% | 41.2% | |
| Cohabiting | 73.3% | | 26.7% | 44.6% | 28.8% | |
| Other | 63.5% | | 36.6% | 30.4% | 33.0% | |
| Number of children | | + | | | | ns |
| 0 | 63.1% | | 36.9% | 27.8% | 35.3% | |
| 1+ | 70.8% | | 29.8% | 34.4% | 35.8% | |
| Number of male partners in the past year | | * | | | | ns |
| 1 male partner in the past year | 69.8% | | 30.5% | 32.6% | 36.9% | |
| Two or more male partners in the past year | 57.5% | | 43.8% | 28.8% | 27.4% | |
| Working mother cannot establish just as warm a relationship with her child as a mother who does not work (Strongly disagree to Strongly Agree 1-5) | | ns | | | | ** |
| Disagree | 64.4% | | 35.8% | 39.9% | 24.2% | |
| Agree | 69.1% | | 31.4% | 29.9% | 38.7% | |
| Better if man earns the main living and the woman stays home (Strongly disagree to Strongly Agree 1-5) | | ns | | | | ** |
| Disagree | 66.9% | | 33.7% | 38.6% | 27.7% | |
| Agree | 69.0% | | 31.3% | 27.2% | 41.6% | |
| | | | | | | |
| **N** | **999** | | | | | |
| * p<.05 **p<.01 ***p<.001 | | | | | | |

| **Table 3: Results from logistic regression models predicting the use of contraceptive services** | |
|---|---|
| *Acculturation and Country of Origin* | |
| Generation and language status | |
| Native-born or 1.5 gen/English-speaking | 0.72 |
| Native-born or 1.5 gen/Spanish-speaking | 0.32** |
| Foreign-born | (1.00) |
| Mexican origin | 1.16 |
| | |
| *Individual and Background Characteristics* | |
| Age at interview | 0.91** |
| Poverty | |
| <100% | (1.00) |
| 100-249% | 1.12 |
| >250% | 1.33 |
| Lived with two bio parents age 14 | 1.18 |
| At least one parent has some college+ | 1.33 |
| Currently enrolled in school | 1.27 |
| Lives with at least one parent figures | 1.16 |
| Age at first sex <15 | 0.65* |
| Current relationship status | |
| Married | (1.00) |
| Cohabiting | 1.17 |
| Neither | 0.86 |
| R had had one child or more | 2.13** |
| Two or more partners in the past year | 0.63 |
| Working mother cannot establish just as warm a relationship with her child as a mother who does not work (1-5) | 1.00 |
| Better if man earns the main living and the woman stays home (1-5) | 0.94 |
| | |
| **N** | **999** |
| * p<.05 **p<.01 ***p<.001 | |
| Note: Difference between native born or 1.5 gen/English speaking and native born or 1.5 gen/Spanish speaking was mariginally significant at p=.052 | |

| **Table 4: Results from multinomial regression models predicting contraceptive service use / type of provider used** | | | |
|---|---|---|---|
| | Clinic services | Non-clinic services | clinic services |
| *Acculturation and Country of Origin* | vs no services | vs no services | vs. non-clinic |
| Generation and language status | | | |
| Native-born or 1.5 gen/English-speaking | 0.37** | 1.43 | 0.26*** |
| Native-born or 1.5 gen/Spanish-speaking | 0.34* | 0.34* | 0.99 |
| Foreign-born | (1.00) | (1.00) | (1.00) |
| Mexican origin | 2.29*** | 0.69 | 3.31*** |
| | | | |
| *Individual and Background Characteristics* | | | |
| Age at interview | 0.89** | 0.93 | 0.95 |
| Poverty | | | |
| <100% | (1.00) | (1.00) | (1.00) |
| 100-249% | 0.84 | 1.49 | 0.56* |
| >250% | 1.10 | 1.59 | 0.69 |
| Lived with two bio parents age 14 | 1.06 | 1.27 | 0.84 |
| At least one parent has some college+ | 0.88 | 1.72* | 0.51** |
| Currently enrolled in school | 1.19 | 1.43 | 0.83 |
| Lives with at least one parent figures | 0.93 | 1.35 | 0.69 |
| Age at first sex <15 | 0.55* | 0.72 | 0.76 |
| Current relationship status | | | |
| Married | (1.00) | (1.00) | (1.00) |
| Cohabiting | 1.81* | 0.79 | 2.30** |
| Neither | 1.24 | 0.68 | 1.82 |
| R had had one child or more | 1.80 | 2.33* | 0.77 |
| Two or more partners in the past year | 0.87 | 0.44 | 1.97 |
| Working mother cannot establish just as warm a relationship with her child as a mother who does not work (1-5) | 1.03 | 0.97 | 1.06 |
| Better if man earns the main living and the woman stays home (1-5) | 0.93 | 0.92 | 1.00 |
| | | | |
| **N** | **994** | **994** | **994** |
| * p<.05 **p<.01 ***p<.001 | | | |