Discussion

Women and men who are sexually active and fecund but who do not want to have a child soon have a variety of contraceptive options, ranging from nonprescription methods for use at coitus to nonpermanent medical methods of varying duration and to permanent methods. Among the many factors that enter into people’s decisions about what method to use at any particular time in their lives are such issues as how a method is used, its potential negative and positive health effects, and the method’s costs and ease of accessibility, as well as personal preferences and relationship characteristics.

A method’s effectiveness is also a factor in contraceptive choice. However, method effectiveness is neither particularly simple to measure nor easy to convey. Contraceptive failure due to the method alone (often called method failure or perfect-use failure) cannot be observed directly, since there is always some error in people’s typical use of contraceptives.

Estimates of contraceptive failure during typical use that are presented here for U.S. women relying on nonpermanent contraceptives indicate that method choice makes a large difference in users’ success at avoiding unintended pregnancy. The range of expected contraceptive failure is wide, from 2–4 accidental pregnancies in a year among 100 women using the long-acting hormonal methods to more than 20 per 100 women who begin a year using spermicides, withdrawal or periodic abstinence.

Most pregnancies during contraceptive use result from incorrect or inconsistent use. Exactly how a woman and her partner use a contraceptive method is likely to be related to a number of issues, including (but not limited to) the degree of communication and cooperation between the woman and her partner; the predictability and frequency of intercourse; the attitudes of the woman and her partner about sexuality, the method itself and having an unintended pregnancy; the amount of experience or practice each has had using a particular method; and how easy it is to obtain and to afford contraceptive medical care and supplies. While we have not been able to investigate the impact of such factors directly, social and demographic variables available in the NSFG reflect some of these differences.

The strong influence of income on contraceptive failure rates suggests that access barriers and the general disadvantage and disruption of poverty continue to interfere with effective contraceptive use. However, while the total 12-month failure rate for women at and above 200% of poverty remained essentially stable between 1988 (10%) and 1995 (10%), the failure rate among lower income women fell slightly, from 21% to 18%. It is unclear whether this decline is attributable to improved access—for example, through such developments as expanded eligibility for family planning services under Medicaid and the efforts of the national Title X family planning program. Other factors in poor women’s lives may also play a role. For example, lower income women are more likely than others to rely on long-acting reversible methods, primarily injectables and implants: In 1995, 12% of women with an income less than 200% of poverty who were using reversible methods of contraception were relying on long-acting methods, compared with only 5% of higher income women.

The higher failure rates among younger women are consistent with special concerns about adolescents’ ability to avoid unplanned pregnancies when they are sexually active. Yet these data make clear that age itself is not the sole determinant of method effectiveness. Among unmarried women who are not living with a man (the overwhelming majority of sexually active adolescents), adolescents’ failure rates are similar to those of women in their early and late 20s. Moreover, there is only a small difference between the failure rates of married adolescents and married women in their early 20s. The only group in which adolescents have markedly different failure rates is unmarried cohabiting women, among whom failure rates are highest for teenagers.

These findings suggest that union status is more important than age in predicting contraceptive failure. The highest failure rates at almost every age are among unmarried women, especially among those who are cohabiting. Indeed, among all women, cohabiting women (especially teenagers) are most likely to experience a contraceptive failure during the first year of use. The lowest rates are for married women, especially for higher income married women aged 30 and older.

The value of race and ethnicity in predicting contraceptive failure depends on income. The racial and ethnic differences in failure rates were in fact much smaller among lower income women than among higher income women. Lower income Hispanic and white women are more likely to have difficulties using methods successfully than are higher income women, while income makes little difference among noncohabiting women who are no more than four percentage points higher than for married women in comparable age-groups.

• Failure rates by poverty status and race and ethnicity. In Table 4, we present estimates of overall failure rates by race or ethnicity and by poverty status. Both race or ethnicity and poverty status are significantly associated with the likelihood of contraceptive failure. Black women are more likely to experience contraceptive failure than Hispanic women, who in turn experience higher failure rates than white women. Differences in failure rates by poverty status are notable—18% among women with an income below 200% of poverty, compared with 10% among those with an income at or above the poverty threshold.

However, these differences are not consistent across racial and ethnic subgroups: The 12-month failure rates for poor white and Hispanic women are substantially higher than those of their more affluent counterparts, while black women experience similar rates of contraceptive failure, regardless of poverty status. More affluent Hispanic women are slightly more likely to experience contraceptive failure than their white counterparts, while poorer Hispanic women share the same level of contraceptive failure as black women. This suggests that relative access to resources (poverty status) is an important factor mediating the effect of race for white and Hispanic women, but not for black women.*

\*In an analysis of 1988 NSFG data, poor black women were found to experience higher rates of failure than were more affluent black women (Source: Jones EF and Forrest JD, 1992, reference 2). However, in that analysis, the group “black” also included nonwhite, non-Hispanic women; in contrast, in this article, we assumed that the characteristics and behavior of such women would more closely resemble that of white women. Thus, we grouped nonwhite, non-Hispanic women who were not black into the category “white.” This may explain the difference between our findings and those from the analysis of 1988 data.