refused to use condoms) and social norms (particularly if the woman’s partner disapproved or her family was not supportive of birth control use).

### Insurance Status

When we compared the nine groupings of Likert-scaled items by insurance status (private vs. Medicaid vs. none), the multivariate analyses of variance revealed statistically significant differences in four (Table 4): access, embarrassment, side effects and forced sex.

Using univariate analysis to determine which scores for individual statements in these groups differed significantly by insurance status pointed to only one statement in each. The mean scores for each statement (Table 4) indicate that women with no insurance were more likely to cite transportation difficulties than were the other women. In contrast, privately insured women were more likely than either of the other subgroups to agree that it is embarrassing to buy condoms. Women covered by Medicaid were significantly less likely than the others to cite concern over menstrual irregularities associated with use of injectables, while they were more likely than the privately insured and the uninsured to report having been pressured or forced to have sex.

We also compared two levels of insurance coverage: some insurance (private and Medicaid combined) vs. no insurance (not shown). In this comparison, women with no insurance reported more agreement with the fatalism item (“It doesn’t matter whether I use birth control, when it is my time to get pregnant it will happen”) than did women with some insurance.

### Education

In the multivariate analysis of variance, the only group that differed significantly by educational level was the side effects group (Table 5). Mean values for two individual side effects statements (both related to the injectable) indicate that worries about the injectable’s side effects and dislike for irregular periods were perceived as greater barriers to use by the more highly educated than by less-educated women.

### Race

Because previous studies have shown that black women have higher rates of unintended pregnancy than white women, we examined potential barriers to contraceptive use by race. In the multivariate analysis of variance, six groups of variables were statistically significant by race (Table 6, page 130): access, norms, denial, embarrassment, forced sex and other.

In three of these groups (denial, embarrassment and forced sex), only one item each was statistically significant by race: Black women reported higher agreement than white women with the ideas that they did not think they could get pregnant and that they had been pressured or forced to have sex, but reported lower agreement that it is embarrassing to buy condoms. Four access factors exhibited significant differences by race; in each instance, black women were more in agreement that an access barrier affected their contraceptive use than were white women. Black women were also more likely than white women to agree that normative factors (parental opposition to contraception and lack of family support for pill use) constituted barriers to use. For the “other” factors, black women were more likely than white women to agree that two (infrequent sex and lack of a nearby clinic) represented barriers, while white women were more likely than black women to say that partners’ opposition to injectable use and the condom’s negative impact on sexual pleasure served as barriers to use.

### Discussion

The variety of access issues differentiating frequent contraceptive users from infrequent users in this analysis highlights the need for continued efforts to improve access to care. As with other studies, we found that black women identified more problems with clinic services than did white women. Transportation problems...