Religious Affiliation, Religiosity, Family-related Attitudes, and Contraceptive Use in the United States, 2002

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INTRODUCTION

Demographic research since the Baby Boom has often examined the correlates of contraceptive choice and its effects on fertility because of its clear implications for intended and unintended pregnancy and family size. Factors such as education, race, marital status, and parity have been shown to affect contraceptive choice (Westoff and Ryder, 1977; Mosher and Westoff, 1982; Mosher, 1990; Mosher and Bachrach, 1996; Piccinino and Mosher, 1998). But studies since World War II have consistently shown that religious affiliation and religiosity have also been associated with contraceptive choice from the 1950's through the end of the 1980's (Westoff and Ryder, 1977; Westoff, 1975; Mosher and Goldscheider, 1984; Goldscheider and Mosher, 1988 and 1991; Mosher and McNally, 1991, e.g.).

In the last decade, as part of the interest in reducing rates of teenage pregnancy and Sexually Transmitted Diseases (STDs), there has been both scholarly and practical interest in the effects of religious variables on the sexual and contraceptive behavior of teenagers (Whitehead, Wilcox, and Rostosky, 2001; Smith, 2003; Regnerus, 2003; Regnerus and Elder, 2003; Regnerus et al, 2003; Rostosky, Regnerus, and Wright, 2003; Jones et al, 2005), and in teenagers' patterns of religious participation (Smith et al, 2002; Regnerus and Burdette, 2006). These recent studies have used the National Longitudinal Study of Adolescent Health (Add Health) and other data sets to investigate these relationships.

During the same period, however, less attention has been paid to the associations of religious variables with contraceptive use, method choice and consistency of use among teens and adults. This paper uses recent national data from the NSFG to address these questions in more satisfactory ways than in past research. These data include religious affiliation, religiosity, and measures of family and gender role attitudes. The relationships of these measures with contraceptive use can be examined among white, Black, and Hispanic women separately in a recent national sample.

The preliminary analyses presented here show that religiosity is strongly related to family and gender role attitudes, and that religiosity and religious affiliation are associated with contraceptive choice in the contemporary United States. The presented version of the paper will use multivariate analyses to sort out the determinants of these patterns and test alternative hypotheses that may explain the differences.

DATA AND METHODS

This paper uses data from a national sample of 7,643 women 15-44 years of age in the United States in 2002 (Groves et al, 2005). These women were asked extensive questions about their past and current use of contraceptive methods (Mosher et al, 2004), a series of questions on religious affiliation and religiosity, and a series of questions on their attitudes towards sexual activity, gender roles, and marriage. We use data from the 4,619 women who reported that they were using a contraceptive method (including male methods, vasectomy, condom and withdrawal) at the date of interview, to examine whether family and gender role attitudes, religion, and religiosity are associated with contraceptive choice.

The questions on religious affiliation were:

"In what religion were you raised?"

and,

"What religion are you now, if any?"

Answers were coded into 29 categories. Given the sample sizes available in the data set, these were condensed to 7 categories for this analysis:

No religion;
Baptist (including Southern Baptist);
Fundamentalist Protestant;
Latter Day Saints (Mormon);
Other Protestant;
Catholic; and
Other Religions.

These were followed by a question on the importance of religion:

"Currently, how important is religion in your daily life?
Would you say very important, somewhat important, or not important?"

The question on importance of religion is closely correlated with many outcomes in the 2002 NSFG (Martinez et al, 2006; Chandra et al, 2006).

Finally, respondents were asked:

"About how often do you attend religious services?"

They were shown a card listing the following categories:

More than once a week,
once a week,
1-3 times per month,
less than once a month,
never.

In this paper, we will also examine whether the results change if the religion in which the respondent was raised is used rather than her current religion (we do not expect the results to change significantly). We will also consider whether we can shed light on the results presented here by examining data on:

(a) non-use of a method at the date of interview (i.e, contraceptive risk-taking),

(b) use at first intercourse,
(c) ever-use of methods,
(d) reasons given for stopping use of contraceptive methods, and
(e) reasons for non-use among women who have recently had an unplanned pregnancy.

Each allows a more complete understanding of the influence of social factors on the contraceptive choices women and their partners make.

BACKGROUND

In recent decades, demographers have often followed Goldscheider's conceptualization of the relationship between religious affiliation and demographic variables (Goldscheider, 1971; Goldscheider and Mosher, 1988 and 1991). Goldscheider's work suggested that three kinds of hypotheses were often used to explain religious differentials in fertility, contraceptive use, and marriage:

(1) The characteristics hypothesis suggested that religious differentials, if any, were simply the result of differences in socio-economic characteristics such as education and rural/urban residence, and that, after controls for these socio-economic characteristics, religious differentials would disappear. Thus, this paper will include controls for important socio-economic characteristics such as age, education, and marital status (to test the characteristics hypothesis).

(2) The minority group status hypothesis, which suggested that demographic differences were related to the efforts of minority groups toward socio-economic achievement. While this hypothesis (Goldscheider 1971) generated a great deal of research over the years, it was difficult for researchers to reach consensus on how the variables should be measured and when the theory was applicable. The results were complex and difficult to summarize.

(3) The norms hypothesis posited that the norms of groups concerning the intermediate variables (or proximate determinants) of fertility, such as contraceptive use, marriage, premarital sexual activity, family size ideals, and so on, affect fertility and contraceptive use. At first, demographic researchers tended to view this hypothesis narrowly, to mean that researchers should look at official statements of particular norms or tenets related to contraception, marriage, etc.

Goldscheider and others, however, urged attention to a broader set of issues, including "values about the importance of children and the priority of family, and …family and gender roles." (Goldscheider and Mosher, 1991: 102). We will expand on this point below, because this set of ideas appears to be more consistent with our own findings. Goldscheider also hypothesized that "those who are more committed to religious values, who have been socialized in religious institutions, and who are more involved in religious communities are more likely to emphasize family-oriented values and behavior

and greater sex-role segregation" (Goldscheider and Mosher, 1991: 102). Such ideas imply greater preference for certain methods of contraception over others (Mosher and Goldscheider 1984: 56).

Sociologists of religion have advanced parallel ideas, which suggest that the effects of religious affiliation and participation may bring people together to share common values and perspectives, reinforce those perspectives, and influence each other's beliefs and behaviors over time. In the course of this interaction, ideas and norms about many aspects of behavior may be shared, as they are in any other group. For example, McQuillan (2004) suggested that the effects of religious affiliation and participation on fertility depended on certain other conditions being in place, as in Quebec, Ireland, Poland, and other places.

Finally, McCullough and Smith (2003) suggest that religions in contemporary society provide social support and material support for their members' everyday problems: McCullough and Smith suggest that religious participation provides "meaningful and tangible connections to other people," "a sense of belonging" and a place to get social support and material help for those who need it. Religious groups also create institutions, such as schools, hospitals, and clinics, which may pass on norms on a number of life issues (including sex roles and family size norms, and shape health care and other behaviors relevant to health and family. This further extends Goldscheider's suggestion that religions should be viewed by researchers as communities, which may share both interaction and broad normative orientations.

The oral contraceptive pill and female sterilization are, and have been, the two most-used methods of birth control in the United States for the past 2 decades. Both of these methods, as well as most other effective methods of contraception, can only be obtained from a doctor or clinic. Researchers exploring differential contraceptive use should, therefore, take into account whether respondents have access to health care—including health insurance, and the type of insurance they have.

There are two strains to this issue of access to health care. First, some have suggested that access to certain types of reproductive health care, such as sterilization, emergency contraception, and others, may be limited or not offered by certain types of health care organizations (Catholics for a Free Choice, 2000, 2002). Such factors may affect the contraceptive choices available to women. This hypothesis is difficult to quantify, measure and test with the data available for this paper.

Easier to measure, however, may be the absence or presence and type of health insurance coverage women have. For example, Mosher and Bachrach (1996: 6) have suggested a number of extant hypotheses that may explain differences between groups (by race, education, religion, etc) in the use of male and female sterilization. Resistance to the use of male methods among some subgroups has been used to explain these differences, but we urge researchers to consider "…lack of access to health care and health insurance" as another possible reason. Besides the gender-role attitudinal data already mentioned, the NSFG also has data on health insurance coverage, marital

histories, and other variables that can be helpful in analyzing such differences in contraceptive choice.

Here are some examples of the questions that can be addressed with NSFG data:

- Do religious variables continue to have independent effects on contraceptive choice? If so, what do these differences tell us about the factors that affect contraceptive choice more generally?
- If not, what variables explain the large religious differences shown here?
- Do religious variables affect use wholly or partly through norms measured by the attitudinal variables shown here?
- What additional variance, if any, do the new measures of attitudes and religious involvement explain?

FINDINGS: The old approach

Table 1 shows trends in contraceptive use among 3 traditionally-used categories of Non-Hispanic White women 15-44 years of age between 1982 and 2002, and also illustrates the limitations of the old approach, and the relative strengths of the approach taken in the rest of the paper. During these two decades, HIV/AIDS was identified and concern about it increased, affecting contraceptive use in the United States (Mosher, 1990; Piccinino and Mosher, 1998). In addition, the IUD was withdrawn from the market in the 1980s, prompting users to switch to other methods. And new cohorts of women aged into the reproductive ages, bringing new patterns of religious participation.

Several patterns are apparent in table 1. First, use of the diaphragm and IUD decreased to near zero in all groups. Protestant women were more likely—in 1982, 1988, and 2002—to use female sterilization as a method of birth control: 27 percent of Protestant compared with 21 percent of Catholic women and those with no religious affiliation[1]. Second, the proportion using the pill increased most (8 percentage points, from 28 to 36 percent) among Catholics. Third, use of periodic abstinence methods (calendar rhythm, natural family planning, etc) was low in all groups. Finally, increasing proportions were using other methods (including the new hormonal methods[2], which will be shown separately in the paper).

But this approach has limitations that can be addressed with the new data in Cycle 6 of the NSFG, conducted in 2002. Three of these will be highlighted here.

First, Cycle 6 contained a series of questions on attitudes related to the family, marriage, sexual activity, and gender roles. These questions can be used to profile different views (norms) in each group.

Second, the large and diverse Protestant category can be sub-divided into several groups (as sample sizes allow) to show variable patterns.

Third, a new measure of religiosity, the importance of religion, can be used to test ideas related to Goldscheider's hypothesis quoted above.

[1] Significance testing on differences discussed in this paper has yet to be completed. We believe, however, that differences discussed here will be statistically significant.

[2] Hormonal methods include Norplant, Lunelle, Depo-Provera, and the contraceptive patch.

Table 2 shows data on the percentage of women who agreed or strongly agreed with 8 selected statements designed to measure attitudes toward families, children, sexual activity, and marriage. The report from which these numbers were taken (Martinez et al, 2006) also showed fairly modest differences in these proportions by other demographic characteristics such as age, race, education, and income, but large differences by importance of religion, for both men and women.

For example, in the first line of table 2, we see that among those who report that religion is "very important" in their daily lives, 35 percent agree (or strongly agree) that "it is all right for unmarried 18 year olds to have sexual relations with each other if they have strong affection for each other." In contrast, among those who said that religion is "not important" in their daily lives, 76 percent—more than double—agree with the statement. On the fourth line of table 2, 51 percent of those for whom religion is very important agree that "A young couple should not live together unless they are married," compared with just 14 percent of those for whom religion is not important. Clearly, these data need to be looked at in a multivariate context, but these differences are striking across all eight measures—and they show that those for whom religion is "very important" have strikingly different attitudes about families, sexual activity, and gender roles than those for whom religion is "not important." Following Goldscheider's hypothesis, we would expect such differences to result in differences in contraceptive choices by importance of religion.

(Note: We will show these attitudinal data by the religious affiliation categories shown in these tables, as well as by the importance of religion variable.)

FINDINGS: A new approach

Table 3 shows the percent distribution of contraceptive methods used by religious affiliation and importance of religion in 2002. The table is based on 4619 women in the NSFG sample who were using contraception at the date of interview. First, the proportion using female sterilization varies strikingly by religious affiliation, but these variations do not strictly follow the Protestant-Catholic-None division shown in table 1, and in much of the previous work on this topic. For example, the highest proportions of contraceptors using female sterilization are among Fundamentalist Protestants (41 percent) and Baptists (37 percent). The lowest proportions are among Mormons (27 percent), Other Protestants (25 percent), Catholics (24 percent), and other religions (12 percent). Variations in the leading method, the pill, tend to be the reverse of those for sterilization: the lowest are among Fundamentalist Protestants (20 percent), Mormons (25 percent), and Baptists (25 percent), while the highest were among those of other Protestants and other religions (35 percent each). Use of periodic abstinence (temperature and calendar rhythm) methods was rare in all groups.

Table 3 also shows variations by importance of religion. Among all Protestants and other Protestants, use of sterilization varied sharply by importance of religion. Among "other Protestants (not Baptist, Fundamentalist, or Mormon) for whom religion was very important,

27 percent chose female sterilization, compared with 14 percent of other Protestants for whom religion was not important.

The same was true for male sterilization (vasectomy) in table 3: among other Protestants, 13 percent of those for whom religion was very important were using male sterilization, compared with 1 percent of those for whom religion was "not important." Pill use was the mirror image of these findings: 30 percent of other Protestants for whom religion was very important were using the pill, compared with 50 percent of other Protestants for whom religion was not important.

Among Catholics, a similar pattern holds. Catholics for whom religion was very important were the least likely to use the pill and the most likely to use sterilization, and the differences were not small. For example, among Catholics for whom religion was "very important," 27 percent were using the pill, compared with 40 percent of Catholics for whom religion was "not important." (table 3).

Tables 4 and 5 break down the sample into contraceptors who are trying to delay a birth that they want eventually ("Intend to have more children," table 4) and those who do not want or intend to have any more children ("Intend no more", table 5). These tables exclude a small number of women who were not sure about their intent to have more children. (A few women who reported using male sterilization are included here; they are likely unmarried women who currently have a male partner who has had a vasectomy).

As shown in **table 4**, among those who intend to have another child eventually and are postponing a birth, 51 percent were using the pill, 10 percent another hormonal method, and 27 percent were using the male condom. The proportion using the pill varied by 20 percentage points among these groups: Among fundamentalist Protestants, 39 percent were using the pill to delay their next baby, compared with 58 percent of other Protestants, 49 percent of those with no religion, and 45 percent of other religions. The highest proportion using other hormonal methods was 20 percent among Fundamentalist Protestants, compared with 7 percent of other Protestants and 9 percent of Catholics. Importance of religion has an affect on the use of condoms for Baptists, but not the other religious groups.

Table 5 shows women who do not intend to have any more children—they have already had all the children they want. The leading method among these women (or couples) is female sterilization, used by 44 percent of contraceptors. But this proportion varies from 24 percent of those with "other religions" to about 41 percent of those with no religion and 42 percent of Catholics, to 57 percent of Latter Day Saints (Mormons) and 63 percent of Fundamentalist Protestants. In contrast, the proportions using the pill and the condom are lowest among Fundamentalist Protestants and Mormons. Among those who have had all the children they want (table 5), there is little variation by importance of religion.

Tables 6, 7, and 8 show the percentages using each method separately for non-Hispanic whites (table 6), non-Hispanic Blacks (table 7) and Hispanics (table 8). Summarizing

across tables, we find that the well-known differences among white, black and Hispanic populations in the use of female sterilization evident (Mosher, 1990; Mosher et al, 2004; Mosher and Westoff, 1982, e.g.).

	Female Sterilization	Male Sterilization	Pill
No religion-White (t 6)	21%	10	36
No religion-Black (t 7)	35	0	19
No religion-Hispanic (t 8)	31	2	16
Protestant-White (t 6)	27%	12	33
Protestant-Black (t 7)	51	3	23
Protestant-Hispanic (t8)	44	16	16
Catholic-White (t 6)	21%	12	18
Catholic-Black (t 7)	27	2	34
Catholic-Hispanic (t 8)	31	4	24

Additionally, these tables show that the proportion of women using female sterilization varies sharply by religious affiliation within racial and ethnic groups. For example:

- 35 percent of blacks with no religious affiliation were using female sterilization, compared with 51 percent of black Protestants and 27 percent of black Catholics.
- Among Hispanics, 44 percent of Hispanic Protestants were using female sterilization, compared with 31 percent of Hispanic Catholics and 31 percent of Hispanics with no religious affiliation.

DISCUSSION: Summary of findings, next steps, and implications

The tables shown here demonstrate that, overall and for each subgroup examined, religious groups differ—often sharply—in their contraceptive method choice and use patterns. These differences are particularly noteworthy for the 2 leading contraceptive methods used in the United States in 2002, the pill and female sterilization, and are evident for blacks and Hispanics as well as whites. Among non-Hispanic whites, Baptists and Fundamentalist Protestants show the highest proportions using female sterilization (35 percent) and the lowest proportions using the pill. Mormons and Fundamentalist Protestants have the highest (10 and 8.percent), and Catholics the lowest, proportion (3 percent) using hormonal methods.

In addition, it appears that, even within the Protestant and Catholic categories, those for whom religion is important make different contraceptive choices than those for whom religion is not important. Very small proportions of most groups were using periodic abstinence methods. Current use of the condom does not appear to vary systematically by religious variables, at least as measured here. (Study of dual use of the condom with other methods, or condom use at first intercourse, may yield different results, but those are beyond the scope of this paper at this time.)

This paper and the data on which it is based do have limitations. The first is that we have used the current religion in this analysis, and a small proportion of respondents do change religions during this period of their lives. The presented version of this paper will examine whether our results change at all when we look at categories that are limited to those who were raised in and still are the same religion, versus the much smaller number who have changed religions. In previous research, this did not affect the findings at all, except in the very small group that was raised in a religion and had no religious affiliation at the date of interview (Mosher and Johnson, 1999).

The second limitation of the current analysis is sample size. While the NSFG's sample size of 7,643 women in 2002 is more than adequate for the larger groups, it is too small to produce reliable statistics for women affiliated with religions with fewer national members. This is an unfortunate limitation. For instance, previous research has shown that Jewish women had lower fertility and sharply different contraceptive method use patterns compared with women with other religious affiliations from the 1950s through the 1980s, and that Jewish couples used those methods very effectively during this time period (Goldscheider and Mosher, 1984; Mosher and Goldscheider, 1988, 1991). In 2002, the number of Jewish women in the NSFG sample is insufficient to be able to continue this trend analysis.

Similarly, the sample sizes of Mormons, black Catholics, and Hispanic Protestants are too small to produce reliable estimates. To address these size limitations, consideration will be given to combining the NSFG samples in 1995 and 2002. Before doing so, trends between the two surveys will have to be assessed to see if there were strong trends in contraceptive use within religious groups between 1995 and 2002. If so, such a combination may not be justifiable--but having adequate samples of these 4 groups and others would be a good reason to combine the samples. Mosher and Goldscheider (1984) combined NSFG Cycles 1 and 2, and Mosher, Williams and Johnson (1992) combined NSFG Cycles 3 and 4, with good results.

The "other religions" group is very diverse, including Jews, Muslims, Hindus, Buddhists, Eastern Orthodox, Unitarian/Universalist, and other groups. Both sample size and coding procedures unfortunately prevent further breakdowns of these groups.

The final limitation is that we have not done multivariate analyses yet. In previous analyses of religious differences in fertility and contraceptive use (Mosher and Hendershot, 1984; Mosher and Goldscheider, 1984; Goldscheider and Mosher, 1991, e.g.), multivariate adjustments for such variables as age, education, and marital status did not reduce the differences in contraceptive use by religious categories, so we expect that our results will persist after controls.

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Table 1. Percent distribution of contraceptive methods use for Non-Hispanic white women 15-44 years of age, by religious affiliation: U.S., 1982, 1988, 2002

Characteristic	Total	Female Sterilization	Male Sterilization	Pill	IUD	Dia-phragm	Condom	Periodic Abstinence	Other methods
Protestant									
1982	100	26	16	26	6	6	11	3	7
1988	100	30	15	28	2	5	13	2	5
2002	100	27	12	33	-	-	15	1	14
Catholic									
1982	100	17	10	28	4	19	18	6	7
1988	100	18	14	34	1	7	18	3	6
2002	100	21	12	36	-	-	18	4	10
No religion									
1982	100	14	10	33	7	22	11	2	3
1988	100	20	14	32	2	12	17	1	3
2002	100	21	10	36	-	-	20	1	14

NOTE: Percentages may not add to 100 due to rounding.
Jewish women and those of other religions not shown separately due to sample size limitations.
Source of data for 1982 and 1988: Goldscheider and Mosher, 1991, table 2.

Table 2. Percentage of women 15-44 years of age who agree or strongly agree with selected attitude statements, by importance of religion in their daily lives: U.S., 2002

Characteristic	Very important	Somewhat important	Not important
	Percent who agree or strongly agree		
"It is all right for unmarried 18 year olds to have sexual relations with each other if they have strong affection for each other."	35	60	76
"It is all right for unmarried 16 year olds to have sexual relations with each other if they have strong affection for each other."	7	16	25
"It is better to get married than to go through life being single."	57	48	39
"A young couple should not live together unless they are married."	51	22	14
"Divorce is usually the best solution when a couple can't seem to work out their marriage problems."	40	52	56
"Gay and Lesbian Adults should have the right to adopt."	40	66	78
"It is much better for everyone if the man earns the main living and the woman takes care of the home and family."	42	27	24
"It is okay for an unmarried female to have a child."	57	79	86

Source: Martinez et al., 2006.

Table 3. Percent distribution of contraceptive method for women using contraception, by religion and importance of religion: US, 2002

Characteristic	Sample number	Weighted number (in thousands)	Female sterilization	Male sterilization	Pill	Condom	Periodic abstinence 1/	Other hormonal 2/	Other methods 3/
All women	4619	38,109	27.0	9.2	30.6	18.0	1.5	6.5	7.2
No religion	703	5,566	22.9	7.1	31.2	21.9	0.9	9.1	6.9
Protestant 4/	2335	20,067	30.9	9.9	29.4	15.8	1.1	6.2	6.8
Very important	1500	12,396	33.2	11.0	26.2	16.1	1.2	5.6	6.7
Somewhat important	730	6,757	28.7	9.0	33.2	15.1	0.8	6.6	6.7
Not important	100	850	17.9	1.8	42.3	15.7	2.0	9.6	10.8
Baptist/Southern Baptist 4/	877	6,734	37.2	8.9	25.2	14.7	0.6	8.2	5.3
Very important	610	4,558	37.8	9.4	25.8	12.9	0.6	8.2	5.2
Somewhat important	248	2,009	36.4	8.1	23.3	18.1	0.5	7.9	5.9
Not important	*								
Fundamentalist Protestant	284	2,178	41.4	6.4	19.7	15.8	1.0	8.0	7.7
Latter Day Saints/Mormon	117	1,182	27.3	7.7	24.9	20.1	0.6	8.9	10.7
Other Protestant 4/	1057	9,973	24.9	11.6	34.9	15.9	1.5	4.1	7.2
Very important	588	5,315	27.4	13.4	29.8	17.7	1.6	2.9	7.0
Somewhat important	392	3,992	23.3	10.9	39.4	13.6	1.1	5.4	6.4
Not important	75	642	14.3	1.1	50.0	14.6	2.6	3.1	14.3
Catholic 4/	1344	10,637	24.4	8.8	31.6	18.1	2.5	6.3	8.3
Very important	684	5,199	28.5	10.8	26.5	16.7	3.0	6.6	7.9
Somewhat important	563	4,552	21.0	7.1	36.0	20.3	0.7	6.4	8.6
Not important	94	861	17.7	6.3	39.8	15.8	9.4	2.1	9.0
Other religion	237	1,840	10.9	10.8	36.5	29.1	2.9	4.4	5.4

1/ Natural family planning, cervical mucus test, temperature rhythm, and calendar rhythm

2/ Norplant, Depo-Provera, Lunelle and the contraceptive patch

3/ Morning-after pill, IUD, diaphragm, female condom/vaginal pouch, foam, cervical cap, Today sponge, suppository or insert, jelly or cream alone, withdrawal, and other method.

4/ Includes women with missing information on importance of religion, not shown separately.

* Figure does not meet standard of reliability or precision.

NOTE: Percentages may not add to 100 due to rounding.

Table 4. Percent distribution of contraceptive method for women using contraception who intend to have children in the future, by religion and importance of religion: US, 2002

Characteristic	Sample number	Weighted number (in thousands)	Female sterilization	Male sterilization	Pill	Condom	Periodic abstinence 1/	Other hormonal 2/	Other methods 3/
All women 4	1846	14,213	0.0	0.2	51.4	26.8	1.5	10.4	9.6
No religion	306	2,320	0.0	1.0	48.6	27.9	1.3	11.8	9.5
Protestant 4/	842	6,814	0.0	0.1	53.1	24.8	1.4	11.3	9.4
Very important	496	3,735	0.0	0.1	52.0	25.1	1.4	11.0	10.5
Somewhat important	294	2,628	0.0	0.0	55.0	25.3	1.3	11.1	7.3
Not important	*								
Baptist/Southern Baptist 4/	273	1,948	0.0	0.2	53.0	23.8	0.0	15.2	7.8
Very important	174	1,223	0.0	0.3	58.2	17.9	0.0	16.0	7.6
Somewhat important	92	666	0.0	0.0	44.4	33.3	0.0	13.4	8.9
Not important	*								
Fundamentalist Protestant	103	701	0.0	0.0	38.8	28.3	1.8	20.0	11.1
Latter Day Saints/Mormon	64	612	0.0	0.0	38.6	33.3	1.1	13.4	13.6
Other Protestant 4/	402	3,553	0.0	0.0	58.4	23.2	2.2	7.0	9.2
Very important	204	1,596	0.0	0.0	56.7	23.3	2.1	5.2	12.8
Somewhat important	159	1,621	0.0	0.0	61.2	23.9	2.1	8.7	4.1
Not important	*								
Catholic 4/	591	4,268	0.1	0.1	50.9	27.1	1.7	9.3	10.9
Very important	258	1,791	0.2	0.2	47.6	27.7	2.7	10.5	11.1
Somewhat important	286	2,095	0.0	0.0	52.4	27.9	0.5	9.9	9.3
Not important	*								
Other religion	107	810	–	0.5	48.2	38.5	2.6	5.6	4.6

1/ Natural family planning, cervical mucus test, temperature rhythm, and calendar rhythm

2/ Norplant, Depo-Provera, Lunelle and the contraceptive patch

3/ Morning-after pill, IUD, diaphragm, female condom/vaginal pouch, foam, cervical cap, Today sponge, suppository or insert, jelly or cream alone, withdrawal, and other method.

4/ Includes women with missing information on importance of religion, not shown separately.

* Figure does not meet standard of reliability or precision.

– Quantity zero.

NOTE: Percentages may not add to 100 due to rounding.

Table 5. Percent distribution of contraceptive method for women using contraception who do not intend to have children in the future, by religion and importance of religion: US, 2002

Characteristic	Sample number	Weighted number (in thousands)	Female sterilization	Male sterilization	Pill	Condom	Periodic abstinence 1/	Other hormonal 2/	Other methods 3/
All women	2,713	23,361	44.0	14.9	17.7	12.3	1.5	4.1	5.6
No religion	380	3,148	40.5	11.9	18.4	16.6	0.6	6.8	5.2
Protestant 4/	1,470	13,034	47.6	15.1	16.5	10.9	0.8	3.5	5.6
Very important	990	8,522	48.3	15.9	14.5	11.9	1.0	3.3	5.1
Somewhat important	430	4,077	47.5	14.9	18.7	8.4	0.4	3.8	6.3
Not important	*								
Baptist/Southern Baptist 4/	596	4,698	53.3	12.7	12.7	10.7	0.8	5.4	4.4
Very important	430	3,262	52.9	13.0	12.7	10.5	0.9	5.5	4.5
Somewhat important	154	1,327	55.1	12.2	11.8	10.7	0.7	5.1	4.4
Not important	*								
Fundamentalist Protestant	177	1,444	62.5	9.6	10.9	9.1	0.0	2.3	5.7
Latter Day Saints/Mormon	53	571	56.5	15.9	10.2	5.9	0.0	4.1	7.5
Other Protestant 4/	644	6,322	39.2	18.2	21.1	11.9	1.1	2.4	6.2
Very important	380	3,684	38.6	19.4	17.7	15.4	1.5	1.8	4.6
Somewhat important	229	2,334	39.8	18.6	23.8	6.1	0.4	3.2	8.1
Not important	*								
Catholic 4/	741	6,231	41.7	14.9	18.5	12.2	3.0	3.9	5.9
Very important	422	3,342	44.3	16.6	15.8	11.1	2.9	4.7	4.7
Somewhat important	270	2,395	39.9	13.4	21.4	13.9	0.9	2.3	8.2
Not important	*								
Other religion	122	949	21.1	20.5	27.1	18.9	3.4	3.8	5.2

1/ Natural family planning, cervical mucus test, temperature rhythm, and calendar rhythm

2/ Norplant, Depo-Provera, Lunelle and the contraceptive patch

3/ Morning-after pill, IUD, diaphragm, female condom/vaginal pouch, foam, cervical cap, Today sponge, suppository or insert, jelly or cream alone, withdrawal, and other method.

4/ Includes women with missing information on importance of religion, not shown separately.

* Figure does not meet standard of reliability or precision.

NOTE: Percentages may not add to 100 due to rounding.

Table 6. Percent distribution of contraceptive method for non-Hispanic white women using contraception, by religion and importance of religion: US, 2002

Characteristic	Sample number	Weighted number (in thousands)	Female sterilization	Male sterilization	Pill	Condom	Periodic abstinence 1/	Other hormonal 2/	Other methods 3/
All women	2,546	25,513	23.9	11.7	34.4	16.6	1.7	4.9	6.9
No religion	433	3,999	20.7	9.5	35.8	19.7	0.7	7.5	6.6
Protestant 4/	1,359	14,061	27.3	12.3	32.8	14.8	1.0	5.0	6.9
Very important	747	7,760	26.9	14.9	30.4	15.9	1.1	4.1	6.8
Somewhat important	526	5,510	29.2	10.0	34.1	13.4	0.8	5.5	7.0
Not important	83	746	18.8	2.1	45.4	15.4	1.4	8.5	8.4
Baptist/Southern Baptist 4/	414	4,003	34.5	12.5	29.5	12.4	0.7	4.5	6.0
Very important	259	2,446	32.4	13.6	33.2	9.7	1.0	4.5	5.6
Somewhat important	144	1,442	38.0	10.9	22.6	16.1	0.4	4.9	7.1
Not important	*								
Fundamentalist Protestant	94	1,127	35.2	9.8	22.6	14.7	0.0	8.3	9.6
Latter Day Saints/Mormon	91	1,015	24.1	8.9	27.2	19.0	0.6	10.4	9.8
Other Protestant 4/	760	7,916	23.0	12.9	36.6	15.6	1.2	4.1	6.7
Very important	366	3,824	23.3	16.5	31.3	18.4	1.4	2.8	6.4
Somewhat important	326	3,486	23.9	11.1	39.9	12.6	1.0	5.2	6.4
Not important	67	592	15.5	1.2	52.6	15.1	1.7	3.4	10.5
Catholic 4/	605	6,166	21.0	11.6	36.0	17.5	3.5	3.4	7.0
Very important	249	2,507	23.6	16.6	29.5	15.7	4.2	3.1	7.2
Somewhat important	295	2,997	19.4	8.5	40.6	19.8	0.9	4.2	6.6
Not important	61	663	18.2	7.3	39.5	13.2	12.2	1.5	8.2
Other religion	149	1287	9.8	13.6	40.4	22.7	3.8	3.2	6.5

1/ Natural family planning, cervical mucus test, temperature rhythm, and calendar rhythm

2/ Norplant, Depo-Provera, Lunelle and the contraceptive patch

3/ Morning-after pill, IUD, diaphragm, female condom/vaginal pouch, foam, cervical cap, Today sponge, suppository or insert, jelly or cream alone, withdrawal, and other method.

4/ Includes women with missing information on importance of religion, not shown separately.

* Figure does not meet standard of reliability or precision.

NOTE: Percentages may not add to 100 due to rounding.

Table 7. Percent distribution of contraceptive method for non-Hispanic black women using contraception, by religion and importance of religion: US, 2002

Characteristic	Sample number	Weighted number (in thousands)	Female steriliza-tion	Male sterilization	Pill	Condom	Periodic abstinence 1/	Other hormonal 2/	Other methods 3/
All women 4/	853	4,754	39.2	2.3	22.7	19.8	0.6	10.3	5.1
No religion	110	511	35.0	0.0	19.3	23.3	0.0	18.6	3.9
Protestant 5/	663	3,896	40.5	2.5	22.7	19.7	0.6	8.8	5.2
Very important	535	3,139	44.6	2.5	20.4	18.3	0.6	8.3	5.2
Somewhat important	120	692	24.0	2.7	34.3	24.9	0.4	10.1	3.5
Not important	*								
Baptist/Southern Baptist 5/	395	2,230	40.1	1.0	21.4	20.0	0.4	12.4	4.8
Very important	306	1,746	43.6	1.0	19.4	18.7	0.3	11.9	5.2
Somewhat important	83	445	27.1	1.1	29.4	24.9	0.7	13.3	3.4
Not important	*								
Fundamentalist Protestant	96	522	55.1	2.9	15.8	15.7	0.5	6.2	3.9
Other Protestant 5/	167	1,120	34.0	5.4	29.1	20.8	1.0	2.9	6.8
Catholic 5/	54	229	27.1	1.8	34.0	13.7	0.0	15.3	8.2

1/ Natural family planning, cervical mucus test, temperature rhythm, and calendar rhythm

2/ Norplant, Depo-Provera, Lunelle and the contraceptive patch

3/ Morning-after pill, IUD, diaphragm, female condom/vaginal pouch, foam, cervical cap, Today sponge, suppository or insert, jelly or cream alone, withdrawal, and other method.

4/ Includes women of other religions, not shown separately.

5/ Includes women with missing information on importance of religion, not shown separately.

* Figure does not meet standard of reliability or precision.

NOTE: Percentages may not add to 100 due to rounding.

Table 8. Percent distribution of contraceptive method for Hispanic women of any race using contraception, by religion and importance of religion: US, 2002

Characteristic	Sample number	Weighted number (in thousands)	Female sterilization	Male steriliza-tion	Pill	Condom	Periodic abstinence 1/	Other hormonal 2/	Other methods 3/
All women 4/	921	5,370	33.8	4.4	22.0	18.5	1.5	10.4	9.5
No religion	105	646	31.3	2.2	15.5	22.6	0.0	14.2	14.21
Protestant 5/	197	1,128	44.4	6.8	16.4	13.4	3.9	6.6	8.53
Fundamentalist Protestant	73	388	39.5	3.6	21.1	14.8	3.3	7.4	10.38
Other Protestant	71	433	40.7	10.7	19.7	12.3	7.3	2.5	6.83
Catholic 5/	608	3,555	31.1	4.2	24.4	19.5	1.0	10.9	9.0
Very important	358	2,201	32.9	4.6	23.8	17.8	1.5	11.1	8.36
Somewhat important	222	1,192	28.9	3.5	24.0	22.5	0.3	10.6	10.29
Not important	*								

1/ Natural family planning, cervical mucus test, temperature rhythm, and calendar rhythm

2/ Norplant, Depo-Provera, Lunelle and the contraceptive patch

3/ Morning-after pill, IUD, diaphragm, female condom/vaginal pouch, foam, cervical cap, Today sponge, suppository or insert, jelly or cream alone, withdrawal, and other method.

4/ Includes women of other religions, not shown separately.

5/ Includes women with missing information on importance of religion, not shown separately.

* Figure does not meet standard of reliability or precision.

NOTE: Percentages may not add to 100 due to rounding.