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Skin tone discrimination and birth control avoidance among women in Harris County, Texas: a cross-sectional study

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Abstract

Introduction Structural racism plays a major role in reproductive health inequities. Colorism, discrimination based on skin color, may profoundly impact reproductive health access and service delivery. However, quantitative research in this area is limited.

Methods We administered an online survey of women*n*(= 1,299) aged 18–44 from Harris County, Texas to assess the relationship between skin color discrimination and reproductive health service avoidance. The survey included questions on demographics, self-reported skin tone, and dichotomous measures of previous discrimination experiences and avoidance of care because of perceived discrimination. Binary logistic regression was used to examine whether race/ethnicity, skin tone, and previous discrimination experiences were related to avoidance of contraceptive care because of perceived discrimination.

Results Approximately one-third (31.5%) of the sample classi□ed themselves as non-Hispanic Whites (31.5%), 22.4% as Black, 27.4% as Hispanic and born within the US, and 7.6% as Hispanic born outside of the US. Approximately one-third of women classi□ed themselves in the lightest skin tones, whereas almost one in □ve women classi□ed themselves in the darkest skin tone palates. Darker skin tones had increasingly greater odds of reporting that they avoided seeking birth control out of a concern for discrimination compared to the lightest skin tone. After adjusting for race/ethnicity and sociodemographic variables (model 3), darker skin tones remained signi□cantly associated with avoiding birth control.

Discussion This study demonstrates the role that skin color discrimination plays in negative reproductive health experiences. While this is not surprising given that those with racist ideologies developed the concept of these racial and ethnic categories, the apparent association with darker skin colors and avoidance of seeking birth control provides evidence that structural and individual racism continues to have far-reaching and insidious consequences.

Conclusion Contraception is recognized for reducing maternal mortality, improving child health, increasing female empowerment, and decreasing poverty. However, not all women equally enjoy the bene□ts of access to contraception. Addressing colorism within reproductive healthcare has become critically important as the nation

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Introduction

Racial and ethnic disparities in reproductive health access, services, and outcomes are prevalent [1]. ese disparities are evidenced by the lower use of contraception among Hispanic and non-Hispanic Black women over the last decades, resulting in higher rates of unintended pregnancies and poorer maternal outcomes [1–3]. Barriers to hormonal contraceptive methods have been well described and include costs, proximity to a ordable clinics, lack of over-the-counter access, a ordable copays, and patients' lack of awareness or misconceptions [4, 5]. Other factors include healthcare providers' attitudes, misconceptions, and limited training. For adolescent patients, consent and confidentiality are major barriers [4, 5]. Mounting evidence suggests that structural racism

listed a unique passcode that respondents needed to log

Table 1 Characteristics of Study Sample

	Total Sample	
	N **= 1299 (unweighted %)**	**Weighted %**
Age		
18–24	247 (19.0)	23.5
25–29	237 (18.2)	19.9
30–39	532 (41.0)	38.3
40–44	283 (21.8)	18.3
Race/Ethnicity		
White, Non-Hispanic	409 (31.5)	27.6
Black, Non-Hispanic	291 (22.4)	21.9
Hispanic, born inside the US	356 (27.4)	25.5
Hispanic, born outside the US	99 (7.6)	14.6
Other, Non-Hispanic	144 (11.1)	10.5
Skin Tone		
Lightest	445 (34.3)	31.9
2	188 (14.5)	14.5
3	217 (14.5)	18.6
4	194 (14.9)	14.6
Darkest	255 (19.6)	20.4
Marital Status		
Single, never married		
Single, living with partner		
Married		
Separated, Widowed, Divoren-tUSer		

and public opinion surveys. e combined ABS and non-probability samples were then weighted to the same demographic benchmarks used for the ABS sample as well as the internal benchmarks derived from the stepwise calibration.

e data was analyzed using the 'survey' package in R with base weights applied to account for the probability of selection. Binary logistic regression was used to examine whether race/ethnicity and skin tone were related to whether women avoided birth control because of perceived discrimination. Crude odds ratios were calculated for each variable. Adjusted odds ratios were calculated to examine whether demographic and other factors explained the relationship between race/ethnicity and the outcome variable (models 2 and 3) and whether these factors explained the relationship between skin tone and the outcome variable (models 3 and 4).

Results

Table 1 displays the characteristics of the study sample, weighted and unweighted. Based on unweighted data, of the 1,299 women in the analysis, 41% were aged 30 and 39. Almost one-third of the sample classified themselves as non-Hispanic Whites (31.5%), 22.4% as Black, 27.4% as Hispanic and born within the US, and 7.6% as Hispanic born and outside of the US. Approximately one-third of women classified themselves in the lightest skin tones, whereas almost one in five women classified themselves in the darkest skin tone palates. irty-seven percent said they were single and never married, 14.6% were single and living with a partner, and 41.3% of women reported being married. Almost half (47.6%) reported being college educated. e majority (68.9%) of the sample reported being employed.

Table 2 displays the sample's self-reported reproductive health experiences unweighted and weighted. Based on weighted data, overall, 14.9% of women aged 18–44 in Harris County said they avoided seeking birth control

from a doctor or healthcare provider out of concern that they would be discriminated against or treated poorly because of their race or ethnicity, and 11.1% of women said they avoided seeking birth control out of concern that they would be discriminated against or treated poorly because of their skin tone. One in five women said they had previously experienced discrimination when going to a doctor or health clinic for birth control because of their race/ethnicity (21.1%), and 15.3% said they experienced discrimination when going to a doc

Table 4 Multivariate association between race/ethnicity, skin tone, and care avoidance after adjusting for sociodemographic factors

	Adjusted OR (95% CI)
Model 1: Race/ethnicity adjusted for family income, education, marital status, employment, and age	
Race/Ethnicity	
White, non-Hispanic	Reference
Black, non-Hispanic	**6.5(3.0-13.8)**
Hispanic, born in the US	**6.5(3.0-13.8)**
Hispanic, born outside of the US	**10.3(4.3–24.9)**
Other, non-Hispanic	**2.7(0.9–7.2)**
Model 2: Skin tone adjusted for family income, education, marital status, employment, and age	
Skin Tone	
Lightest	Reference
2	**3.7 (1.8–7.7)**
3	**3.3 (1.6–6.7)**
4	**5.6 (2.9–10.9)**
Darkest	**7.5 (4.1–13.9)**
Model 3: Skin tone adjusted for race/ethnicity, family income, education, marital status, employment, and age	
Skin Tone	
Lightest	Reference
2	1.6 (0.7–3.6)
3	**3.0 (1.3–7.2)**
4	1.4 (0.6–3.4)
Darkest	**3.1 (1.3–8.8)**

out of a concern for discrimination compared to the lightest skin tone. After adjusting for race/ethnicity and sociodemographic variables (model 3), darker skin tones remained significantly associated with avoiding birth control.

Discussion

is study demonstrates the role that racial and ethnic categories and skin color play in negative reproductive health experiences. While this is not surprising given that the concept of these racial and ethnic categories was developed by those with racist ideologies, the clear association with darker skin colors and avoidance of seeking birth control provides further evidence that structural and individual racism continues to have far-reaching and insidious consequences.

Contraception is known as one of the greatest public health achievements of the 20th century and is recognized for improving the world's health, reducing maternal mortality, improving child health, increasing female empowerment, and decreasing poverty [21]. However, not all women equally enjoy the benefits of access to contraception [21]. Documented disparities in contraception access and reproductive healthcare are multifactorial and complex and include availability and access to healthcare, transportation, health insurance, employment, and education [22]. ese factors are confounded by centuries of structural racism and discrimination. For the past twenty years, studies have documented historical abuse and discrimination in healthcare settings stemming from bias and prejudice against minorities, greater clinical uncertainty when inter- with minority patients, and beliefs or stereotypes held by the provider about the behavior or health of minorities [23]. In 2020, the Kaiser Family Foundation reported that one in five Black and Hispanic adults said they were personally treated unfairly because of their race or ethnicity while getting healthcare in the past year [24].

Researchers must move past simply describing racial and ethnic di erences in reproductive health and attributing these di erences solely to social determinants such as poverty, education, and employment. Instead, colorism must be addressed as a global product of structural racism that impacts interpersonal and internalized experiences of discrimination that will require further study on solutions to address reproductive health inequities. Further, colorism in the American context is unique in that it is inextricably tied to the lasting vestiges of chattel slavery, Jim Crow segregation, and the subsequent policies that kept groups of people segregated and subjugated based on phenotype and ancestry [10]. We must be able to admit the role that racism rooted in anti-blackness has on reproductive health outcomes and how colorism functions as an agent of this phenomena [24].

Limitations

e study is conducted exclusively in a large urban southern city, potentially limiting the generalizability of the findings to rural or suburban areas, or even to other urban areas with di erent socio-economic or cultural contexts. e administration of the online survey might have excluded individuals without internet access or digital literacy.

Additionally, this study includes temporal limitations as polling captures opinions at a specific point in time, which may not reflect changes in public opinion over time. Events occurring after the data collection period can significantly alter public perceptions and attitudes.

By acknowledging these limitations, the study provides a transparent account of potential sources of bias and constraints on the findings, thereby o ering a more nuanced interpretation of the results. Future research could aim to address these limitations by incorporating broader geographic samples, longitudinal designs, and methodological triangulation to enhance the robustness and generalizability of the findings.