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Continuing social disparities despite upward trends in sexual and reproductive health service use among young women in the United States☆

Kelli Stidham Hall[a,*], Caroline Moreau[b], James Trussell[b,c]

[a]Office of Population Research, Center for Health and Wellbeing, Princeton University, Princeton, NJ 08544, USA
[b]Princeton University, Gender and Reproductive Health, Inserm
[c]The Hull York Medical School

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Abstract

Background: Building upon previous work describing declining rates and socioeconomic disparities in sexual and reproductive health (SRH) service use among young women in the United States, we reexamined patterns and determinants of SRH service use in 2006–2010.
Study Design: We used the latest data from the National Survey of Family Growth to evaluate SRH service use including contraceptive, sexually transmitted infection (STI) and other gynecological exam services among 3780 women ages 15–24 years. We compared proportions of service use across survey years and employed multiple logistic regression to estimate the influence of time and women's sociodemographic characteristics on the likelihood of SRH service use.
Results: The proportion of women using SRH services increased from 50% (2006–2007) to 54% (2007–2008) and 57% (2008–2010) [all year odds ratios (ORs) 1.4, p values<.03]. Among sexually experienced women, the proportions using SRH and contraceptive services were unchanged, while STI service use increased from 22% (2006–2007) to 33% (2008–2009) (OR 1.7, confidence interval 1.1–2.4, p=.009). Differentials in service use existed across sociodemographic groups, largely with lower proportions of service use among women of social disadvantage.
Conclusions: Our results suggest a reversal of negative trends but continuing social disparities in young women's use of SRH services in the United States.

Keywords: Sexual and reproductive health; Health services; Contraception; Sexually transmitted infection; United States

1. Introduction

Between 2002 and 2006, negative trends and disparities in sexual and reproductive health (SRH) outcomes were noted among young women in the United States. Disproportionate rising teen pregnancy and sexually transmitted infection (STI) rates and stalled contraceptive use and abortion rates contrasted with previously improving outcomes prior to 2002 [1–8]. We recently described corresponding declining trends in young women's use of SRH services, including contraceptive services, between 2002 and 2006 [9]. We also described disparities in service use that negatively impacted young women of social disadvantage [10], which also occurred in the context of inequalities in SRH outcomes for poor and racial/ethnic minority women in the United States [2–8].

Building upon this work, we analyzed more recent trends and determinants of use of SRH services among adolescent and young adult women in the United States using updated data from 2006 through 2010.

2. Materials and methods

Data were drawn from the US population-based SRH survey, The National Survey of Family Growth (NSFG), which collects information on family life, marriage and

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* Corresponding author. Tel.: +1 609 258 8087; fax: +1 609 258 1039.
E-mail address: kshall@princeton.edu (K.S. Hall).

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divorce, pregnancy, infertility, use of contraception and health. Data were collected continuously via in-person household interviews with 12,279 US women ages 15 to 44 years from 2006 through 2010. Black and Hispanic women and young women were oversampled. The response rate was 77%. Additional information about the design and sampling of the NSFG can be found at http://cdc.govnchs/nsfg.htm [11].

We focused on adolescent and young adult women (15–24 years) (n=4360); pregnant women (n=580) were excluded. Our final sample included 3780 young women. The Institutional Review Board of Princeton University approved this study.

We have described our methods and measurement of SRH service use within the NSFG elsewhere [9,10]. Briefly, women were asked about receipt of SRH services from a medical provider within the 12 months preceding the survey and how many visits were made. Women were also asked the reason for services, which could include contraceptive services (contraceptive method provision, checkup, counseling, emergency contraceptive provision and counseling), STI testing/treatment services and other gynecological services (Pap smear, pelvic exam). We considered women to have used any recent SRH services if they responded that they had made one or more visits to a provider within the last year.

We used a 4-point indicator of the time frame in which the survey was administered: year 1=June 2006–June 2007; year 2=July 2007–June 2008; year 3=July 2008–June 2009; year 4=July 2009–June 2010.

For analysis of data, we described and compared estimates (weighted proportions) of SRH service use overall, by survey year and by type of service using descriptive and bivariate statistics (unadjusted χ^2 tests). We examined SRH service use for all young women and then among sexually experienced women only. We performed multivariable logistic regression modeling to estimate the influence of survey year on the likelihood of using SRH services while adjusting for age, sexual experience and other potential sociodemographic and reproductive history confounders. A description of our theoretical basis for selection of sociodemographic covariates can also be found elsewhere [9,10]. Variables were considered for inclusion in regression models if their p value in univariate models was .25 or less. In final reduced multivariate regression models, we retained only those covariates that were significantly associated with the outcome (p<.05). For variables that appeared to be collinear (e.g., many of the reproductive history variables), we chose variables with the strongest effect to retain in final models. Finally, we tested for trends over time and examined potential disparate changes in service use across sociodemographic groups using interaction terms for survey year. We used survey weights and the SVY Stata 11.0 commands in all analyses to account for the complex, stratified sampling design of the survey (Stata Corporation, College Station, TX, USA).

3. Results

Demographic, social and reproductive characteristics of the sample are described in Table 1. Briefly, the mean age of the sample was 19 years, with 54% adolescents (15–19 years) and 46% young adults (20–24 years). White race/ethnicity accounted for over half of young women (62%); 15% identified as Black; 18% identified as Hispanic; 7% identified as other. Forty-three percent were still in secondary school, while 36% reported having had at least some college education. Over half the sample (53%) was below 200% of the federal poverty level; 25% was uninsured at some point during the previous year. Nearly two thirds of young women (60%) had experienced vaginal sexual intercourse, with 16% reporting history of pregnancy and 16% reporting diagnosis of a gynecological problem.

Overall, 55% of young women between 2006 and 2010 used SRH services including contraceptive (45%) and STI (18%) services. Among sexually experienced women, 77% used SRH services including contraceptive (64%) and STI (29%) services.

In 2006–2007 (survey year 1), half of young women reported SRH service use (50%), with the proportion of service use increasing to 54% in 2007–2008 (year 2) and then to 57% in 2008–2010 (years 3 and 4) (Table 2). Compared to 2006–2007, women in all other subsequent year periods were 1.4 times as likely to use services [all odds ratios (ORs) 1.4, p values<.03]. Among sexually experienced women, proportions of SRH service use were stable across years (74% in 2006–2007 to 78% in all other year periods, p values>.14). The proportions of women using contraceptive services use ranged from 61% in 2007–2008 to 67% in 2008–2009 but were also statistically similar across time (p values>.20) (Table 3). However, there was an increase in STI service use from 22% in 2006–2007 to 31% in 2007–2008 [OR 1.6, confidence interval (CI) 1.1–2.4, p=.02] and to 33% in 2008–2009 (OR 1.7, CI 1.1–2.4, p=.009) (Table 3).

SRH service use varied by women's sociodemographic characteristics (Tables 2 and 3). Black women; older, college-educated and insured women; and those with less frequent religious service participation, sexual experience, more sexual partners and gynecological problems had greater odds of using SRH services compared to their counterparts. Greater odds of contraceptive service use (among sexually experienced women) were noted among White women; older, college-educated, rural-residing and insured women; and those with more sexual partners and gynecological problems. For STI service use among sexually experienced women, greater odds were noted among older and urban-residing women, women from a disrupted childhood family situation and those with more sexual partners. We were unable to stratify results by survey year due to insufficient sample sizes across sampling strata by year; however, all disparities appeared persistent across time as suggested by insignificant year-by-sociodemographic interaction terms (not shown).