# Contraceptive Use Among Cisgender Women with Bacterial Sexually Transmitted Infections: A Cross-Sectional Study

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A thesis

submitted in partial fulfillment of the

requirements for the degree of:

Master of Public Health

University of Washington

2021

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Program Authorized to Offer Degree:

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**Abstract**

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Little is known about contraceptive use among women with bacterial sexually transmitted infections (STIs), despite their high risk for unplanned pregnancy. This analysis describes contraceptive use and interest in long-acting reversible contraception (LARC) among women with bacterial STIs. This cross-sectional study included 1,623 women ages 13 to 45 with bacterial STIs who completed a public health Partner Services interview between January 2017 and December 2019 in King County, WA. For women not using LARC and not planning pregnancy, public health disease intervention specialists (DIS) delivered a brief educational message on LARC and assessed interest in switching to LARC. Contraceptive method type was divided into two groups consisting of highly or moderately effective methods and least effective, other, or no method. We conducted univariate analyses between individual level factors and contraceptive method followed by a multivariate logistic regression analysis adjusting for factors found to be statistically significant in the univariate analyses. Just over half of the women (52.8%) interviewed reported using highly or moderately effective contraception. Black women were less likely to use a highly or moderately effective method compared to White women (aRR 0.58, 95%CI 0.43-0.80) and women with private insurance were more likely to use a highly or moderately effective method

compared to those with public insurance (aRR 1.67, 95% CI 1.28-2.19). After brief counseling, fewer than one in five women were interested in switching to LARC. These data suggest there is an opportunity for public health partner services to fill an unmet need for contraception access and reproductive health programming more intensive than brief educational counseling is likely needed to increase LARC use among women with bacterial STIs.

## INTRODUCTION

In recent years, the number of reported cases of chlamydia, gonorrhea, and syphilis in cisgender women (henceforth referred to as women) has been climbing. Chlamydial infections and gonorrhea were the first and second most commonly reported infections in 2018 in the United States, with an estimated 3.25 million infections among U.S. women, almost all of whom were of reproductive age.(1) The CDC reported a 13.8% increase in reported cases for chlamydia and a 48.3% increase for gonorrhea in 2018 compared to 2014.(2) Additionally since 2014, cases of primary and secondary syphilis in women have increased by a staggering 173% and cases of congenital syphilis by 185%.(2)

Women with sexually transmitted infections (STIs) are at high risk for unplanned pregnancy.(3-5) Despite this risk, few women report using highly effective long acting reversible contraception (LARC), such as the intrauterine device (IUD) and contraceptive implant.(6-8) In addition to high efficacy, LARC users report higher satisfaction rates and higher continuation rates than short-acting contraceptives.(9) Reported rates of both unplanned pregnancies and STIs are also marked by stark racial and ethnic disparities, with Black, Latina, and Indigenous women disproportionately impacted.(10) These disparities reflect deeply-rooted social and economic inequities in American society influenced by structural racism as well as differential access to health care.(2)

Interventions to promote contraception among women with STIs who seek to avoid or delay pregnancy could potentially prevent unplanned pregnancies and address disparities by focusing on this key population of women. However, our current understanding of contraceptive use among this population is limited. The goal of this study was to describe contraceptive use and associated factors among women with bacterial STIs as well as evaluate interest in LARC among women using less effective contraceptive methods.

## METHODS

*Analysis Population*

This cross-sectional study included reproductive-age women, ages 13 to 45, with chlamydia, gonorrhea, or syphilis who completed a public health Partner Services interview between January 2017 and December 2019. In Washington State, minors are able to obtain testing and treatment for STIs if they are 14 years of age or older without parental consent.(11) We limited the analysis population to cisgender women whose sex partners included men with the rationale of focusing on individuals with the potential for pregnancy. The analyses excluded women who were currently pregnant or trying to conceive. Pregnancy intention was determined in response to the multiple-choice question, "Are you planning to get pregnant now, at some other time in the future, or not at all?" Women answering "trying to get pregnant now" were excluded from the analyses. This study was waived by the University of Washington Institutional Review Board as it was not considered human subjects research.

*Partner Services Procedures*

Partner Services is a county-wide program run by Public Health-Seattle King County (PHSKC) for the tracking, evaluation, and prevention of STIs in King County, Washington. Throughout the analysis period of January 2017 and December 2019, disease intervention specialists (DIS) attempted to reach all women with a diagnosis of gonorrhea and syphilis as well as a random sample of approximately 5% of women with chlamydial infection for an interview. Using structured interview forms, DIS asked women about their age, gender, race, ethnicity, sex partner genders, and health insurance status. As part of the routine Partner Services interview between January 2017 and March 2018, the DIS also administered a questionnaire about pregnancy history and, for women not using LARC, their interest in switching contraceptive methods. This occurred during a period of a pilot study to deliver same-day contraceptive services to women with bacterial STIs. If a woman reported a history of sterilization or already had an

IUD or implant, the interview was discontinued at that point. Otherwise, women were then provided standardized counseling regarding IUDs and contraceptive implants, and then queried regarding their interest in initiating or switching methods (yes/no/not sure).

*Measures*

We examined the following predictors of current contraceptive use and interest in changing to a LARC: age, race, ethnicity, current STI type, whether sex partners were men only or both men and women, prior pregnancy, prior abortion, and health insurance status.

The two outcome variables in this study were contraceptive method and interest in switching. We divided the first outcome variable, the type of contraceptive method used, into two groups: (1) highly or moderately effective method and (2) least effective, other, or no method. The effectiveness categories, as defined by the CDC, are based on the number of pregnancies per 100 women in the first year of typical use of each method.(12) The rate of pregnancy while using a highly effective method is fewer than 1 pregnancy per 100 women. These methods included permanent contraception, IUDs, and implants. Moderately effective methods such as injectables, oral contraceptive pills, patches, and vaginal rings, have a rate of 6-12 pregnancies per 100 women per year. For this study, we combined the highly and moderately effective methods into one group. Least effective methods, including condoms, diaphragms, withdrawal method, and rhythm method, have a rate of pregnancy of 18 or more per 100 women per year.(12) In this study, we combined the least effective methods into one group that also included individuals reporting abstinence, infertility, and no method. The second outcome variable was interest in switching methods to an IUD or implant, categorized as yes, no, or not sure.

The outcome variables and all predictor variables except for sex and current STI were self-reported during the DIS interview. Race and ethnicity were asked as separate, mutually exclusive interview questions.

*Statistical Analysis*

We performed a descriptive analysis with summary statistics to illustrate individual demographic and clinical characteristics. Women with missing current contraceptive method data were excluded from the univariate and multivariate analyses. To describe differences in contraceptive method choices, we conducted univariate analyses between each individual level factor and the contraceptive method used. Because the outcome was common, we reported relative risks (RR) rather than odds ratios with 95% confidence intervals (CI).(13) For the multivariate analysis, we prespecified age as a potential confounding factor based on evidence that contraceptive use increases with age.(14) Additionally, in advance of the analysis, we decided to incorporate any factors found to be statistically significant in the univariate analyses into the multivariate model. We conducted a multivariate logistic regression analysis to assess the independent association between patient level factors and contraceptive method, adjusting for age, race, ethnicity, and health insurance status, as the latter three variables were found to be statistically significant in the univariate model.

Due to concerns that important associations within racial and ethnic groups could have been obscured in the aggregate data, we performed a sensitivity analysis stratifying the predictor variables by race and ethnicity. Throughout this study, race and ethnicity are being evaluated not as intrinsic risk factors, but as markers of otherwise unmeasured social and structural factors that may impact a woman's views of pregnancy and contraception, as well as influence her access to and experience of sexual healthcare. All analyses were conducted using STATA IC version 16.0.

**RESULTS**

Between January 2017 and December 2019, 1,623 women with bacterial STIs completed Partner Services interviews. Baseline characteristics are presented in Table 1. The largest group of women were between the ages of 18 and 24 (752, 46.3%). Over a third of women identified as White (590, 36.4%), followed by Black (392, 24.2%), and Hispanic (313, 19.3%) and most had public health insurance (714, 44.0%). Compared to the racial demographics of King County, women included in this analysis were more likely to identify as Black (24.2% vs 7.0%) and Hispanic (19.3% vs 9.9%), and less likely to identify as White (36.4% vs. 66.2%) and Asian (7.1% vs 19.7%).(15)

*Contraceptive Method Use*

Among 1,490 (91.8%) women who were not currently pregnant or trying to conceive, contraceptive methods reported at the time of the interview are shown in Table 2. A total of 786 (52.8%) individuals reported using highly or moderately effective methods while 470 (31.5%) individuals reported using least effective, other, or no method of contraception. The most commonly used methods were IUDs (253, 17.0%), oral contraceptive pills (OCP) (231, 15.5%), no method (209, 14.0%), and condoms/diaphragm (159, 10.7%). Contraceptive method data were missing from 234 (15.7%) individuals and these women were excluded from the subsequent analyses. There were no significant demographic differences between excluded and included individuals.

*Individual Level Factor Associations*

The univariate and multivariate associations between individual level factors and contraceptive methods used are shown in Table 3A. Since White women represented the highest proportion of individuals, we selected this racial category as the referent group. Compared to White women, Black women were significantly less likely to use a contraceptive method categorized as highly or moderately effective as compared to a least effective, other, or no method (RR 0.79, 95%CI 0.65-0.95). After

adjusting for age and insurance status, this association was even stronger (adjusted RR (aRR) 0.58, 95%CI 0.43-0.80). Women identifying as Native American/Pacific Islander, Asian, additional identity/multiracial, or Hispanic were also less likely to report using a highly or moderately effective method compared to White women. Compared to women with public insurance, women with private insurance were more likely to report using a highly or moderately effective method (RR 1.25, 95% CI 10.7-1.47). When adjusting for age, race, and ethnicity, this association was strengthened (aRR 1.67, 95% CI 1.28-2.19). Women with unknown or missing insurance status were also more likely to report using a highly or moderately effective method (RR 1.37, 95% CI 1.09-1.73; aRR 2.25, 95%CI 1.42-3.57). Table 3B shows the univariate and multivariate analyses among the 353 women with a known pregnancy history. There were no statistically significant differences in contraceptive method choice among women with varying pregnancy or abortion history. Additionally, the sensitivity analysis stratifying the predictor variables by race did not reveal any significant differences in trends from the univariate analysis results.

*Interest in Switching Methods*

Individual characteristics and interest in switching can be seen in Table 4. Overall, most women were not interested in switching to a LARC method (215, 67.4%), with 56 women interested (17.6%), and 48 unsure (15.0%) about switching. Women who were interested in switching to a LARC method were more often aged 25-34, of White or Asian race, and had no health insurance.

**DISCUSSION**

This cross-sectional study examined contraceptive method use and interest in switching methods among women with bacterial STIs. Women of color were less likely to report currently using a

highly or moderately effective method compared to non-Hispanic White women, even after adjusting for age and insurance status. Women with private insurance were more likely to use a highly or moderately effective method compared to those with public insurance. Lastly, after a brief public health intervention discussing LARC methods, fewer than one in five women were interested in switching to a LARC method. Although we anticipated that women with a prior history of unplanned pregnancy may be more likely to use LARC methods or be interested in switching to LARC, that was not the case.

Consistent with national data on racial and ethnic demographics of people with STIs, individuals in this study identifying as Black and Hispanic were disproportionately represented. Different than national data, at baseline a much higher portion of individuals in this study reported LARC use (25.5%), compared to 10.4% LARC use nationally.(16) This may be related to the large portion of women reporting a history of prior pregnancy leading to interest, the increasing general awareness and acceptance of LARC, an increase in access to contraceptive services given their urban residence, or increased STI screening in women with LARC.

Our study confirmed results from prior studies examining the relationship between race and contraceptive use which found that Black women were less likely to report current use of highly effective methods compared to White women.(17, 18) Although this analysis was underpowered to detect significance due to the smaller sample sizes, all racial and ethnic groups in our study were less likely to use highly or moderately effective methods compared to White women. These findings may be related to a number of factors including limited access (19) to and the prohibitive cost (10) of contraception, but also other social, cultural, and religious factors (20) that influence pregnancy planning and personal preferences for contraceptive method. Another possible contributor to the racial differences observed is the history of reproductive rights abuses and ongoing social injustices in the U.S. that influence individuals' contraceptive choices.(21) The American College of Obstetrics and Gynecology recommends several policy and programmatic strategies to help address racial disparities

around contraception including removing cost barriers, increasing access via pharmacist training, expanding Medicaid to strengthen health insurance access, and improving patient-centered shared decision making for contraceptive counseling.(22) Many of these barriers may have contributed to this study's main findings of racial differences among contraception methods.

Insurance type influences access to and affordability of some types of contraception, although study results vary by population. Similar to our study, a 2018 retrospective chart review showed that women with public insurance were less likely to receive LARC than those with private insurance.(23) However, in a large survey of post-partum women, LARC use was associated instead with having public insurance as compared to private insurance.(24) The investigators postulated that this reflected Medicaid post-partum timing restrictions as well as differential provider recommendations based on socioeconomic status or race/ethnicity.(24, 25)

Although LARC methods are a key tool for preventing unplanned pregnancies, increasing the use of LARC among women requires access, individual interest, and trust in the methods as important first steps. In this analysis, fewer than one fifth of women with STIs were interested in switching to LARC after a brief discussion with public health DIS. This low level of interest could be explained by a multitude of factors including safety concerns, awareness, convenience, competing priorities, uncertainty, or distrust of the medical system.(17) Additionally, the intervention itself may have been too low intensity. On the other hand, the women might have simply preferred to continue their current method. In the 2015 Contraceptive CHOICE Project, which provided a more in-depth intervention including contraceptive counseling, same-day insertion, as well as removed cost barriers, 75% of study participants chose to initiate a LARC method over non-LARC methods.(26) The CHOICE study participants, however, were recruited via convenience sampling and expressed interest in reversible contraception at baseline, unlike our study in which individuals were receiving public health partner services interviews. In addition to education and cost barriers, social networks may play a role in level of

interest. A 2020 study of contraceptive care programs found that women who were more familiar with LARC methods and knew someone who had one, were more likely to be interested in them themselves.(18) Lastly, provider knowledge and comfort level with LARC can also impact a person's choice. A cluster randomized trial of 40 reproductive health clinics in the US demonstrated that patients receiving care at clinics in the intervention arm, whose providers received dedicated contraceptive counseling and insertion training, were almost twice as likely to choose LARC.(27) Thus, prior conversations with providers or lack thereof may have influenced uptake in our study.

The main strength of this paper is the provision of new data on current contraceptive use, associated factors, and interest in switching methods among women with bacterial STIs, a unique patient population at high risk for pregnancy. Remarkably, over 75% of women queried about their pregnancy history reported having a prior unplanned pregnancy. These data highlight a need for additional reproductive health services for women with bacterial STIs. In a survey of women at an inner-city STI clinic in Baltimore, there was high interest in obtaining contraceptive services within the STI clinic setting.(28) The combination of services was shown to be successful in a 2003 randomized controlled trial that provided enhanced contraceptive counseling and initial provision of contraception at an urban STI clinic which helped women both initiate and continue effective contraception use.(5) Although LARC methods may not be right for everyone, being able to discuss the range of contraceptive options and provide appropriate care if interested is warranted.

This study has two main limitations. Firstly, not all eligible women were able to be reached, thus there may be unknown confounding differences among the interviewed subjects as compared to eligible women who were unable to be reached for an interview. A second limitation is that our survey was limited to King County, WA which has unknown generalizability to women in other geographic areas. Future work could include qualitative research to learn why individuals were not interested in or unsure

about switching to LARC. This knowledge could help inform next steps for how to best provide care for this population.

Sexual health clinics, in addition to screening for and treating bacterial STIs, can be excellent access points to offer and provide reproductive health care. Among women with STIs in this analysis, baseline use of LARC, although higher than national levels, was low and a brief public health intervention discussing LARC methods did not appear to have a notable impact on interest. Important next steps in providing this population with effective contraceptive options include implementing programming to provide affordable, equal access to the broad spectrum of contraceptive method choices as well as training providers at sexual health clinics to offer family planning services.

**TABLES**

**Table 1**. Baseline characteristics of the analysis population (N=1,623).

| | **N, %** |
|---|---|
| ***Demographic and clinical characteristics*** | |
| **Age, years** | |
| 13-17 | 126, 7.8% |
| 18-24 | 752, 46.3% |
| 25-34 | 551, 34.0% |
| 35-45 | 194, 12.0% |
| **Race/Ethnicity** | |
| White | 590, 36.4% |
| Black | 392, 24.2% |
| Native American/Pacific Islander | 73, 4.5% |
| Asian | 115, 7.1% |
| Additional Identity/Multiracial | 140, 8.6% |
| Hispanic | 313, 19.3% |
| **Health Insurance** | |
| Public | 714, 44.0% |
| Private | 549, 33.8% |
| None | 145, 8.9% |
| Unknown/Refused/Missing | 215, 13.3% |
| **Current STI** | |
| CT only | 427, 26.3% |
| GC only | 765, 47.1% |
| CT & GC | 321, 19.8% |
| Syphilis only | 98, 6.0% |
| Syphilis & CT and/or GC | 12, 0.7% |
| **Gender of Sex Partners** | |
| Men | 1457, 89.8% |
| Men and Women | 166, 10.2% |
| **Pregnancy Intention** | |
| Would like to get pregnant now | 89, 5.5% |
| Not wanting to get pregnant now, but planning to get pregnant in the future | 621, 38.3% |
| Not planning future pregnancy | 399, 24.6% |
| Not Sure | 251, 15.5% |
| Missing | 263, 16.2% |
| ***Pregnancy history***[1] | |
| **Prior Pregnancy** (n = 418) | 284, 67.9% |
| **Prior Abortion** (n = 430) | 108, 25.1% |
| **Prior Unplanned pregnancy** (n = 268) | 203, 75.7% |

[1]Only includes participants with completed data to these questions.

**Table 2**. Self-reported current contraceptive method among participants not currently pregnant or trying to conceive. (N = 1,490).

| What are you using to not get pregnant now? | |
|---|---|
| **Highly Effective Methods**[1] | N, % |
| Permanent (tubal ligation, hysterectomy) | 46, 3.1% |
| IUD | 253, 17.0% |
| Implant | 127, 8.5% |
| **Moderately Effective** | |
| Injection (Depo Provera) | 81, 5.4% |
| Oral contraceptive pills | 231, 15.5% |
| Patch/ring | 48, 3.2% |
| **Least Effective** | |
| Condoms/Diaphragm | 159, 10.7% |
| Withdrawal/Rhythm | 11, 0.7% |
| **Other** | |
| Abstinence | 74, 5.0% |
| Infertile | 17, 1.1% |
| **No method** | 209, 14.0% |
| **Missing** | 234, 15.7% |

[1]Categorization based on: https://www.cdc.gov/mmwr/volumes/65/rr/rr6504a1.htm#F-1-1_down

**Table 3A.** Univariate and multivariate[1] analyses of associations between participant level factors and chosen contraceptive method[2] (N = 1,256).

| Characteristic | Highly or Moderately Effective Method | Least Effective, Other, or No Method | | |
|---|---|---|---|---|
| | *N, Column %* | *N, Column %* | *Univariate RR, 95% CI* | *Multivariate RR, 95% CI* |
| **Age, years** | | | | |
| 13-17 | 74, 9.4% | 30, 6.4% | 1.09 (0.85, 1.40) | 1.25 (0.78, 2.01) |
| 18-24 | 389, 49.5% | 208, 44.3% | Ref | Ref |
| 25-34 | 237, 30.2% | 163, 34.7% | 0.91 (0.77, 1.07) | 0.81 (0.62, 1.06) |
| 35-45 | 86, 10.9% | 69, 14.7% | 0.85 (0.67, 1.08) | 0.67 (0.46, 0.97) |
| **Race/Ethnicity** | | | | |
| White | 321, 40.8% | 141, 30.0% | Ref | Ref |
| Black | 167, 21.2% | 138, 29.4% | 0.79 (0.65, 0.95) | 0.58 (0.43, 0.80) |
| Native American/Pacific Islander | 27, 3.4% | 21, 4.5% | 0.81 (0.55, 1.20) | 0.64 (0.35, 1.19) |
| Asian | 57, 7.3% | 37, 7.9% | 0.87 (0.66, 1.16) | 0.68 (0.42, 1.08) |
| Additional Identity/Multiracial | 61, 7.8% | 43, 9.1% | 0.84 (0.64, 1.11) | 0.61 (0.39, 0.95) |
| Hispanic | 153, 19.5% | 90, 19.1% | 0.91 (0.74, 1.10) | 0.80 (0.57, 1.12) |
| **Current STI** | | | | |
| CT only | 225, 28.6% | 99, 21.1% | Ref | |
| GC only | 366, 46.6% | 240, 51.1% | 0.87 (0.74, 1.03) | |
| CT & GC | 157, 20.0% | 100, 21.3% | 0.88 (0.72, 1.08) | |
| Syphilis only | 33, 4.2% | 28, 6.0% | 0.78 (0.54, 1.12) | |
| Syphilis & CT and/or GC | 5, 0.6% | 3, 0.6% | 0.90 (.037, 2.18) | |
| **Gender of Sex Partners** | | | | |
| Men | 697, 88.7% | 419, 89.1% | Ref | |
| Men and Women | 89, 11.3% | 51, 10.9% | 1.02 (0.82, 1.27) | |
| **Health Insurance** | | | | |
| Public | 303, 38.5% | 242, 51.5% | Ref | Ref |
| Private | 324, 41.2% | 141, 30.0% | 1.25 (1.07, 1.47) | 1.67 (1.28, 2.19) |
| None | 65, 8.3% | 58, 12.3% | 0.95 (0.73, 1.24) | 0.89 (0.60, 1.33) |
| Unknown/ Refused/Missing | 94, 12.0% | 29, 6.2% | 1.37 (1.09, 1.73) | 2.25 (1.42, 3.57) |

[1]The multivariate model adjusted for age, race, and insurance status.
[2]Outcome reference category: Least effective, other, or no method.

**Table 3B.** Univariate analysis of associations between participant level factors and chosen contraceptive method in participants with known pregnancy history (N = 353).

| Characteristic | Highly or Moderately Effective Method | Least Effective, Other, or No Method | |
|---|---|---|---|
| | *N, Column %* | *N, Column %* | *Univariate RR, 95% CI* |
| **Age, years** | | | |
| 13-17 | 12, 5.6% | 3, 2.2% | 1.24 (0.68, 2.25) |
| 18-24 | 109, 50.1% | 60, 43.8% | Ref |
| 25-34 | 69, 31.9% | 53, 38.7% | 0.88 (0.65, 1.19) |
| 35-45 | 26, 12.0% | 21, 15.3% | 0.86 (0.56, 1.32) |
| **Race/Ethnicity** | | | |
| White | 92, 42.6% | 47, 34.3% | Ref |
| Black | 43, 19.9% | 29, 21.2% | 0.90 (0.63, 1.30) |
| Native American/Pacific Islander | 11, 5.1% | 6, 4.4% | 0.98 (0.52, 1.83) |
| Asian | 10, 4.6% | 10, 7.3% | 0.76 (0.39, 1.45) |
| Additional Identity/Multiracial | 18, 8.3% | 16, 11.7% | 0.80 (0.48, 1.33) |
| Hispanic | 42, 19.4% | 29, 21.2% | 0.89 (0.62, 1.29) |
| **Current STI** | | | |
| CT only | 54, 25.0% | 28, 20.4% | Ref |
| GC only | 107, 49.5% | 76, 55.5% | 0.89 (0.64, 1.23) |
| CT & GC | 48, 22.2% | 30, 21.9% | 0.93 (0.63, 1.38) |
| Syphilis only | 5, 2.3% | 3, 2.2% | 0.95 (0.38, 2.37) |
| Syphilis & CT and/or GC | 2, 0.9% | 0, 0.0% | 1.52 (0.37, 6.23) |
| **Gender of Sex Partners** | | | |
| Men | 194, 89.8% | 125, 91.2% | Ref |
| Men and Women | 22, 10.2% | 12, 8.8% | 1.06 (0.68, 1.65) |
| **Prior Pregnancy** | | | |
| No | 82, 38.0% | 47, 34.3% | Ref |
| Yes | 134, 62.0% | 90, 65.7% | 0.94 (0.72, 1.24) |
| **Prior Abortion** | | | |
| No | 74, 34.3% | 48, 35.0% | Ref |
| Yes | 60, 27.8% | 38, 27.7% | 1.01 (0.72, 1.42) |
| Missing | 82, 38.0% | 51, 37.2% | 1.02 (0.74, 1.39) |
| **Health Insurance** | | | |
| Public | 91, 42.1% | 77, 56.2% | Ref |
| Private | 88, 40.7% | 35, 25.5% | 1.32 (0.99, 1.77) |
| None | 26, 12.0% | 19, 13.9% | 1.07 (0.69, 1.65) |
| Unknown/ Refused/Missing | 11, 5.1% | 6, 4.4% | 1.19 (0.64, 2.23) |

**Table 4**. Characteristics of participants and interest in switching to HERC (N=319).

| Characteristic | Interest in Switching Methods | | |
|---|---|---|---|
| | **No** | **Yes** | **Not Sure** |
| | *N, Row %* | *N, Row %* | *N, Row %* |
| **Age, years** | | | |
| 13-17 | 18, 66.7% | 3, 11.1% | 6, 22.2% |
| 18-24 | 106, 63.9% | 30, 18.1% | 30, 18.1% |
| 25-34 | 65, 68.4% | 19, 20.0% | 11, 11.6% |
| 35-45 | 26, 83.9% | 4, 12.9% | 1, 3.2% |
| **Race/Ethnicity** | | | |
| White | 77, 67.5% | 23, 20.2% | 14, 12.3% |
| Black | 47, 66.2% | 11, 15.5% | 13, 18.3% |
| Native American/Pacific Islander | 12, 66.7% | 1, 5.6% | 5, 27.8% |
| Asian | 20, 76.9% | 6, 23.1% | 0, 0.0% |
| Additional Identity/Multiracial | 20, 60.6% | 5, 15.2% | 8, 24.2% |
| Hispanic | 39, 68.4% | 10, 17.5% | 8, 14.0% |
| **Current STI** | | | |
| CT only | 45, 56.3% | 19, 23.8% | 16, 20.0% |
| GC only | 112, 69.1% | 27, 16.7% | 23, 14.2% |
| CT & GC | 51, 75.0% | 9, 13.2% | 8, 11.8% |
| Syphilis only | 7, 100.0% | 0, 0.0% | 0, 0.0% |
| Syphilis & CT and/or GC | 0, 0.0% | 1, 50.0% | 1, 50.0% |
| **Gender of Sex Partners** | | | |
| Men | 198, 67.6% | 51, 17.4% | 44, 15.0% |
| Men and Women | 17, 65.4% | 5, 19.2% | 4, 15.4% |
| **Prior Pregnancy** | | | |
| None | 62, 71.3% | 18, 20.7% | 7, 8.0% |
| 1 or more | 89, 66.9% | 24, 18.0% | 20, 15.0% |
| Missing | 64, 64.6% | 14, 14.1% | 21, 21.2% |
| **Prior Abortion** | | | |
| No | 106, 66.7% | 25, 15.7% | 28, 17.6% |
| Yes | 41, 67.2% | 11, 18.0% | 9, 14.8% |
| Missing | 68, 68.7% | 20, 20.2% | 11, 11.1% |
| **Prior Unplanned pregnancy** | | | |
| No | 20, 74.1% | 3, 11.1% | 4, 14.8% |
| Yes | 62, 64.6% | 19, 19.8% | 15, 15.6% |
| Missing | 133, 67.9% | 34, 17.3% | 29, 14.8% |
| **Health Insurance** | | | |
| None | 18, 51.4% | 14, 40.0% | 3, 8.6% |
| Public | 105, 72.4% | 21, 14.5% | 19, 13.1% |
| Private | 74, 68.5% | 17, 15.7% | 17, 15.7% |
| Unknown/Refused/Missing | 18, 58.0% | 4, 12.9% | 9, 29.0% |
| **Total** | 215, 67.4% | 56, 17.6% | 48, 15.0% |

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