GYNECOLOGY

Contraceptive continuation in Hispanic women

S. Rose Werth, BA; Gina M. Secura, PhD, MPH; Hilary O. Broughton, MSW; Maria E. Jones, BA; Viani Dickey, BA; Jeffrey F. Peipert, MD, PhD

OBJECTIVE: The purpose of this study was to examine the effect of Hispanic ethnicity on the continuation and satisfaction of reversible contraceptive methods.

STUDY DESIGN: We analyzed 12 months of data that were collected from 7913 participants in the Contraceptive CHOICE Project. Kaplan-Meier survival curves were used to estimate continuation, and Cox proportional hazard models were used to estimate the risk of discontinuation.

RESULTS: Hispanic women were more likely to choose a long-acting reversible contraceptive (LARC) method compared with non-Hispanic black and non-Hispanic white women (80%, 73%, and 75%, respectively; $P < .05$). The 12-month continuation rates were higher for LARC methods than combined hormonal methods for all race/ethnicity (Hispanic women, 87% vs 40%; non-Hispanic black women, 85% vs 46%; non-Hispanic white women, 87% vs 56%). There was no statistical difference in discontinuation of LARC methods at 12 months. Eighty percent of LARC users reported high satisfaction levels at 12 months, regardless of race/ethnicity.

CONCLUSION: Hispanic women in the Contraceptive CHOICE Project experienced high continuation and satisfaction for LARC methods, similar to women of other ethnicities.

Key words: continuation, ethnicity, long-acting reversible contraception, race

Cite this article as: Werth SR, Secura GM, Broughton HO, et al. Contraceptive continuation in Hispanic women. Am J Obstet Gynecol 2015;212:312.e1-8.

Hispanics are the largest minority group in the United States and have the highest fertility and birth rates.[1,2] More than one-half of the pregnancies (54%) among Hispanic women are unintended, second only to non-Hispanic black women (67%).[3] Even with recent declines in teenage births, the 2012 birth rate for Latina teens 15-19 years old was 46.3 per 1000 teens, which is higher than both non-Hispanic white women (20.5 per 1000 teens) and non-Hispanic black women (43.9 per 1000 teens).[4]

Hispanic women report lower current use of contraception and are less likely to have used contraception at first intercourse, compared with non-Hispanic women.[5] Among those currently using contraception, Latina women most commonly choose female sterilization followed by the oral contraceptive pill (OCP) and male condoms, which have typical use failure rates of 9% and 18%, respectively.[5,6] When compared with other races/ethnicities, fewer Latina women use the pill compared with non-Hispanic white women; in 2008 a higher percentage of Latina women reported use of the intrauterine device (IUD) compared with non-Hispanic white and non-Hispanic black women (4.8%, 3.3%, and 2.2%, respectively).[5] Previous research suggested that the high rate of unintended pregnancy among Hispanic and non-Hispanic black women has led to greater use of sterilization within these groups.[7]

Long-acting reversible contraception (LARC), which includes IUDs and the subdermal implant, offer an alternative to sterilization. LARC has been shown to be highly effective, safe, and cost-effective and is now recommended as first-line contraception for most women.[8-13] Nationally, we have observed a significant increase in LARC use between 2007 and 2009 across all races and ethnicities: non-Hispanic black women (2.3-9.2%), non-Hispanic white women (3.4-8.3%), and Hispanic women (5.5-8.5%).[14] Studies have demonstrated high levels of continuation and satisfaction with LARC methods among women, including teens and postpartum adolescents.[10,15,16] However, no studies to date have reported the effect of Hispanic ethnicity on method continuation and satisfaction. In this analysis, we compared 12-month method continuation rates and satisfaction levels by race and ethnicity among women enrolled in the Contraceptive CHOICE Project (CHOICE). We hypothesize that Hispanic women will report similar or higher rates of LARC continuation and satisfaction compared with non-Hispanic white and non-Hispanic black women.

Materials and Methods

CHOICE is a prospective cohort study of 9526 St. Louis–area women. Through convenience sampling, we recruited women 14-45 years old in university

From the Division of Clinical Research, Department of Obstetrics and Gynecology, Washington University in St. Louis School of Medicine, St. Louis, MO.

Received May 30, 2014; revised Aug. 3, 2014; accepted Sept. 3, 2014.

Supported in part by an anonymous foundation.

J.F.P. has served on advisory boards for TEVA Pharmaceuticals, Activis, Bayer Healthcare, and MicroChips and is a Nexplanon trainer for Merck. The remaining authors report no conflict of interest.

Corresponding author: Jeffrey F. Peipert, MD, PhD. peipertj@wustl.edu

0002-9378/$36.00 • http://dx.doi.org/10.1016/j.ajog.2014.09.003

and community clinics that provided contraceptive care and 2 facilities that provided abortion services. CHOICE promoted the use of LARC methods by removing the cost, education, and access barriers that often are experienced in contraceptive services. A detailed explanation of the methods of CHOICE has been published previously.[17] All participants provided written informed consent, and the study was approved by the Washington University School of Medicine Human Subjects Protection Office before participant recruitment.

To be eligible to participate in CHOICE, women had to meet the following inclusion criteria: 14-45 years old, sexually active with a male partner (or intent to be within the next 6 months), willing to try a new contraceptive method or not currently using contraception, not desiring pregnancy in the next 12 months, residing in or seeking clinical services at recruitment sites in the St. Louis area, and consenting in English or Spanish.

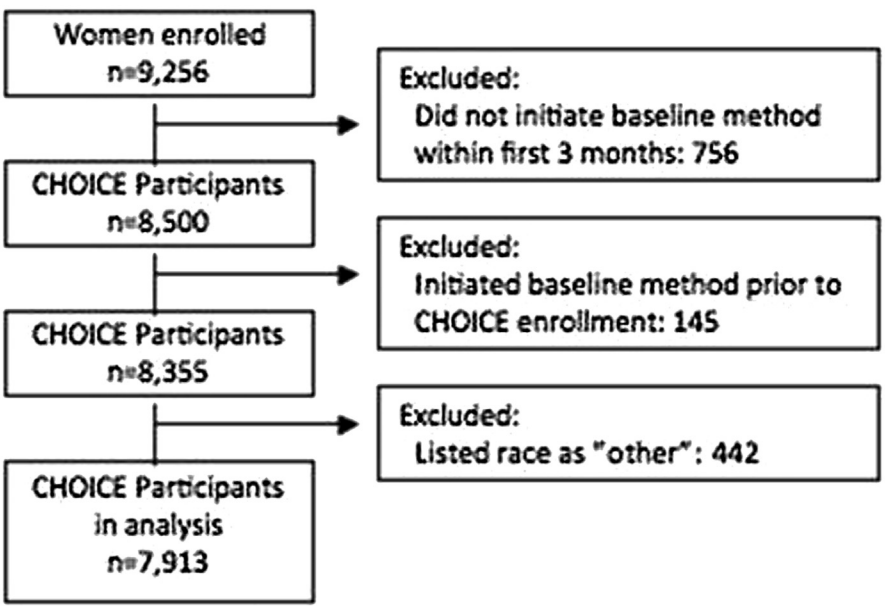
To recruit a diverse participant sample that included Hispanic women, we created recruitment and study materials in English and Spanish. Research assistants who were fluent in Spanish recruited Spanish-speaking study participants and conducted follow-up surveys. At enrollment, study participants underwent standardized contraceptive counseling that presented evidence-based and accurate information about each contraceptive method in the order of method effectiveness.[18] Participants chose and were provided their method at no cost for 2-3 years. Staff members administered a baseline survey to collect demographic information and a reproductive history. Participants were followed with telephone surveys at 3 months, 6 months, and every 6 months thereafter for the duration of follow-up period. Participants were paid $10 for each completed survey.

Information regarding method use and satisfaction was collected at each follow-up survey. To be included in this analysis, a participant had to receive and start her baseline chosen method of contraception within 3 months of enrollment. We defined method continuation as reporting method use at 3, 6, and 12 months without a period of nonuse of >1 month. Women were coded as having discontinued their method if they reported discontinuation or removal of their contraceptive method at <12 months or reported a gap in contraceptive coverage longer than 1 month at any follow-up survey. Women who experienced IUD expulsion during the first 12 months were considered continuers if the IUD was replaced within a month; women who did not have it replaced or chose a new method were coded as discontinuers. We measured 12-month method satisfaction as "very satisfied," "somewhat satisfied," or "not satisfied" with their current contraceptive method when asked during the 12-month survey. Women who discontinued their method were coded as "not satisfied." Women who discontinued because of a pregnancy or a desire to conceive were excluded from the satisfaction analysis.

At baseline, we recorded Hispanic ethnicity and race as 2 separate categories. In this analysis, we defined 3 groups. A woman was coded Hispanic when she reported her ethnicity as Hispanic, regardless of race. The other 2 groups represented women who reported themselves as non-Hispanic white and non-Hispanic black. Women who self-identified as other race were not included in this analysis.

To describe the demographic characteristics of the participants who were included in this analysis, we used frequencies, percentages, means, and standard deviation. To compare these variables, we used χ^2 tests for categoric variables and Student *t* tests for continuous normally distributed variables. A histogram was used to assess normality. We estimated continuation rates by constructing Kaplan-Meier survival functions and compared continuation between ethnicities and among different methods using the log-rank test. We used Cox proportional hazard models to estimate the risk of method discontinuation. The interaction

FIGURE 1
Exclusion criteria for final analysis sample



Flowchart depicts the exclusion criteria that were used to determine which participants would be included in the final analysis.

CHOICE, Contraceptive CHOICE Project.

Werth. Contraceptive continuation in Hispanic women. Am J Obstet Gynecol 2015.