were of greater concern to black women than to white women, and to women with no health insurance than to women insured through work. Transportation has been noted as a barrier to other health services, such as prenatal care, for low-income women. But transportation alone cannot account for lack of contraceptive acquisition and use, since some contraceptives are available over the counter at many locations, including supermarkets, pharmacies and retail stores such as Wal-Mart.

Institutional barriers to care, such as waiting time at the clinic and delays in obtaining an appointment, also differentiated frequent from infrequent contraceptive users. This is consistent with previous research in which women’s satisfaction with care affected their contraceptive use. Previous research has shown that the primary barrier to clinic use is women’s belief that clinics offer less personalized and lower quality care than private physicians, while the primary barrier to women’s use of private physicians for family planning services is cost and lack of reimbursement from Medicaid. Nevertheless, regardless of provider type, women are satisfied with their care if they perceive that the clinic staff is courteous, respectful and helpful.

Expanding clinic hours and making services more user-friendly could improve patient satisfaction and increase contraceptive utilization.

Sociocultural barriers identified here include general attitudes towards birth control. Women who think that “planning ahead for sex spoils the fun” have been found to be no less likely than others to use contraceptives, although they are less likely to be satisfied with their method.

In our study, women who were infrequent contraceptive users had higher agreement scores that “planning ahead spoils the fun” than women who always or quite often practiced contraception, although the mean scores for both groups reflected general disagreement with that statement.

Negative attitudes towards contraception have been found to influence contraceptive use; we found that infrequent contraceptive users are more likely to have negative attitudes toward contraception, to worry about side effects and to note that condom use may be problematic because of the need for cooperation from the male partner. Given persistent fear of side effects from the pill and other hormonal contraceptives, providers need to ensure that women are educated about the benefits and effectiveness of these methods, while addressing their concerns or misperceptions about potential side effects.

Partners, peers and family strongly influence contraceptive use. We found that infrequent contraceptive users are more likely to perceive these influences as barriers. There may also be a relationship between partners’ influence and race in the case of condom use: White women in our study perceived more barriers to condom use than did black women, corroborating the research finding that black women are more accepting of condom use than are white women. This may reflect the fact that black men are more likely than white men to report condom use and the influence of perceived partner attitudes. It is possible that social marketing of condoms in the black community for AIDS and STD prevention has resulted in greater acceptance of condoms by black women and men.

Among the disadvantages noted about condoms was the necessity for partner cooperation and the ability to trust the man to use them. These present potential difficulties in partner negotiation due to economic dependence, social norms and fear of physical violence. Although we could not measure such difficulties in our study, they represent potential barriers to successful condom use. Directing condom promotion toward couples rather than at women alone would not place the burden of negotiation solely on the woman and might lend support to her efforts to obtain male cooperation.

Although one-third of women in our study perceived themselves as being at low risk of pregnancy, they nonetheless were seeking a pregnancy test, perhaps due to unexpected or infrequent sex. Although we did not specifically ask about rape, it is also possible that some who reported unexpected sex were actually victims of nonconsensual sex. Nevertheless, only 2% agreed that they were pressured or forced into having sex.) Access to emergency contraception is essential for women who have experienced coercive sex or unprotected sex.

Embarassment about acquiring and using condoms is a barrier to their use. We identified embarrassment as a factor in three of the four comparison groups based on frequency of contraceptive use.