Factors influencing partners' involvement in women's contraceptive services

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Introduction

Almost half of all pregnancies in the United States are unplanned (1), and unplanned pregnancies have been shown to have negative health and social outcomes for both the mother and child (2, 3). Despite efforts to reduce rates by increasing overall contraceptive use, little significant progress in decreasing unintended pregnancy has been made nationally (1). Recent recommendations have emphasized incorporating a couple-focused perspective into family planning service delivery, with the goal of helping women and couples to be more successful in their use of contraceptives (4).

Unintended pregnancy rates are particularly high among low-income women (1). Thus, publicly supported clinics, funded through the federal Title X program, play an important role in assisting disadvantaged women to plan their families and avoid unintended pregnancies. A recent survey of Title X family planning clinics found that the majority of clinics offer couple-focused counseling, but only a few currently offer couple-focused classes or workshops (5).

Indirect evidence suggests that communication between partners may influence method choice and frequency of use and contribute to contraceptive success by improving overall use and consistency and effectiveness among women already using contraception (6-8). Analytical models which incorporate men's attitudes and characteristics find that they are important predictors of couples' contraceptive use, even net of women's own direct influences (7, 9, 10).

To date, most research on couples and family planning has focused on the relationship between partner and/or partnership characteristics and contraceptive use patterns. However, in order to use most forms of highly effective contraception, women must visit a health care provider. Partner participation in accessing these services may positively influence women's contraceptive use. Therefore we sought to identify characteristics of individual women and of their partnerships that are associated with partners' involvement in seeking and obtaining contraceptive services from publicly supported family planning clinics.

Materials and Methods

Data collection

A nationally representative sample of 2,113 women aged 18-49 receiving family planning services from 45 Title X-funded family planning clinics serving 200 or more clients per year in the United States were surveyed from May to November of 2009 (5). Respondents were identified by first randomly sampling clinics from a regularly updated database of all known publicly funded family planning clinics in the United States. The clinic sampling frame was stratified according to client caseload, facility type and geographic region of the country.

Clinic administrators at sampled facilities were contacted and requested to participate in the study. Participation required that staff distribute the questionnaire to all patients aged 18-49 years old seeking family planning services during a one to two week fielding period. Questionnaires were distributed and filled out on-site; anonymity and confidentiality were ensured by requesting that clients return their questionnaires to clinic staff in a sealed envelope. We conducted extensive follow-up telephone calls with administrators at all sampled and replacement sites in order to solicit their participation and maximize response from sampled sites.

Respondents completed a four-page survey instrument, available in both English and Spanish, consisting of mostly closed-ended questions and asking women about their contraceptive use, childbearing and family planning history and current partner's involvement in family planning decisions. The survey also measured characteristics of the client's current main partner (if she had one) and relationship dynamics, including partners' involvement in past clinic visits.

Facilities that refused and facilities that did not obtain questionnaires from at least 40% of eligible clients seen during the study period were replaced by the next clinic in the stratified sample, which ensured that the replacement clinic was similar to the clinic originally selected for the sample. Eighty clinics were sampled originally. Forty two clinics declined to participate. An additional 32 clinics agreed to participate,

but failed to obtain usable surveys from at least 40% of the eligible patients and 21 clinics were identified as ineligible. In the end, usable data were obtained from 45 clinics.

Participating clinics reported serving a total of 3,538 eligible female clients during the survey period; we obtained useable data from 2,113 of these clients, for a response rate of 60% among clinics surveyed. More detailed information on the sampling and data collection procedures have been previously described (5). The survey instrument and fielding protocol were approved by our organization's Institutional Review Board.

Data Analysis

We limited our analytical sample to women reporting a current sexual partner (N = 1764). Respondents who indicated that they were in a sexual relationship with more than one partner were asked to respond to the survey questions in reference to their main partner. Data were weighted to reflect the total population of women obtaining services at Title X family planning clinics that served 200 or more adult patients annually in 2006, the last year for which information on this universe was available (11).

We focused on partner involvement in contraceptive services as our primary outcome of interest. Three types of *partner involvement* in contraceptive services were measured: assistance with paying for birth control or a clinic visit, accompaniment to the clinic (driving a woman to the clinic or waiting for her during the appointment), and accompaniment during the appointment (either attending the woman's appointment or talking with a clinician regarding her service) (Table 1). From these measures we developed a composite measure of the overall level of partners' involvement: no involvement, partial involvement (women indicated their current partner had been involved in one or two of the three possible involvement categories), and high involvement (women indicated their current partner had been involved in all three of the involvement categories).

From a programmatic perspective, interest in increasing partner involvement in contraceptive services is motivated by an interest in improving contraceptive use. Accordingly, a second outcome of

interest, contraceptive use at last sex (0=No, 1=Yes), was also examined, as was the relationship between this outcome and partners' involvement.

We conducted bivariable and multivariable analyses to examine the association of demographic, reproductive and partner characteristics with our two outcomes, partners' involvement in contraceptive services and use of contraception at last sex. These characteristics included: respondent age, respondent race, respondent education, current union status, duration of relationship, birth history with partner, partner age, partner education, relationship satisfaction, attitude about women's responsibility for contraceptive decision making, whether respondent knew her current partner had had sex with someone else, whether respondent had ever been physically abused or forced to have sex and whether respondent's partner had ever interfered with her contraception. This key independent variable of *partner interference* with contraceptive use was based on women's responses to the statement "He tries to interfere with my birth control use" in reference to their main partner. It was originally measured on a Likert scale of 5 = strongly disagree to 1 = strongly agree and was condensed into a dichotomous outcome of yes (agree or strongly agree) and no (neutral, disagree and strongly disagree). Relationship satisfaction was also measured on a five-point Likert scale ranging from 5 = very satisfied to 1 = very unsatisfied; we condensed this variable into satisfied (scores of 4 or 5), neutral (score of 3) and dissatisfied (scores of 1 or 2). For bivariable analyses we relied on chi-square statistics for categorical variables and we report significant associations at $p < 0.10$.

We constructed two multivariable models. We used ordinal logistic regression to model the relationship between respondent characteristics and the outcome of partners' involvement in contraceptive services. We included all respondent demographic measures as independent variables in the model. Partnership measures with a p value <0.05 in bivariable analyses were included in the multivariable model with the exception of relationship duration and having given birth with current partner, as these two variables were collinear with current union status. We also included the partnership attitudinal measure not

significant in bivariable analysis (women should have main responsibility for contraceptive decisions) because we considered it to have theoretical relevance for our outcome of interest.

In our second model, we used logistic regression to model the relationship between partners' involvement in contraceptive services and the outcome of contraceptive use at last sex, controlling for select respondent characteristics. We included all variables from the first multivariable model of partner involvement in contraceptive services in our original model but, after confirming through testing that the model did not significantly change when omitting independent variables not significantly associated with the outcome in multivariable analyses, we included and report adjusted odds ratios only for our predictor of interest and select respondent demographic characteristics. All analyses were conducted using the survey function within Stata Statistical Software version 11.1 to account for weighting necessary for the clustered sample design in this study (12).

Results

Sample characteristics

Among adult women seeking services at Title X-funded family planning clinics in 2009 who reported having a current male sexual partner, most (53%) were younger than 25 (Table 2). The majority of women in the analytical sample identified as non-Hispanic white (55%), but a substantial proportion was Hispanic (27%) and over half of Hispanic women reported being born outside the US. The distribution of women based on age, race, ethnicity and union status is very similar to the national population of women receiving publicly funded services in 2008 (13).

Approximately half of the sample had attended some college. Most women had used some form of contraception at last sexual intercourse, and this was most often a female-controlled method. More than half of respondents (55%) reported being married or cohabiting with their current sexual partner. A majority had been in the current relationship for more than a year and fewer than a third had given birth to a

child with their current partner. The age distribution for women's partners was slightly older than for women themselves, with 45% of women having partners at least three years older (not shown).

Women's partners' educational attainment was slightly less than for women themselves, with 63% of women having the same education level as their partner and 22% having a higher level (not shown). Overwhelmingly women in the sample reported being satisfied with their relationships. The majority of women disagreed that it should be mainly a woman's responsibility to make decisions about birth control. Slightly more than a quarter of the sample (26%) reported that they had ever been physically abused or forced to have sex by a partner. One in six (17%) women in the sample indicated that their current partner had had sex with someone else, and eight percent reported their current partner had interfered with their use of birth control.

Characteristics by partners' involvement in contraceptive services

More than half of the women in the sample (56%) indicated that their partners were at least partially involved in their contraceptive services — assisting them with payment, accompanying them to the clinic and/or into their appointment — and 20% reported that their partners were involved in all three of these activities. A substantial proportion of women (44%) reported that their partners had not been involved in any aspect of their contraceptive services.

Women's partners' involvement in contraceptive services increased with women's age but not with women's education level. As might be expected, married or cohabiting women were significantly more likely than women not living with their partners to report greater partner involvement in their contraceptive services. Similarly, high partner involvement in contraceptive services was more often reported among women who had been in a relationship for at least a year as compared to women in shorter relationships. Half of women who had given birth with their current partner indicated that their partners were very involved in their contraceptive services, as compared to only 10% of women who had not had a child by their current partner.

Partner age followed a similar trend in relationship to partners' involvement in contraceptive services as did respondent age; as women's partners got older, they were more likely to be very involved in women's contraceptive services. The opposite was true for women's partners' educational level; as partners' educational level increased, their involvement in contraceptive services decreased. Women who reported being satisfied with their current relationship were more likely to have at least partial partner involvement in contraceptive services. However, women who reported being either dissatisfied or satisfied with their current relationship, were more likely to report high partner involvement in contraceptive services than women who were neutral about their relationship. Women who indicated that their current partner had had sex with someone else were marginally more likely to report no involvement by that partner in their contraceptive services. Finally, women who indicated that their partners interfered with their birth control use were twice as likely to report high partner involvement in contraceptive services as were those whose partners did not interfere.

Multivariable findings

The multivariable model of partners' involvement in contraceptive services largely reflects associations observed in bivariable analyses (Table 3). Adjusted odds ratios significant in the ordinal logistic regression model indicate that, compared to the reference category, the characteristic is associated with an increased (OR>1.00) or decreased (OR<1.00) likelihood of partner involvement in contraceptive services. However, once other demographic and partnership characteristics are taken into account, respondent age and partner age were no longer significantly associated with partners' involvement in contraceptive services. After controlling for age, education, partner age and attitude towards women having full responsibility for birth control, we find that race/ethnicity, union status, relationship satisfaction and partner interference with birth control were all significant predictors of partners' involvement in contraceptive services. Specifically, compared to non-Hispanic white women, foreign-born Hispanic women were almost four times as likely and non-Hispanic black women were twice as likely to report partners' involvement with contraceptive

services. Women who were married or cohabiting with their partner were almost nine times as likely as women in casual or multiple relationships to report increasing levels of partners' involvement. Women satisfied in their relationships were almost twice as likely as women who are neutral about their relationships to have involved partners. Finally, even when controlling for demographic and other partnership variables, women reporting that their partners interfere with their birth control were also likely to report those partners being involved in their contraceptive services, a pattern we elaborate on next.

Although only a small proportion of women in the sample indicated that their current partners had interfered with their use of birth control (8.1%), the estimated association between partner interference and partner involvement with contraceptive services prompted us to examine this relationship in greater detail. The proportion of women reporting partner interference with birth control increases significantly as partner involvement with contraceptive services increases (Figure 1). Specifically, 13% of women with partners who are very involved in their contraceptive services indicated that their partners also interfered with their birth control as compared to 4% of women whose partners had no involvement in their contraceptive services.

A similar relationship between the individual components of partner involvement with contraceptive services and partner interference with contraception was observed. Respondents who indicated that their partners (1) helped to pay for birth control or a clinic visit, (2) drove them to the clinic or waited for them during their appointment, or (3) accompanied them during their appointment or talked to a clinician regarding their services were significantly more likely to report partner interference with their contraception in all three instances (data not shown).

Association between partner involvement in contraceptive services and contraceptive use

Our analysis finds that contraceptive use at last sex was not associated with our measure of partners' involvement in obtaining contraceptive services from publicly funded clinics in either bivariable or multivariable analyses, even when controlling for the age, race/ethnicity and union status of the respondent

(Table 4). Women whose partners are partially or very involved in their contraceptive services are equally likely as women whose partners are not similarly involved to indicate that they had used a contraceptive method the last time that they had sex.

Discussion

Couple-focused family planning services have been promoted as a strategy for reducing rates of unintended pregnancy at the national level (4, 14, 15). Our data indicate that certain subgroups of women are more likely than others to already have their partners involved in their contraceptive services, in terms of assisting with payment for and/or transportation to services, accompanying women to family planning clinics and appointments, and talking to a health care provider at the clinic. In designing couple-focused programs, providers may find that clients with more involved partners may more easily be recruited into such programs. For example, women in more committed relationships – married and cohabiting women – are more likely to have partners who have been involved in the logistical aspects of their receipt of clinic-based contraceptive care than are women with non-cohabiting partners and may be more willing to attend a couple-focused program or other service. On the other hand, providers may face challenges in expanding couple-focused services to meet the needs of non-cohabiting women and their partners.

Partner involvement is particularly high among foreign-born Hispanic women. There are a number of potential explanations for greater partner involvement among foreign-born Hispanic women, including an increased need for help from a partner in navigating the health care system; a potential need for partners' assistance with English translation during clinic visits, and a greater need for their partner to drive them to the clinic and pay for the services received (16). Given the greater involvement among the partners of foreign-born Hispanic women, advocating for increased cultural sensitivity in couple-focused service delivery is warranted (17). Additionally, more general efforts to reduce barriers to care for foreign-born women, such as translation services, are needed.

The promotion of couples' family planning services is based on the premise that partner involvement with contraception is an optimal outcome; our findings, however, indicate that this may not necessarily always be the case. The unexpected association observed between partner interference with contraception and partners' involvement in contraceptive services suggests that some partners may use their involvement as a means of controlling when and how and even if a woman is able to obtain contraceptive services. Additionally, both women who indicated that they were satisfied and those who were dissatisfied in their relationship reported higher levels of partner involvement in contraceptive services than did women who felt neutral about their relationship. Clinics should be aware that partners can be over-involved to the point of women feeling that they are interfering with their birth control. Health care providers in these settings can play a role in assisting clients to address their partners' controlling behaviors regarding contraception (18).

Partners' involvement around receipt of clinical contraceptive services was not significantly associated with contraceptive use at last intercourse, even when controlling for personal and partnership characteristics. However, there are likely important substantive differences between the type of partner involvement measured here and the type of partner involvement that includes communication within the dyad of the partnership in the more private sphere. Other studies provide strong evidence of the importance of partner involvement in this private sphere, as measured by union status (19-21) partner communication (22-24) and joint decision making (25-27), on contraceptive use. In designing couple-focused services, providers need to be sure to include activities that encourage or enhance partner involvement in the private sphere, such as facilitating dialogue between partners about contraceptive use and pregnancy planning, rather than on simply encouraging partners to be more involved in the logistical aspects of seeking and obtaining contraception. Our findings indicate that while encouraging or facilitating partners to be involved logistically (e.g. driving their partners to their appointment or accompanying them into their appointments) may be helpful for some women, it is insufficient to impact contraceptive behavior change.

This study faces a number of methodological limitations. By limiting our sample to women with current partners, these findings may not be generalizable to the full population of women seeking services at publicly funded family planning clinics, where 16% of women reported not having a current sexual partner at the time of the survey (5). Additionally, we are limited in the range of types of partner involvement in contraceptive care measured. For example, we do not have any measures regarding partners' involvement in decision-making around contraceptive use.. For married or cohabiting women who have joint finances with their partner, it is difficult to interpret responses regarding payment assistance from a partner. Overall, however, due to the strengths of having a large and randomly selected sample, our findings are robust and generalizable to women with current sexual partners who seek services at Title X funded family planning clinics.

Couple-focused services may offer clinics an innovative approach to assist some women to more effectively use contraception, and ultimately, decrease national rates of unintended pregnancy. The findings of our study suggest a number of challenges that service providers need to consider when implementing this approach. Programs may need to focus on couples' communication and decision making, more than on increasing partners' facilitative role in accessing services. Couple-focused programs and counseling that seek to strengthen and develop joint responsibility and decision making may have potential to improve contraceptive use. Clinics may also consider tailoring classes and counseling sessions given the characteristics of clients who have partners that are already logistically involved with their contraceptive care, and therefore more accessible to these services. Finally, staff involved in couple-focused services need to be sensitive to cases where partner involvement is combined with partner interference and control. Even when serving a female client alone, clinicians must always be cognizant and sensitive to women's reports of the level of male partner involvement with their contraceptive services, as there may be a fine line between partner involvement and partner interference with contraception.

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Table 1: Summary of partner involvement measure

Partners' involvement in contraceptive services - response categories	% (weighted)
Has [your current] sex partner ever...	
…Helped pay for your birth control method or clinic visit?	40
…Driven you to your clinic appointment or gone with you to the clinic and waited while you had your appointment??	54
…Gone with you into the examination room at the clinic or talked with the doctor or nurse that you saw at the clinic?	29

Note: Population includes all women who report having a current sexual partner (N=1764)

Table 2: Percentage distribution of women with current sexual partners seeking services at publicly funded family planning clinics in the United States in 2009 by selected respondent characteristics and bivariable associations between these characteristics and partners' involvement with contraceptive services

	Total	**Partners' involvement with contraceptive services**			
	(N=1764)	No involvement	Partial involvement	High involvement	Total
	%	%	%	%	**%**
Demographic characteristics	100	44	37	20	100
Age					
18-24	53	44**	41	15	100
25-29	25	44	35	21	100
30+	22	42	26	32	100
Race					
Non-Hispanic white	55	50***	37	13	100
Non-Hispanic black	14	43	37	21	100
Other non-Hispanic	4	38	52	11	100
US-born Hispanic	11	42	40	18	100
Foreign-born Hispanic	16	24	25	51	100
Education					
At least some college or above	50	46	36	18	100
0-11th grade	16	42	31	28	100
High school graduate or GED	35	41	39	20	100
Contraceptive use					
Method used at last sex					
None	10	37	39	23	100
Male method	28	47	34	19	100
Female method	40	39	40	21	100
Both male and female method	21	50	34	16	100
Partnership characteristics					
Relationship commitment					
Current union status					
In one or more casual relationships	11	80***	15	6	100
In a steady relationship	34	59	34	6	100
Married or cohabiting	55	24	44	32	100
Duration of relationship					
<= 1yr	30	67***	30	4	100
> 1 yr	70	31	42	28	100
Given birth with current partner					
No	71	53***	37	9	100
Yes	29	16	35	49	100

Partner demographics					
Partner age					
18-24	38	45**	42	14	100
25-29	28	41	38	20	100
30+	33	40	30	30	100
Partner education					
At least some college and above	43	48†	36	17	100
0-11th grade	17	31	40	29	100
High school graduate or GED	40	42	38	21	100
Partnership attitudes					
Satisfaction with current relationship					
Dissatisfied	7	56**	28	17	100
Neutral	14	60	29	11	100
Satisfied	79	38	40	22	100
Women should have main responsibility for contraceptive decisions					
No	60	40	39	21	100
Yes	40	46	35	19	100
Potential vulnerabilities					
Partner had concurrent sex with someone else					
No	83	40†	39	21	100
Yes	17	54	28	18	100
Ever physically abused or forced to have sex					
No	74	43	38	20	100
Yes	26	47	34	19	100
Partner interference with bc use					
No	92	44*	38	19	100
Yes	8	28	34	38	100

Notes: Population is restricted to women who responded “yes” to current sexual partner (N = 1764). Asterisks and daggers indicate that chi-square tests of the entire specific crosstabulation are significant at * p <0.05, ** p <0.01, *** p <0.001, or marginally significant at †p <0.1.

Table 3: Adjusted odds ratios from ordinal logistic regression analysis of partners' involvement with contraceptive services by selected respondent characteristics

	Adjusted Odds Ratios
Demographic characteristics	
Age	
18-24	ref
25-29	0.7
30+	0.78
Race	
Non-Hispanic white	ref
Non-Hispanic black	2.05*
Other non-Hispanic	1.49*
US-born Hispanic	1.54†
Foreign-born Hispanic	3.90**
Education	
At least some college or above	ref
0-11th grade	0.95
High school graduate or GED	0.93
Partnership characteristics	
Relationship commitment	
Current union status	
In one or more casual relationships	ref
In a steady relationship	1.75
Married or cohabiting	8.98***
Partner demographics	
Partner age	
18-24	ref
25-29	1.17
30+	1.24
Partnership attitudes	
Satisfaction with current relationship	
Dissatisfied	1.61
Neutral	ref
Satisfied	1.86*
Women should have main responsibility for bc decisions	
No	ref
Yes	0.77

Potential vulnerabilities	
Partner interference with bc	
No	ref
Yes	1.73†

Notes: Population is restricted to women who responded “yes” to current sexual partner (N = 1764). Asterisks and daggers indicate that differences between the category and the reference category are significant at * p <0.05, ** p <0.01, *** p <0.001, or marginally significant at †p <0.1.

Figure 1

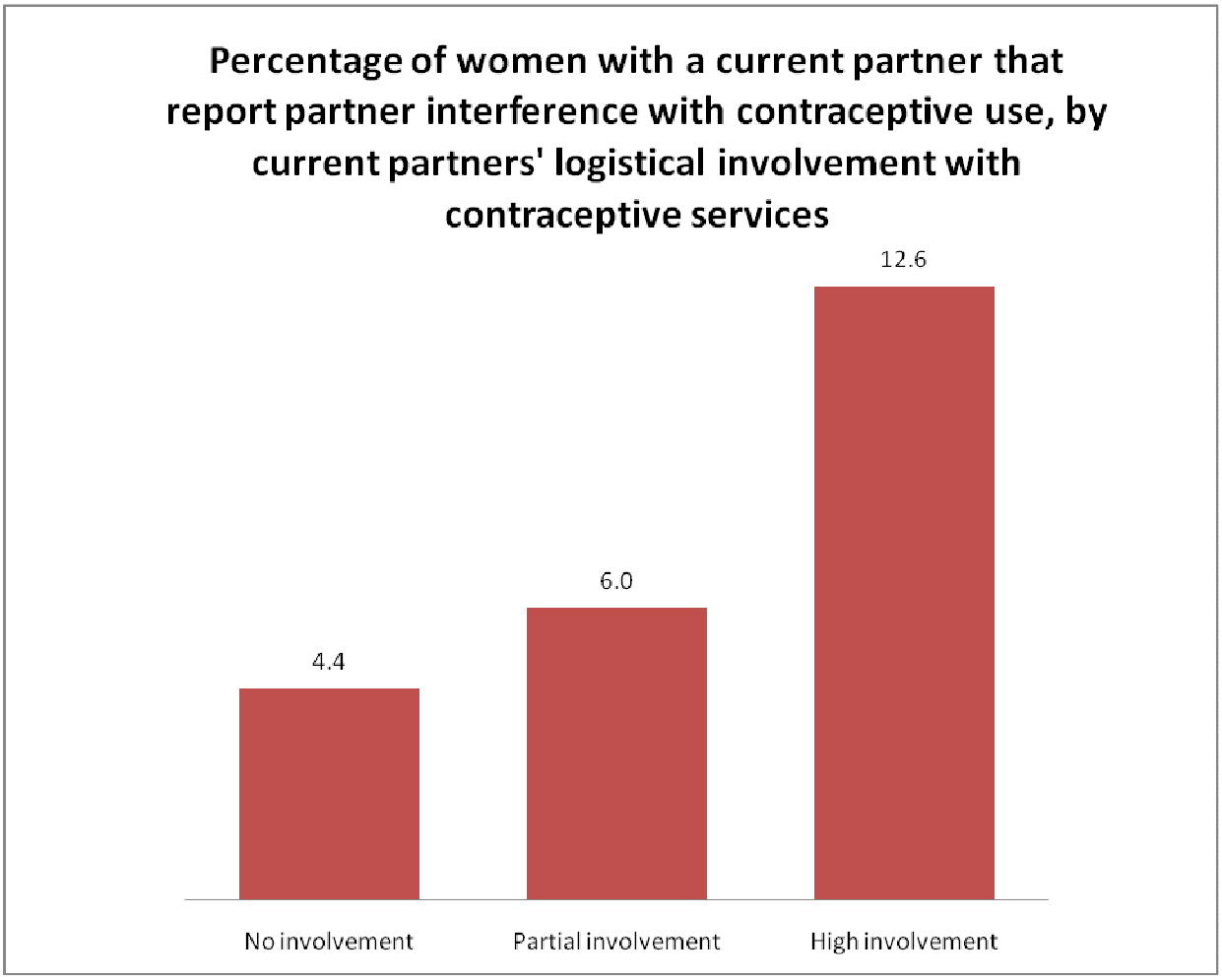
Percentage of women with a current partner that report partner interference with contraceptive use, by current partners' logistical involvement with contraceptive services
12.6
6.0
4.4
No involvement
Partial involvement
High involvement

Table 4: Unadjusted and adjusted odds ratios from logistic regression analysis of use of contraceptive method at last sex by selected respondent characteristics

	Contraceptive method use at last sex	
Characteristics	**Bivariable Odds Ratios**	**Multivariable Odds Ratios**
Age		
18-24	ref	ref
25-29	1.03	0.89
30+	0.95	1.05
Race		
Non-Hispanic white	ref	ref
Non-Hispanic black	1.26	1.26
Other non-Hispanic	0.76	0.78
US-born Hispanic	1.83†	1.93*
Foreign-born Hispanic	0.82	0.56
Current union status		
In one or more casual relationships	ref	ref
In a steady relationship	1.29	1.09
Married or cohabiting	2.39*	2.97**
Partners' involvement with contraceptive services		
No involvement	ref	ref
Partial involvement	1.24	0.86
High involvement	1.45	0.95

Notes: Population is restricted to women who responded “yes” to current sexual partner (N = 1764). Asterisks and daggers indicate that chi-square tests of the entire specific crosstabulation are significant at * p <0.05, ** p <0.01, *** p <0.001, or marginally significant at †p <0.1.