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Factors Influencing Emergency Contraception Use in Indigent Populations

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Factors Influencing Emergency Contraception Use in Indigent Populations

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Abstract

Introduction: Indigent women are disproportionately affected by unwanted, unplanned pregnancies. Studies previously identified lack of knowledge about emergency contraception (EC) as a major deterrent from use. This study was performed to address three potential barriers to the use of EC in indigent populations: culture and religion, patient education, and cost. For the entirety of this study, EC refers to levonorgestrel (LNG).

Objectives: To determine the impact of culture and religion, patient education, and cost on EC use in the indigent population.

Methods: This study was a cross-sectional observational study to explore and investigate relationships between indigent populations and the use of EC. To be included in the study, participants had to be: at least 14 years old, female, and have an annual household income below the federal poverty line (FPL). Those excluded were less than 14 years old, male, and reported an annual household income above the FPL. A questionnaire consisting of 31 survey questions were utilized to assess the endpoints of the study. The study utilized both paper and electronic forms of the survey. Participants signed informed consent to enable them participate in the study. Out of 319 participants, 59 met all inclusion criteria and were used in statistical analyses.

Results: Based on Kruskal-Wallis results, religious groups' acceptance of EC influenced indigent women's decision to use it ($p=0.016$). Level of education also influenced women's understanding of EC as an abortifacient and knowledge of when LNG is effective. Spearman rho revealed correlations between participants' willingness to pay for EC or routine birth control and knowing that EC was an option (coefficient 0.391; p -value 0.005). There was also a correlation between the cost of EC and ultimate use (coefficient -0.603; p -value

Conclusion: Our research found that religious groups' acceptance of EC use and knowledge about how LNG works does affect the decision to use EC. Neither cultural identification nor cost of EC appears to have a significant impact on the final decision to use.

Keywords

Emergency contraceptives, indigent populations

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Factors Influencing Emergency Contraception Use in Indigent Populations

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Abstract

Introduction: Indigent women are disproportionately affected by unwanted, unplanned pregnancies. Studies previously identified lack of knowledge about emergency contraception (EC) as a major deterrent from use. This study was performed to address three potential barriers to the use of EC in indigent populations: culture and religion, patient education, and cost.

Objectives: To determine the impact of culture and religion, patient education, and cost on EC use in the indigent population.

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Results: Based on Kruskal-Wallis results, religious groups' acceptance of EC influenced indigent women's decision to use it ($p=0.016$). Level of education also influenced a woman's understanding of EC as an abortifacient and knowledge of when levonorgestrel (LNG) is effective. The Spearman's rank correlation coefficient revealed correlations between participants' willingness to pay for EC or routine birth control and knowing that EC was an option (coefficient 0.391; p -value 0.005). There was also a correlation between the cost of EC and ultimate use (coefficient -0.603; p -value <0.01). There were several associations between religion and the final decision to use EC, but there were none with self-identified cultural groups. There was a correlation between agreeing that LNG causes abortions and unwillingness to use EC (coefficient 0.464; p -value 0.001).

Conclusion: Our research found that religious groups' acceptance of EC use and knowledge about how LNG works does affect the decision to use EC. Neither cultural identification nor cost of EC appears to have a significant impact on the final decision to use the product.

Introduction:

The indigent population in America is defined as persons who do not have the financial means to support themselves and are below the federal/state poverty line.¹ According to the 2010 United States Census, 13.8% of Americans live below the poverty line.¹ Indigent populations often rely on aid from others, either family, friends, or the government, to meet basic needs. Indigent women are disproportionately affected by unwanted, unplanned pregnancies. It is a continuous cycle that plagues families, often causing poverty and increased dependence on the welfare system.² In Medicaid-eligible populations, many women have reported taking their routine birth control inconsistently after having their first child.³ Inconsistent use of birth control may result in future unplanned and/or unwanted pregnancies. This has led to a push for contraceptive education, about both routine and emergency options, to be integrated in numerous settings, including schools, physicians' offices, women's clinics, and pharmacies.³ In indigent populations there are three potential barriers to using emergency contraceptives (EC): culture and religion, patient education, and cost. This study seeks to address those barriers.

Through EC use, modern medicine provides a method for patients to decrease their risk of pregnancy after unprotected sexual intercourse. There are two commonly used forms of EC: ulipristal (Ella[®]) and levonorgestrel (i.e. Plan B One-Step[®] and Next Choice One Dose[®]). Levonorgestrel (LNG) works to prevent pregnancy through multiple mechanisms.⁴ The first mechanism works by thickening the cervical mucus, which slows or inhibits sperm passage through the uterus so that it does not reach the oocyte. LNG also prevents ovulation via a negative feedback mechanism on the hypothalamus, which decreases the secretion of both follicle stimulating hormone (FSH) and luteinizing hormone (LH).⁴ The final proposed mechanism is alteration of the endometrium which may affect implantation of a fertilized egg.⁴ While LNG may prevent pregnancy after unprotected sexual intercourse, it has a short duration of action and is ineffective once implantation of the egg occurs.⁴

Abbot et al. conducted a prospective study over 8 weeks among 232 women ages 18 to 45 at an inner-city emergency department.⁵ Their objective was to measure women's knowledge, attitudes, practices, and perceived needs regarding EC. When the participants were asked about their current sexual and contraceptive

practices in a survey, 52% of the participants reported having one or more unintended pregnancies, and 28% had at least one abortion.⁵ This study illustrates that a barrier to EC use is the overwhelming lack of patient knowledge.

Lack of education is even greater in indigent populations, with published reports claiming that only 1 in 5 indigent women are aware that EC is an option. This lack of education is especially prevalent in populations with a high number of immigrants and migrant workers.⁶ In an exploratory study involving low-income Hispanic immigrant women, many had limited knowledge about reproduction and normal contraceptive methods. On the questionnaire, 56% of the participants said a woman could not become pregnant if it was her first time having sex, and 56% also believed that a woman could not become pregnant if there was no penetration or if their partners withdrew before ejaculation. Additionally, 33% of the women believed that taking an oral contraceptive only on the day of intercourse would prevent them from becoming pregnant.⁷ With this lack of knowledge and education about routine birth control, it is likely that this population also has a deficit in knowledge about EC. Indigent women who have never talked to their healthcare provider about emergency options may not know LNG can be taken within the first 72 hours, (and up to 120 hours in some cases), after unprotected sexual intercourse and still effectively prevent pregnancy.⁶

Limited financial resources also create a barrier to the use of EC. Many indigent women with limited financial resources do not have access to proper healthcare, prohibiting them from accessing EC such as LNG. Though EC can be expensive, assistance through government programs such as Medicaid and various State programs are available.⁸

Some women refuse to use EC because of the moral implications or personal religious beliefs. Although research has shown that LNG's mechanism of action is the same as the mechanism of routine birth control and not as an abortifacient, some do not trust the science, or have not seen the evidence.⁶ Population-based studies reveal that fewer women hold to their religious objections against EC after they are educated about the mechanism of action.⁹

Previous studies have identified knowledge barriers to the use of routine contraceptives in various ages and diverse populations. This study will address additional factors that may influence the low rate of EC usage in indigent women. EC can be costly, which may

deter women with limited finances from using it. Culture and religion lay the foundation for how women view conception and contraception; therefore, culture and religion likely play a large role in a woman's decision to use EC. It is also unknown how patient education affects the use of LNG specifically. This study will explore potential relationships between these three factors and LNG use.

Methods:

This study was a cross-sectional observational study designed to explore and investigate the relationship between indigent women and their use of EC. Cross-sectional designs reduce threats to validity, such as testing and history effects, because subjects are only tested once. Original Cedarville IRB approval was granted in the Spring of 2013, but LNG became available over the counter in April of 2013. An amendment was made to reduce the age of inclusion from 18 years of age to 14 years of age and was approved in the Fall of 2013.

Participants included in the study were at least 14 years old, female, and their annual household income fell below the FPL as described in Table 1.¹ Patients were excluded if their annual household income exceeded the FPL, if they were male, or were less than fourteen years old. Inclusion and exclusion criteria were based upon the psychometric testing of the instruments utilized in this study.

Table 1: 2015 Federal Poverty Guidelines

Persons in Household	Poverty Guideline	Persons in Household	Poverty Guideline
1	\$11,770	5	\$28,410
2	\$15,930	6	\$32,570
3	\$20,090	7	\$36,730
4	\$24,250	8	\$40,890

The study utilized both paper and electronic format surveys. A questionnaire consisting of 31 survey questions was utilized to assess the objectives and endpoints of the study. The paper surveys were distributed and collected at Walgreens Pharmacy in Springfield, Ohio. The responses were then entered into Qualtrics and combined with the data gathered electronically. Electronic survey distribution occurred in a closed Facebook group where the Qualtrics survey link was shared. Facebook group participants were invited to

take the survey via invitation from the research team. Anyone initially invited to the closed group was able to invite others to participate by sharing the link or sending additional invitations to the closed group. All participants provided informed consent when initiating the survey. Participants were able to discontinue the survey at any point. No patient identifiers were reported; therefore confidentiality was maintained throughout the study. The survey included fifteen close-ended demographic questions and twenty-three mixed positive and negative Likert-scale questions to evaluate the influence that the participant's culture and religious beliefs, education about LNG, and cost of the medication had on their decision to use EC.

This survey collected nominal data. The only quantitative values were related to demographic information and used to determine inclusion in the study. With the Likert-scale questions, no person could fall into more than one category for each question. Frequencies of demographic characteristics were reported for all participants in Appendix A.

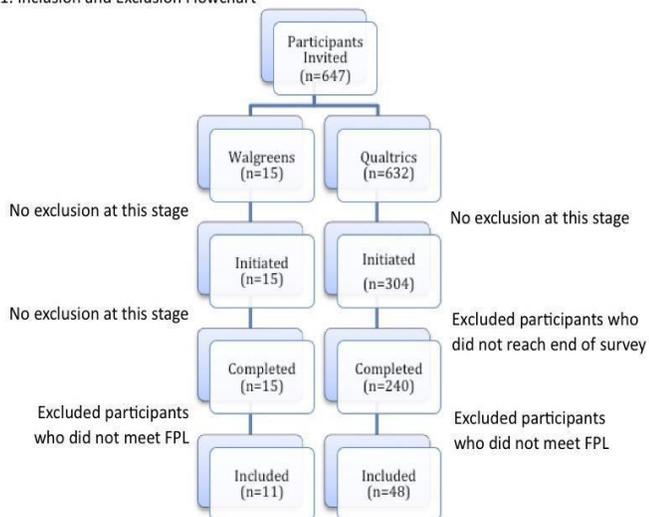
All responses were recorded through Qualtrics and exported into Microsoft Excel to determine inclusion. Surveys were excluded if any of the following conditions were met: the participant was male, age indicated but less than 14 years old, or participant-indicated income and household size did not meet the criteria to fall below the FPL. Surveys were included if all of the following conditions were met: the participant was female, age was 14 or older, and participant-indicated income and household size fell below the FPL. All analyses were completed with SPSS version 22 by IBM.

The sample size was calculated with a G*Power 3.1 calculator. The study used a power of 0.8 and an alpha of 0.05 to determine the necessary sample size. The *a-priori* sample size calculated was 35 participants.

A total of 647 individuals were invited to participate in the survey through personal interaction at a Springfield, OH Walgreens Pharmacy or through an online Qualtrics survey distributed via an invitation-only Facebook group. Of the 647 people who received access to the survey, 319 individuals initiated it (n=15 through Walgreens and n=304 through Qualtrics, response rate 49%), but only 255 completed it (n=15 through Walgreens and n=240 through Qualtrics). After evaluating the data for completeness and inclusion, 59 surveys were included and used for statistical analysis.

Figure 1 is a visual representation of the inclusion and exclusion method.

Figure 1: Inclusion and Exclusion Flowchart



Due to the observatory nature of the study and the cross-sectional design, the data gathered was categorical. Descriptive statistics were used to represent the collected demographic information and were reported as mean, mode, median, or percent frequencies with standard deviation. A Kruskal-Wallis test was performed to compare nominal variables to ranked variables to determine if the mean ranks were the same across all groups. This test was appropriate for analyzing data from the Likert-scale questions in relation to participant demographics. A Spearman rho rank correlation was also utilized to further describe correlations between ranked categories.

Results:

The primary objectives of this study was to determine if indigent women were influenced by cultural and religious beliefs, education, or cost when deciding to use EC.

The Kruskal-Wallis analysis showed a significant difference in responses to question 22 (“Use of ‘the morning after pill’ is accepted by my religious group;” $H = 17.223$; $df = 7$; p -value 0.016) compared to question 5, which had subjects identify their religious group, with mean ranks reported in Table 2. However, there was no significant difference between the number of religious events per week or the amount of time in religious activities per day and the willingness to use EC.

There were two statistically significant findings comparing participants’ level of education in

demographic question 14 and their understanding of how long after unprotected sexual intercourse EC is effective in questions 31 and 32. Question 31 had patients indicate level of agreement with the statement “The ‘morning after pill’ is effective when taken within 12 hours of unprotected sex” ($H = 12.523$; $df = 4$; p -value = 0.014), mean ranks reported in Table 3. Question 32 had patients indicate level of agreement with the statement “The ‘morning after pill’ is effective when taken within 24 hours of unprotected sex” ($H = 10.115$; $df = 4$; p -value = 0.039), mean ranks reported in Table 4.

Table 2: Mean Ranks Question 22 vs 5

Catholic	19.25	Presbyterian	40.83
Baptist	23.43	Jewish	41.50
Lutheran	41.50	No Religion	46.00
Methodist	31.33	Other	26.97

Table 3: Mean Ranks Question 31 vs 14

Associate’s Degree	33.00
High School/GED	11.42
Bachelor’s Degree	31.66
Some College	26.64
Doctorate or Ph.D	14.88

Table 4: Mean Ranks Question 32 vs 14

Associate’s Degree	24.50
High School/GED	25.58
Bachelor’s Degree	34.63
Some College	21.88
Doctorate or Ph.D	15.25

There were no significant differences between groups according to participants’ cultural identification in the Kruskal-Wallis analysis. Questions 23, 25, and 27 investigated the relationships between participants’ ethnic cultures as set in the demographics. The respective p -values were 0.587, 0.565, and 0.388.

Analysis with Kruskal-Wallis was also unable to find a significant link between the costs of EC compared to participants’ cultural identification. Questions 16-21 assessed responses to different statements about cost, and the p -values were 0.113, 0.578, 0.574, 0.377, and 0.218, respectively.

After utilizing Spearman rho rank analysis, many correlations were evident relating to participant religious groups and the decision to use EC. A negative correlation was found between questions 22 (“Use of ‘the morning after pill’ is accepted by my religious

group”) and 24 (“I would not use ‘the morning after pill’ because my religious group does not approve of it”) with a correlation coefficient -0.316 and a p-value of 0.017 . This was a weak but significant correlation. Between questions 24 and 26 (“I would use ‘the morning after pill’ even if my religious group did not approve of it”), there was a moderate negative correlation (correlation coefficient -0.565 and p-value <0.001).

There were also correlations evident between responses to question 26 and responses to questions 37 and 38. Question 26 asked participants to indicate their level of agreement with the statement “I would use ‘the morning after pill’ even if my religious group did not approve of it.” This question with question 37 (“I would be willing to use ‘the morning after pill’”) had a strong positive correlation (correlation coefficient 0.722 and p-value <0.001). Questions 26 and 38 (“I would not be willing to use ‘the morning after pill’”) had a strong negative correlation (correlation coefficient -0.653 and p-value <0.001).

The questions evaluating participants’ cultures did not have any significant correlations with their ultimate decision to use or not use EC.

In questions 30, 37, and 38 there were two moderate strength correlations related to patient education about LNG. Participants who indicated agreement with the statement that EC causes abortions were likely to indicate agreement with the statement that they would not use EC (correlation coefficient 0.464 and p-value 0.001). There was a related negative correlation in participants who responded that they disagree with the statement that EC causes abortions being more likely to indicate that they would use EC (correlation coefficient -0.563 and p-value <0.001).

Exploring cost, there was a weak positive correlation between questions 16, where patients identified agreement with the statement “I would not pay for any kind of birth control,” and 35 where they chose agreement with the statement “I have not used ‘the morning after pill’ because I did not know it was an option for me” (correlation coefficient of 0.391 and p-value = 0.005).

There was also a weak positive correlation between questions 17 (“I would rather pay for ‘the morning after pill’ than for regular birth control”) and 35 (correlation coefficient 0.337 and p-value = 0.016). There was a strong negative correlation between question 21, where participants selected their level of agreement with the statement “If I needed it, I would buy ‘the morning after

pill’ no matter how much it cost” and question 38 where they selected their level of agreement with the statement “I would not be willing to use ‘the morning after pill’” (correlation coefficient -0.603 and p-value <0.001).

Women who responded with agreement that they would use EC if it were affordable in question 20 (“If I needed it, I would buy ‘the morning after pill’ if the cost were affordable to me”) were more likely to indicate agreement with the statement that they would use EC in question 37 (“I would be willing to use the ‘morning after pill’”) with a correlation coefficient of 0.789 and a p-value <0.001 . This demonstrates a strong positive correlation between these statements.

In the final four summary questions, there was a weak positive correlation between the statements “I have never been in a situation where I have needed ‘the morning after pill’” and “I would not be willing to use ‘the morning after pill’” (correlation coefficient 0.283 and p-value 0.044). There was also a weak negative correlation between “I have never been in a situation where I have needed ‘the morning after pill’” and “I would be willing to use ‘the morning after pill’” (correlation coefficient -0.341 and p-value 0.014).

Discussion:

This observational study used paper and electronic surveys to evaluate the relationships between indigent women and their use of EC. There were a total of 255 participants who completed the survey; 196 reported an annual household income that fell above the FPL and were excluded, leaving only 59 whose annual income fell below the FPL to be included in the statistical analyses. The Kruskal-Wallis test revealed significant differences between groups in the responses to questions regarding participants’ religious affiliation. The Spearman rho correlations revealed that study subjects within the same religious category were more likely to indicate the same level of agreement or disagreement about using EC. No significant differences were found between the number of religious events per week or the amount of time in religious activities per day and the decision to use EC.

Another statistically significant finding was between the participants’ level of education and their understanding of how long EC is effective after unprotected sexual intercourse. Participants with a higher level of education had a better understanding of how EC works. There were no significant differences between cultural identification and cost of EC.

The study had several areas of strength. It was able to identify a valuable need in the area of education. It is clear that many women are not educated on the way EC works or how to use it properly. The survey also had a 49% response rate, although only 23% of completed surveys met all inclusion criteria. However, there were enough participants that met the inclusion criteria to meet the sample size of the study.

After study initiation, a state legislative change allowed for LNG to be sold over the counter without any age restriction. This change removed pharmacist control over LNG dispensing and increased the population that had access to the medication. As a result of the law change, the study was updated to include participants aged 14 or greater. Another limitation was the challenge of site recruitment for survey distribution. Many sites, especially federally qualified health centers, had a religious affiliation and did not want to be associated with EC research. Lastly, the study required multiple IRB submissions and approvals due to several changes in the study design and survey improvements.

Conclusion:

Previous studies have shown that a lack of knowledge about EC is a major deterrent from using EC. This study was designed to investigate the relationships between religion and culture, cost, and education with EC use. One significant finding of this study was a correlation between education level and EC use. Women who believed that EC causes an abortion were less likely to be willing to use it. Therefore, this study showed that there is a need to educate patients about EC.

It is also important to ensure pharmacists are educated so they can effectively counsel their patients on the proper use of EC. Study results showed that culture had no significant impact on EC use among the population, while religion did influence the decision to use EC. However, it cannot be determined which religious groups have the greatest impact. Cost was determined to have a limited impact on a woman's decision to use EC. The study found that women were willing to pay if they thought EC was necessary to prevent pregnancy.

In the future, it would be beneficial to conduct a similar study with a more diverse population to increase the generalizability of the results. Educational materials should also be produced to increase education about EC among the indigent population.

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Appendix A: Complete Demographic Information

Demographic	Response (Frequency)	Percent of Total Responses (%)
Age (years)	18 (2)	3.4
	20 (3)	5.1
	21 (8)	13.6
	22 (11)	18.6
	23 (20)	33.9
	24 (6)	10.2
	25 (3)	5.1
	26 (1)	1.7
	27 (2)	3.4
	29 (1)	1.7
	31 (1)	1.7
	40 (1)	1.7
	Ethnicity	Asian (2)
Latino/Hispanic (5)		8.5
American Indian (1)		1.7
Other (3)		5.1
Black/White (2)		3.4
White/American Indian (1)		1.7
White/Caucasian (44)	81.4	
Relationship Status	Single (49)	83.1
	Married (6)	10.2
	Separated (1)	1.7
	Other (3)	5.1
	Engaged (2)	3.4
	In relationship (1)	1.7
Insurance Status	Medicare (1)	1.7
	Medicaid (7)	11.9
	None (5)	8.5
	Tricare (1)	1.7
	Private (45)	76.3
Religious Group	Catholic (10)	16.9
	I do not have a Religion (6)	10.2
	Baptist (14)	23.7
	Lutheran (2)	3.4
	Hindu (1)	1.7
	Methodist (3)	5.1
	Presbyterian (3)	5.1
	Jewish (1)	1.7
	Other (19)	32.2
	Nondenominational (11)	18.6
	Evangelical (3)	5.1
	Anabaptist (1)	1.7
	Sikh (1)	1.7
Not sure (1)	1.7	
Time spent in Religious Events (events/week)	None (21)	35.6
	1 (16)	27.1
	2-3 (14)	23.7
	4-5 (5)	8.5
	6 or more (3)	5.1

Time Spent in Religious Activities (min/day)	<10 (16)	27.1
	10-30 (20)	33.9
	30-60 (12)	20.3
	>120 (1)	1.7
	I do not participate (10)	16.9
Members in Household	1 (14)	23.7
	2 (8)	13.6
	3 (13)	22.0
	4 (10)	16.9
	5 (7)	11.9
	6 (4)	6.8
	7 (3)	5.1
Number of Pregnancies	None (53)	89.8
	1 (1)	1.7
	2 (2)	3.4
	4 (2)	3.4
	5 or More (1)	1.7
Number of Children	None (54)	91.5
	1 (2)	3.4
	2 (2)	3.4
	5 or More (1)	1.7
Currently Pregnant	Yes (1)	1.7
	No (57)	96.6
	No Response (1)	1.7
Current Contraceptive Method	Oral Birth Control Pill (20)	33.9
	IUD (4)	6.8
	Natural Family Planning (2)	3.4
	Other (2)	3.4
	COC with Condoms (1)	1.7
	No Response (1)	1.7
	NuvaRing (3)	5.4
	Abstinence (14)	23.7
	Condoms (3)	5.1
	Withdrawal (2)	3.4
None (9)	15.3	
Previous Use of EC	Yes (14)	23.7
	No (45)	76.3
Highest Level of Education Completed	High School/GED (7)	11.9
	Associate's Degree (5)	8.5
	Some College (25)	42.4
	Bachelor's Degree (16)	27.1
	Doctorate/PhD (6)	10.2
Annual Household Income	<\$12,000 (46)	78.0
	\$12,000 - \$15,999 (6)	10.2
	\$16,000 - \$19,999 (3)	5.1
	\$20,000 - \$23,999 (2)	3.4
	\$32,000 - \$35,999 (2)	3.4