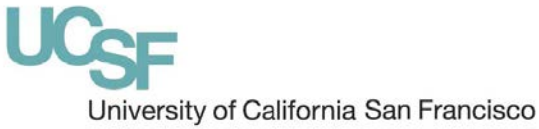

California Women's Perceptions about their Male Partners' Involvement in Contraceptive Decision-making and Use, 2008-2010

October 2012

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California Women's Perceptions about their Male Partners' Involvement in Contraceptive Decision-making and Use, 2008-2010

October 2012

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Background

Nearly half of all pregnancies in the United States (U.S.) are unintended,[1] which can result in significant consequences for the health and well-being of a woman, her family, and the community.[2,3] Family planning services are critical in the prevention of unintended pregnancy. Thus, the U.S. Department of Health and Human Services (DHHS) through its Healthy People 2020 initiative acknowledges the importance of family planning to improve pregnancy planning and spacing, and prevent unintended pregnancy.[4]

Given that most prescription contraceptive methods are designed to be used by women, many men do not consider themselves in need of family planning services. The introduction of intrauterine and hormonal contraception in the 1960s focused the family planning efforts toward improving women's access to contraception and emphasized women's empowerment and control over their fertility without their partners' involvement.[5] However, both men and women play an important role in reproductive health, and in one study the majority of men perceived the need for shared responsibility in contraceptive decision-making.[6]

There have been increasing efforts to include men in reproductive health programs and to make them a target of family planning services.[7] Since the 1970s, DHHS has funded a range of demonstration projects through Title X of the Public Health Service Act to encourage the participation of men in reproductive health programs and promote prevention of unplanned pregnancy and sexually transmitted diseases. These efforts were spurred partly by the spread of human immunodeficiency virus infection (HIV) infection and other STDs that led the public health community to investigate the reproductive and contraceptive behaviors of men.

In the early 2000s, states implementing the 1115 Medicaid Family Planning Research and Demonstration Waiver increasingly sought to include men as one of the target populations in their waiver goals.[8] During the implementation of the California's 1115 family planning demonstration waiver, the percentage of male clients increased from eight percent in fiscal year (FY) 1998-99 to 14 percent in FY 2009-10.[9,10]

Research suggests that there are advantages when men share responsibility in contraceptive decision making and use beyond receiving direct services.[11] In a survey of women with HIV, women who perceived that they shared relationship power with their partners were more likely to make birth control decisions with them.[12] Joint contraceptive decision-making was associated with increased likelihood of using contraceptives, such as condoms, among intravenous drug-using women as well.[13] Another study showed that women were more likely to be effective contraceptive users if they believed their partners favored contraception.[14] Recommendations from the Office of Population Affairs have also emphasized incorporating a 'couple-focused' model into family planning service delivery, with a goal of helping women and their partners use contraception consistently and effectively.[15] Thus, involving men in the family planning decision-making process may lead to the effective and consistent use of contraception resulting in a more favorable outcome in the prevention of unintended pregnancy.

However, in some relationships, male involvement may be counterproductive and lead to birth control sabotage and sexual coercion.[16] In a 2009 survey of female Title X clients, women reporting that their partners interfere with their birth control use were nearly twice as likely as women without interfering partners to report that their partners were involved in their contraceptive services as measured by assistance with paying for birth control, accompaniment to the clinic or being present during clinic visit.[17]

There is limited information to guide interventions for engaging men in contraceptive communication and decision-making and on whether shared involvement between men and women varies by sociodemographic group or contraceptive method. This report examined the association of California women's perceptions of their partners' involvement in contraceptive decision-making and utilization with sociodemographic characteristics and women's current contraceptive use, using three-year data from the California Women's Health Survey (CWHS) (2008-10).

Data Sources and Methods

The CWHS is an on-going monthly telephone survey conducted since 1997. The survey includes various health related attitudes and behaviors from a randomly selected sample of women ages 18 and over. Since 1997, the California Department of Public Health (CDPH), [a] Office of Family Planning (OFP), has sponsored and participated in the CWHS, and has contributed questions related to contraceptive use and relevant reproductive behavior among adult California women.

From 2008 to 2010, the CWHS included three questions which explored men's role in the decision-making process and use of birth control methods. Women ages 18-49, were asked the following questions: 1) "Who initiates/initiated discussions about birth control use?; 2) "Who chooses/chose the type of birth control?"; and, 3) "Who makes/made sure that birth control is/was used?" The response categories were: "Shared;" "You (the respondent herself);" "Current/most recent partner;" and "Refused" for those who did not provide any answer. The response "Shared" means both respondent and her partner shared the decision-making on the birth control use. The responses "You" and "Partner" indicate respondents perceived herself or her male partner taking a more active role on contraceptive use, respectively. The analytical sample (n=3,580) consisted of three years of pooled CWHS data (2008-10) that included women who were sexually active in the last 12 months, and neither pregnant nor trying to become pregnant. For the purposes of this report, women who "Refused" to respond to any of the questions were excluded from the analysis. Data were weighted to the 2000 California female census population stratified by age and race/ethnicity.

From the three questions above, we developed a composite score, the degree of shared involvement, with categories as follows: 0 = women without a shared response for any of the three questions; 1 = women with one shared response; 2 = women with two shared responses; and 3 = women with three shared responses. We used the data on women who reported their status as a current contraceptive user and the specific methods they reported.

[a] Beginning in FY 2012-13, the OFP has moved from CDPH to Department of Health Care Services (DHCS).

When appropriate we categorized the contraceptive methods into the following: 1 = sterilization (tubal and vasectomy); 2 = long acting reversible contraception (LARC), consisting of intrauterine contraception (IUC) and contraceptive implant; 3 = user-dependent hormonal contraception, consisting of oral conception, injectable contraceptives, patch, and ring; “4 = condoms; and, 5 = other, consisting of diaphragm, foam, jelly, vaginal pouch, withdrawal, natural family planning, and lactational amenorrhea. The women’s demographic and socioeconomic characteristics including marital status, age, race/ethnicity, nativity, educational status, Federal Poverty Level (FPL), and number of sex partners during the last 12 months were used in this analysis.

Descriptive analysis was performed on the demographic and socioeconomic characteristics of reproductive-age women 18-49 stratified by the three questions assessing male partners’ involvement: who initiates/initiated discussion; who chooses/chose; and who makes/made sure of birth control use. Additionally, the composite score, as it related to women’s current contraceptive use, was evaluated. We also conducted the chi-square test to determine which demographic or socioeconomic characteristics are likely to be associated with the three questions.

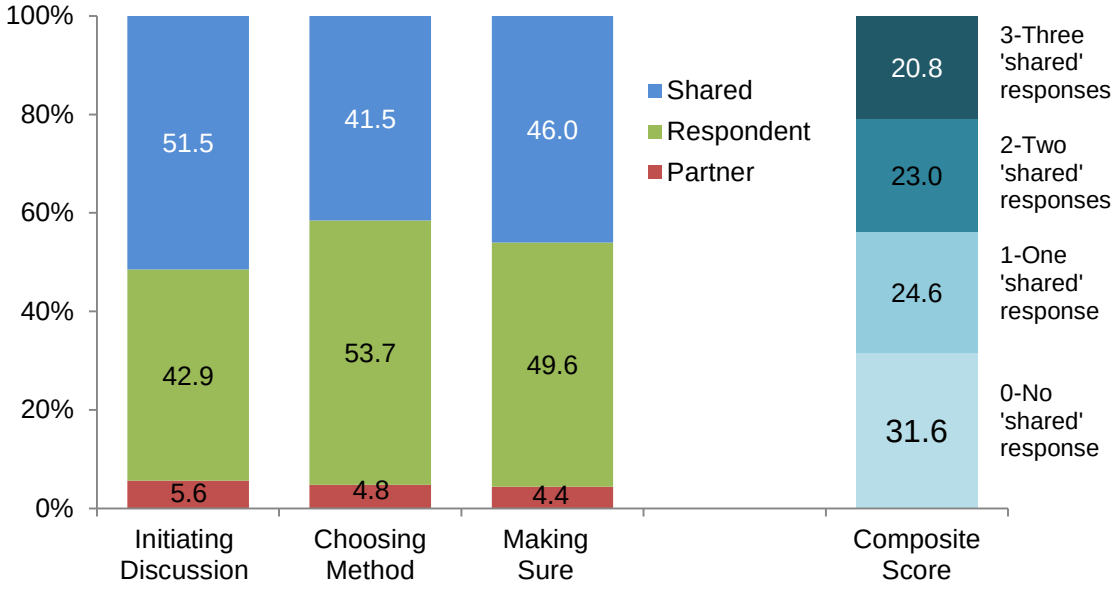
Results

Overall across different subgroups of demographic and socioeconomic characteristics, a considerable higher proportion of women responded “Shared” than “Partner” in initiating discussion, choosing, or making sure to use birth control. There was also a trend among different groups of women showing that most of them chose the type of birth control by themselves.

Women’s Characteristics by Partner and Shared Involvement in Contraceptive Decision-making and Choice

In general, slightly more than half of the women reported that initiating discussions about birth control was shared with their partners (51.5 percent). Fewer than half of the women reported shared decision-making in choosing a method (41.5 percent), and making sure to use a method (46.0 percent). The composite score showed that 20.8 percent of women reported shared decision-making in their reply to all three questions concerning their male partners’ involvement in contraceptive decision-making and choice. See Figure 1.

Figure 1. Percentage Distribution of Women's Perceptions about Their Partners' Involvement in Contraceptive Decision-making and Use and Composite Score



Source: California Women's Health Survey 2008-10.

When asked who initiates/initiated discussion about birth control, more than half (55 percent) of women aged 30-39 responded "Shared," a higher proportion as compared to younger women aged 20-29 (48 percent) and older women aged 40-49 (50 percent). See Table 1. Regarding the question on who chooses/chose the type of birth control, about six in ten (61.3 percent) women aged 18-29 responded "Herself" compared with women aged 30-39 (51.4 percent), and women aged 40-49 (48.6 percent). Those in the age group 40-49, had a higher proportion who reported that their partner chooses/chose the types of birth control than those in the age groups 30-39 and 18-29 (6.8 vs. 4.0 percent and 3.6 percent respectively). Similarly, older women aged 40-49 had also a higher proportion who answered that their partner makes/made sure birth control is used as compared with younger women aged 30-39 and 18-29 (6.4 vs. 3.7 and 3.3 percent, respectively).

Across the four major race/ethnic groups, Hispanic women had the highest percentage of shared involvement in initiating the discussion about birth control use (57.2 percent). While Asian/Pacific Islander (API) had the smallest percentage (42.8 percent) replying shared involvement on this question, they reported the highest shared involvement in making sure the method is used (48.1 percent). Among the three questions, a low proportion of women reported that the partner alone was involved (2.7 to 11.9 percent); however, this response was highest among API women for each of the three questions. For example, 11.9 percent of API women reported that their partner alone initiated discussion about birth control use, while 4.7 percent of white, 2.7 percent of Black, and 5.2 percent of Hispanic women did. Sixty-four percent of women who identified as Black reported that they themselves choose/chose a birth control method, a higher percentage compared to White (54.1 percent), Hispanic (53.4 percent), and API (47.6 percent) women.

Table 1. Percentage Distribution of Women's Perceptions about their Partners' Involvement in Birth Control Use, by Women's Age and Race/Ethnic Background (n=3,580)

Demographic Characteristics	Who Initiates/Initiated Discussion			Who Chooses/Chose			Who Makes/Made Sure		
	Respon-dent	Part-ner	Shared	Respon-dent	Part-ner	Shared	Respon-dent	Part-ner	Shared
Age Group									
18-29	45.0	6.7	48.2	61.3	3.6	35.0	51.3	3.3	45.4
30-39	41.0	4.0	55.0	51.4	4.0	44.6	49.1	3.7	47.2
40-49	43.2	6.4	50.4	48.6	6.8	44.6	48.5	6.4	45.1
	X^2=12.6, p=0.013			X^2=39.4, p<0.0001			X^2=13.0, p=0.011		
Race/Ethnicity									
White	44.5	4.7	50.8	54.1	4.2	41.7	51.5	3.5	44.9
Black	53.9	2.7	43.4	64.4	4.3	31.3	54.6	3.0	42.4
Hispanic	37.6	5.2	57.2	53.4	4.6	42.0	48.5	4.2	47.3
API	45.3	11.9	42.8	47.6	8.5	43.9	42.8	9.1	48.1
	X^2=33.3, p<0.0001			X^2=8.3, p=0.08			X^2=18.6, p=0.017		

Source: California Women's Health Survey 2008-10.

A higher percentage of foreign-born women responded that their partner participated in initiating the discussion (58.6 percent) and ensuring birth control use (50.3 percent) compared to U.S.-born women (47.4 and 43.6 percent, respectively). See Table 2. More than half (56.2 percent) of the women born in the U.S. said that they choose/chose the type of birth control on their own compared with 49.2 percent of foreign-born women.

Table 2. Percentage Distribution of Women's Perceptions about their Partners' Involvement in Birth Control Use, by Women's Place of Birth (n=3,580)

Demographic Characteristics	Who Initiates/Initiated Discussion			Who Chooses/Chose			Who Makes/Made Sure		
	Respon-dent	Partner	Shared	Respon-dent	Partner	Shared	Respon-dent	Partner	Shared
Nativity									
U.S.-born	47.9	4.7	47.4	56.2	4.1	39.7	52.8	3.6	43.6
Foreign-born	34.3	7.2	58.6	49.2	5.9	44.9	43.9	5.8	50.3
	X^2=44.2, p<0.0001			X^2=15.4, p=0.0005			X^2=24.6, p<0.0001		
Place of Birth among Foreign-Born									
Asia	37.4	14.1	48.4	42.5	9.5	48.0	37.3	9.8	52.9
Caribbean/ South America	36.6	7.0	56.3	60.3	7.3	32.5	57.7	5.1	37.2
Mexico	29.6	4.7	65.8	49.4	4.1	46.4	43.9	4.3	51.8
Other	48.0	6.8	45.3	51.7	6.4	41.9	45.0	6.1	48.9
	X^2=91.3, p<0.0001			X^2=34.3, p<0.0001			X^2=45.3, p<0.0001		

Source: California Women's Health Survey 2008-10.

Disaggregating the data by birth place among foreign-born showed that women who were born in Mexico were more likely to report shared involvement in initiating the discussion about birth control use (65.8 percent). A higher proportion of women born in the Caribbean and South America replied that they, themselves, chose the birth control method (60.3 percent) than of women born elsewhere. This group also showed the highest proportion (57.7 percent) of those stating that they, themselves, made sure that the birth control method was used as compared to other women born elsewhere.

The response to the question of who initiates/initiated discussion about birth control had a bimodal trend with regard to the women's educational status. See Table 3. More women at the opposite ends of the educational spectrum (i.e., less than a high school education [61.9 percent] and a college/graduate school education [52.9 percent]), responded shared involvement in initiating discussion about birth control, than respondents in the middle of the educational spectrum, high school, or some college (46.1 percent).

There were not many differences in the response to the three questions by income. However, a slightly higher proportion of women (43.2 percent) with income above 200 percent of the FPL reported shared involvement in the selection of birth control method than women with income at or below 200 percent of the FPL (38.8 percent).

Table 3. Percentage Distribution of Women's Perceptions about their Partners' Involvement in Birth Control Use, by Women's Education and Poverty Level Status (n=3,580)

Socioeconomic Characteristics	Who Initiates/Initiated Discussion			Who Chooses/Chose			Who Makes/Made Sure		
	Respon-dent	Part-ner	Shared	Respon-dent	Part-ner	Shared	Respon-dent	Part-ner	Shared
Education Level									
Less than High School	32.7	5.4	61.9	52.0	4.2	43.8	47.9	4.1	47.9
High School or Some College	47.8	6.1	46.1	58.6	4.9	36.5	52.9	4.0	43.1
College or Graduate School	42.0	5.1	52.9	48.9	4.9	46.2	46.7	4.9	48.4
	X^2=33.9, p<0.0001			X^2=28.3, p<0.0001			X^2=11.1, p=0.025		
Poverty Level									
Above 200% FPL	44.2	5.5	50.3	51.7	5.1	43.2	48.4	4.8	46.8
At or Below 200% FPL	42.2	5.5	52.3	56.9	4.3	38.8	51.7	3.7	44.6
	X^2=5.8, p=<0.214			X^2=11.8, p=0.019			X^2=6.2, p=0.0184		

Source: California Women's Health Survey 2008-10.

Married or cohabiting women were more likely to report shared involvement across the three questions as compared to women of other marital status categories. See Table 4. When asked who initiated discussion about birth control, nearly six in ten married or cohabiting women (56.4 percent) replied 'shared' as compared to four in ten (41.6 percent) single women. A higher proportion of divorced/separated/widowed women (70.2 percent) and single women (67.7 percent) stated that they themselves chose the type of birth control method than married women (47.5 percent).

Table 4. Percentage Distribution of Women's Perceptions about their Partners' Involvement in Birth Control Use, by Women's Marital Status and Number of Male Sex Partners During Last Year (n=3,580)

Demographic Characteristics	Who Initiates/Initiated Discussion			Who Chooses/Chose			Who Makes/Made Sure		
	Respon-dent	Part-ner	Shared	Respon-dent	Part-ner	Shared	Respon-dent	Part-ner	Shared
Marital Status									
Married or Cohabiting	37.9	5.8	56.4	47.5	5.3	47.2	45.2	5.0	49.9
Divorced, Separated, Widowed	61.5	5.8	32.7	70.2	4.2	25.6	68.2	3.0	28.8
Single	53.5	4.9	41.6	67.6	3.1	29.1	57.1	2.9	40.0
	X^2=61.7, p<0.0001			X^2=89.7, p<0.0001			X^2=53.8, p<0.00001		
Number of Sex Partners During the Last 12 Months									
1	39.5	5.7	54.8	50.8	4.9	44.3	47.2	4.6	48.2
2 or More	60.3	6.4	33.3	68.3	3.7	28.0	59.9	4.5	35.5
	X^2=21.3, p<0.0001			X^2=17.0, p=0.0002			X^2=8.1, p=0.01176		

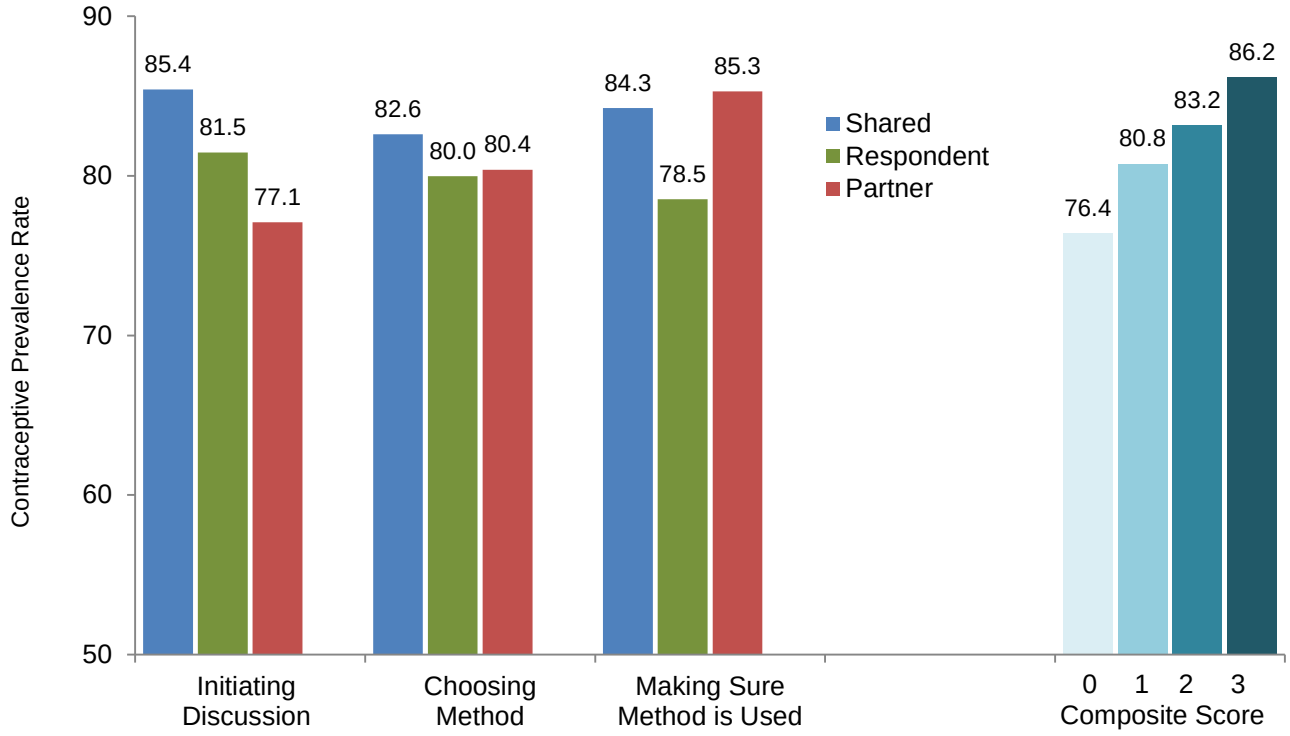
Source: California Women's Health Survey 2008-10.

As seen with married women, a higher proportion of those who had one sex partner in the last 12 months (54.8 percent) reported shared involvement in all three questions compared to women with two or more sex partners (33.3 percent).

Association between Partner and Shared Involvement in Contraceptive Decision-making and Current Contraceptive Use

Women were asked whether they or their male sex partners are currently using a birth control method to prevent pregnancy. Overall, our analytical sample indicated that 81.1 percent of women aged 18-49 replied that they or their partner are currently using a contraceptive method. Examining each of the responses across the three questions, we found that current contraceptive use was highest among women who reported shared involvement in initiating the discussion about birth control (85.4 percent) and when the response was "Partner" in the question on who made sure the birth control method was used (85.3 percent). See Figure 2.

Figure 2. Percentage of Women who are Current Contraceptive Users, by Composite Score and Women's Perceptions of their Partners' Involvement in Contraceptive Decision-making and Use

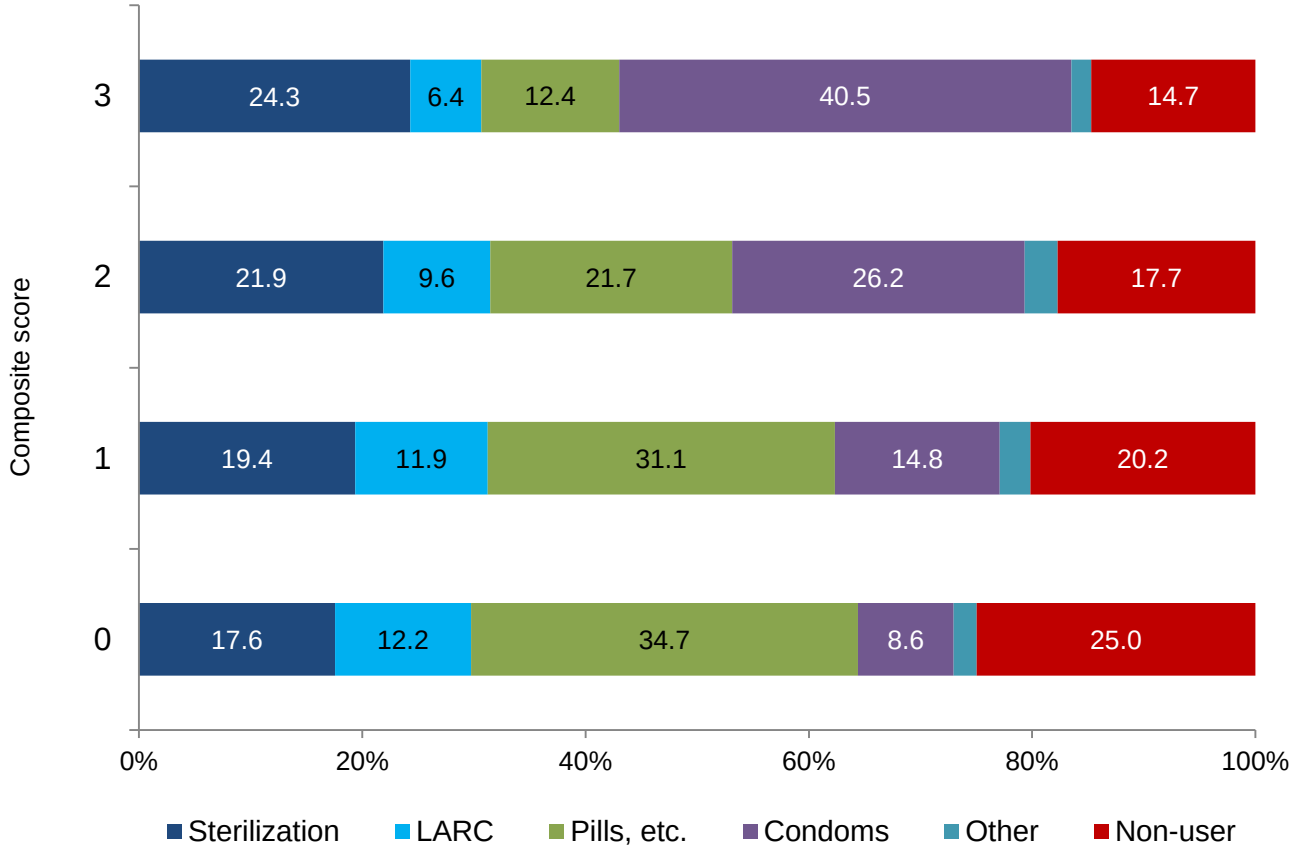


Source: California Women's Health Survey 2008-10.

Investigating the proportion of current contraceptive users by degree of partners' involvement (composite score) revealed a substantial variation. As the number of shared responses increased from zero to three, the proportion of current contraceptive users also increased; among women without a shared response (composite score = 0) in any of the three questions, the proportion of current contraceptive users was 76.4 percent. In contrast, among women who reported shared involvement in each of the three questions (composite score = 3), 86.2 percent were current contraceptive users.

About one in four (25.0 percent) women who reported no shared involvement did not use any contraceptive method; while only 14.7 percent women who had the highest level of shared involvement were nonusers. See Figure 3. Examining women's choice of contraceptive method by degree of shared involvement showed marked differences. Noticeably, the use of pills and LARC decreased with increasing shared involvement.

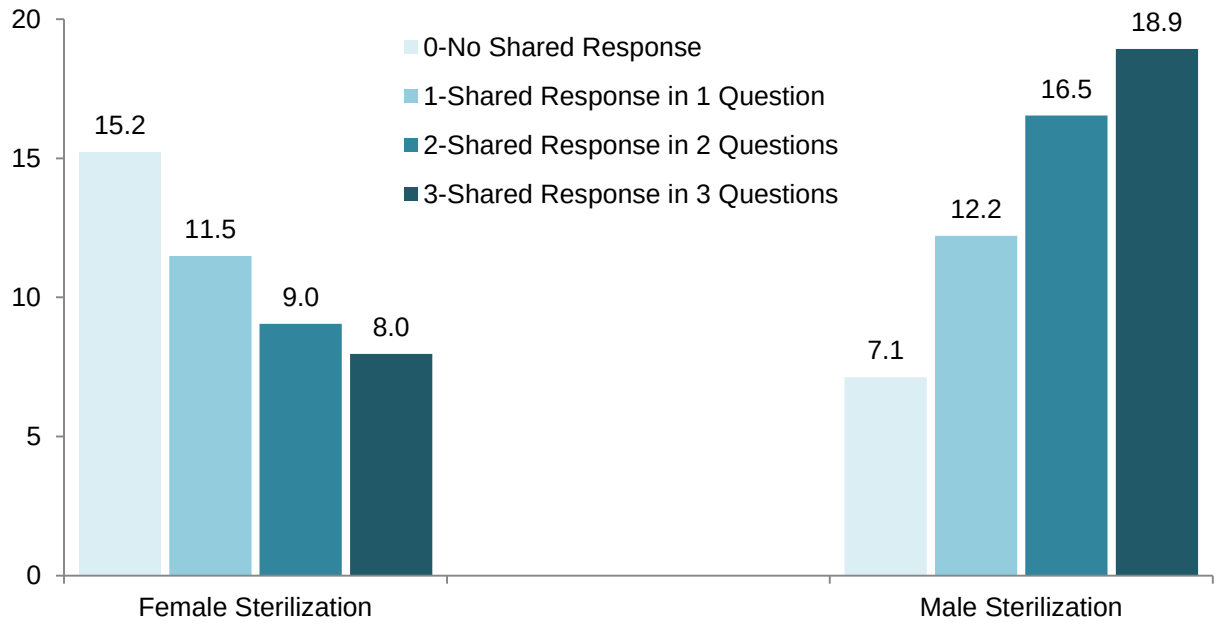
Figure 3. Percentage of Contraceptive Nonusers and Users, by Specific Method and Degree of Shared Involvement



Sterilization consisted of both vasectomy and tubal ligation; LARC (Long-acting reversible contraception); pills, etc. (including oral contraceptive pills), contraceptive injectable and implant, contraceptive vaginal ring, and patch; other included diaphragm, foam/jelly/cream, withdrawal, natural family planning, and lactational amenorhea
Source: California Women's Health Survey 2008-10.

In contrast, the trend for women using condoms was the opposite (8.6 percent among women with composite score = 0 vs. 40.5 percent among women with composite score = 3). Overall, reported use of sterilization followed a trend similar to the use of condoms. However, when disaggregated by female and male sterilization, the data showed that use of female sterilization decreased as male involvement increased while use of male sterilization increased with increasing male involvement. See Figure 4.

Figure 4. Percentage of Women Using Sterilization: Female vs. Male, by Composite Score



Source: California Women's Health Survey 2008-10.

Discussion and Conclusion

Hailed as one of the great public health achievements of the 20th century, family planning has been a crucial determinant in achieving desired birth spacing and family size.[18] Women clearly play a critical role in their own reproductive health, but involving men in the family planning decision-making process is increasingly seen as an important factor that can facilitate the initiation and effective use of contraception.

The results of our analysis of women's perception of their partners' involvement indicated that overall, a large percentage of men were involved in each area of contraceptive decision-making and use. Yet there were some differences by sociodemographic characteristics such as age, race/ethnicity, birth place, educational level, marital status, and number of male sex partners. We found that certain population subgroups of women – older women, those who reported they were foreign-born (in particular Hispanic women born in Mexico), married and monogamous women – were more likely to report shared responsibility than others.

Young adult women (age 18-29) were the least likely to report shared involvement in contraceptive decision-making and method choice. The youngest of these women – those aged 18-24 – appear to be driving the trend. Shared responsibility across the three questions was noticeably higher among foreign-born than U.S.-born women. Moreover, when stratified by race/ethnic group, Hispanic foreign-born women were more likely to have a higher degree of shared involvement as compared with their U.S.-born counterparts. This increased male involvement might be related to the lower odds of unintended pregnancy that Hispanic foreign-born women have compared to U.S.-born Hispanic women and may be the result of

cultural factors related to contraception.[19] Additionally, an increased need among foreign-born Hispanic women for help from their partners in navigating the health care system may explain the trend. The result indicating that Black women took the responsibility themselves concerning contraceptive decision-making was consistent with a study showing that Black men were more likely than men of other races to view the decision to practice contraception as a woman's responsibility.[20]

More women at the opposite ends of the educational spectrum reported shared involvement than respondents in the middle of the educational spectrum (i.e., high school or some college). One factor which may be influencing those women with the least education to have a higher degree of shared involvement was the fact that a relatively high proportion in this group of women was foreign-born (36 percent). Thus, there was a confounding relationship between shared involvement and women's nativity and educational status. The result, suggesting that more women with a college or graduate degree education shared responsibility with their partner, is perhaps owing to them being more likely to marry men from the same educational level. As such, our result is consistent with a research finding showing the egalitarian process involved with decisions about contraception were more common among men with higher education.[20]

Our findings showing that married or cohabiting women were more likely to share the responsibility of contraceptive decision-making with their partners compared to single or previously married women support the findings of previous research indicating high involvement among married or cohabiting women.[17] Also, it was not surprising to find that women with one sex partner during the last 12 months tended to report more shared responsibility than women with two or more sex partners. One sex partner implies a monogamous and possibly longer, stable relationship. This type of relationship may contribute to more trust between partners and might play a role in shared contraceptive decision-making. Women with multiple partners in the last 12 months seem to rely more on themselves to make contraceptive decisions.

The couple's shared responsibility in contraceptive decision-making appeared to be significantly associated with women's current contraceptive use. The contraceptive prevalence rate was highest among women who reported a high degree of shared involvement compared to women without any partner involvement. Conversely, the proportion of contraceptive nonusers was highest among those without partner involvement and lowest among women with a high degree of involvement. Use of male-controlled methods such as condoms and male sterilization were highest among women who reported shared responses across the three questions. This finding is no surprise because joint communication and willingness of male partners to adopt these methods are needed to successfully use them.

Using a cross-sectional survey, this study was unable to establish causality between shared responsibility and contraceptive use or the choice of specific contraceptive methods. Our findings were limited to women's recall of how their partners participate in the shared discussion and selection of a method and assurance that it is used. Additionally, examining couples relationship dynamics without dyadic data[21] was a limitation as we relied solely on the women's response to the questions without taking into account the men's perceptions on

their involvement. These findings were consistent with a study using the National Survey of Men that examined men's perceptions about their role in a couples' decision-making about sex and contraception.[22]

Incorporating couple-focused services, that is involving both men and women into family planning service delivery may be one strategy that could help both of them use contraceptives more successfully. At the same time, the importance of integrating assessment of abuse, both physical and psychological, in family planning counseling should be underscored. Previous research had found that women who reported experiencing psychological abuse or both psychological and physical abuse were significantly less likely to use a contraceptive method than those who had not.[23] Recognizing and addressing the issues of client vulnerabilities and partner interference with birth control are critical components of preventing unintended pregnancy.

Male involvement in the prevention of unintended pregnancy encompasses a broad range of behaviors. Supporting male involvement means not only encouraging them to adopt condoms or male sterilization when appropriate, but equally important, it means providing men with sufficient resources and information to help them and their partners prevent unwanted pregnancy.

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