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Partner Roles in Contraceptive Use: What Do Adolescent Mothers Say?

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Abstract

Study Objective—To examine the role of sexual partners in adolescent mothers' use of non-coital dependent contraceptive methods in the postpartum period.

Design/Setting/Participants—40 African American adolescent mothers completed surveys and qualitative interviews during the first postpartum year as part of a larger longitudinal study in Chicago, Illinois. Themes related to contraception and sexual partners were analyzed.

Main Outcome Measures—Adolescent mothers' reports of partners' roles in the use of non-coital dependent contraceptive methods (i.e., oral contraceptives, intrauterine contraception, and depot medroxyprogesterone acetate).

Results—Partners largely supported the use of non-coital dependent contraceptive methods, yet mechanisms of support varied greatly, from advocating for specific methods to facilitating participants' continuation of their chosen method. Unsupportive partners either expressed concerns about the safety and side effects of specific methods or desired another child in the near future. Participants valued these preferences to different degrees when making their contraceptive decisions.

Conclusions—Partners of adolescent mothers play varying roles in postpartum contraceptive decisions. They thus have the potential to both inhibit and facilitate the use of non-coital dependent contraception. Quantitative research is needed to further evaluate how partner attitudes and support behaviors, among other factors, affect contraceptive initiation and continuation among adolescent mothers.

Keywords

adolescent; African American; postpartum period; qualitative; partner communication; contraception

INTRODUCTION

Adolescent mothers typically resume sexual activity within two to three months of delivery.¹ As many as half of adolescent mothers do not consistently use hormonal

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contraception, and almost two thirds do not consistently use condoms.² Thus, up to 40% of adolescent mothers experience a repeat pregnancy within 24 months of giving birth.² National data indicate that repeat teen births comprise a larger proportion of births to Hispanic and non-Hispanic African American adolescents (22% and 23%, respectively) compared to their non-Hispanic white (17%) and Asian/Pacific Islander (19%) peers.³ As repeat adolescent pregnancy poses risks for both the mother and the child, it is critical to understand the factors influencing contraceptive use among postpartum adolescents, particularly among African Americans.

Partners' attitudes and support behaviors are among the many variables shaping women's initiation and continued use of contraception. Partner influence on condom use has been well documented, in part because condom use requires partner cooperation.^{4,5} It is less understood how partners affect the use of non-coital dependent methods—such as oral contraceptives (OCs), depot medroxyprogesterone acetate (DMPA) and the intrauterine device (IUD)—especially among adolescents. These methods are more effective at preventing pregnancy than condoms and other coital dependent methods such as withdrawal, and therefore play an important role in preventing rapid repeat pregnancy among postpartum adolescents.

Adolescent mothers' contraceptive patterns differ from those of their adult counterparts⁶ and nulliparous peers,⁷ and their partners may influence their contraceptive behaviors in distinct ways. Yet, to date, no study has examined in depth how partners of adolescent mothers affect the initiation and continuation of non-coital dependent contraceptive methods in the postpartum period. We sought to fill this gap by exploring reports of male partners' contraceptive roles among a population at high risk of rapid repeat pregnancy – African American postpartum adolescents.

MATERIALS AND METHODS

We analyzed data from the Postpartum Adolescent Birth Control Study (Postpartum ABCs), a longitudinal, mixed-methods study of African American adolescent mothers exploring contraceptive use and risk of repeat pregnancy in the first postpartum year. Detailed study methods have been published previously.⁸ Briefly, pregnant and postpartum adolescents were recruited via referral from medical staff, social workers, community-based programs, and schools in Chicago and, toward the end of the study, through snowball sampling. Eligibility criteria included self-identified African American race, 14–18 years of age, primiparous, 13 weeks postpartum, and Chicago residence. The University of Chicago's Institutional Review Board approved the research. We obtained written informed consent or assent as well as parental consent from participants under the age of 18.

Following enrollment, participants completed qualitative, in-depth interviews – conducted by female research staff in a private place in their homes – five times (approximately every three months) throughout the year. The interview guide, developed from focus groups with young African American mothers, included questions related to contraceptive use as well as relationship dynamics (with parents, peers, and partners), physical changes in the postpartum period, future goals, and neighborhood safety. Participants were also surveyed at six and 12 months to indicate major life events, including those related to their romantic partners; these data were used to describe general relationship dynamics and contextualize our results. Participants received \$20 for each completed study visit. All data collection took place between October 2006 and August 2008.

Transcribed interviews were reviewed and coded iteratively with emergent themes using ATLAS.ti 5.0 (Scientific Software Development, GmbH, Berlin, Germany). For the present

analysis, we queried codes relating to sexual partners and contraception to examine partners' roles in the use of non-coital dependent contraceptive methods (i.e., OCs, IUDs, and DMPA). We defined "role" to include actual reported behaviors as well as participants' subjective perceptions of partner support. We considered all male sexual partners, including babies' fathers if present, to account for the many relationship types and transitions during the study period. We synthesized our findings in thematic matrices that outlined the levels and mechanisms of partner support for contraception. We chose representative participant quotations to illustrate each theme.

RESULTS

Forty participants enrolled in the study and 31 completed all five study visits. Participants ranged in age from 15 to 18 years old, with the majority initiating sexual activity at the age of 14 or 15 (Table 1). All participants but one were sexually active during the study, and a slight majority of participants remained with the father of the baby during the postpartum year. The remaining participants were either with another steady partner or involved with multiple partners during the study period. While we did not collect the ages of all of the participants' partners, the fathers of their children ranged from ages 15 to 22.

The majority of participants felt that their partners played a supportive role in their contraceptive use. We identified four themes (Table 2) among partners playing supportive roles, which were almost exclusively limited to verbal expressions of opinions and preferences. Some partners merely supported the adolescent mother's own decision to use contraception. In these cases, the participant would suggest a method, and the partner would agree with her, often without expressing additional opinions. A handful of participants, however, reported that their male partners actively encouraged birth control use. These partners were responding to the adolescent mother's ambivalence toward contraception and either took it upon themselves to initiate a conversation about contraception or more firmly insisted that she begin using a method soon after giving birth. While some partners were supportive of any contraceptive method, others advocated for specific methods. These partners mostly supported longer acting methods (i.e., DMPA and the IUD), often due to concerns that the participant would not remember to take OCs every day. Some of these partners developed concerns later in the postpartum period, only after seeing the adolescent mother struggle with OC adherence. Lastly, some partners played a role in method continuation. For example, participants reported their partners picking up prescriptions and reminding them to take their OCs or get their DMPA injection. Yet, another participant described threatening behavior. This participant reported that her partner was very involved in her contraceptive use (going to her doctor's appointments and reminding her to take OCs), however she also explained that: "He get mad at me if I don't take [OC] so I don't tell him, or he'll hit me."

Some adolescents reported that their partners discouraged contraceptive use. We identified three themes describing these unsupportive roles (Table 3). We did not identify any specific behaviors preventing contraceptive use. Rather, unsupportive partners verbally expressed negative contraceptive opinions and attitudes to the adolescent mother. Most commonly, partners worried about evident and potential side effects of highly effective methods like DMPA and the IUD. Concerns were similar to those expressed by participants themselves, including changes in bleeding, weight gain, weight loss and hair loss. One participant reported that her partner said she was going to grow hair on her face from using DMPA. Partners also had misconceptions that methods—like hormonal methods and the IUD—put the adolescent mother in danger. In addition to concerns about the methods themselves, a handful of participants reported that their partner did not support contraception at all due to a desire to have another child in the near future.

Partner support for contraception also fluctuated. Five participants reported their partners changing their level of support for contraception during the study period—in all cases, support decreased. Notably, two partners initially supported contraceptive use, however began discouraging contraceptive use later in the postpartum period after deciding they wanted to have another child. The remaining partners began discouraging contraceptive use after seeing side effects from a method they had initially supported.

Regardless of whether partners encouraged or discouraged the use of non-coital dependent contraception, their roles were further defined by the attitudes and behaviors of the adolescent mother herself. Specifically, participants involved partners in contraceptive decisions to varying degrees. While some adolescent mothers chose to make contraceptive decisions jointly with partners, others did not to take partner opinions into consideration. The latter was most common among participants whose partners discouraged contraceptive use. For example, one participant reported, “If it was up to him, I’d be pregnant again, so... no, I wouldn’t leave it up to him. It’s all up to me.” In this case, then, although the partner discouraged the adolescent mother’s use of contraception, his role in her decision to use contraception was minimal, because she did not value his opinion. A handful of participants did not seek their partner’s opinion at all, instead informing partners of their decision only after initiating the method. These participants’ responses exhibited a high level of perceived agency; for example: “it’s a woman’s thing, you figure it out,” “I really don’t care what he thinks,” and, “whatever I choose, it’s my body, whether he likes it or not.” Thus, partner roles were at times limited to only the period after contraception was initiated. It is important to note that the degree to which participants chose to involve their partners in the contraceptive decisions sometimes changed over time, as they entered into new relationships or as existing relationships evolved.

DISCUSSION

Partners assumed a variety of roles in the context of adolescent mothers’ contraceptive decision-making. Roles fell along spectrums of both support and involvement, and were defined by the attitudes and behaviors of the male partner and the adolescent mother herself. Some partners were active in their support of, or opposition to, specific methods; others were generally encouraging of participants’ chosen methods; while others opposed contraception altogether because they desired another child. Many adolescent mothers seemed to value partner input, yet others chose not to involve their partner in their contraceptive decision-making at all. This study did not examine predictors of partner involvement or support, however previous qualitative research with young men has suggested that relationship type—casual or committed—influences how openly partners discuss contraception.⁹ Quantitative research has also shown that teenagers whose partner had other partners in the past year were less likely to report that he was supportive of their contraceptive clinic visit.¹⁰ Therefore, the variation that we observed in this study partly reflects the many different types of sexual relationships in which adolescent mothers are involved; indeed, 40% of our sample reported at least one relationship dissolution during the study period.

While partners varied greatly in their contraceptive roles, supportive functions were dominant in participants’ responses. A couple of partners recognized the difficulty with which adolescent mothers remembered to take OCs and therefore supported longer-acting, more effective methods. Although our study did not quantify the degree to which partner attitudes and support behaviors affected contraceptive uptake and continuation, research in adults indicates that women who believe that their partners are “very” supportive of contraception are twice as likely to use contraception effectively.¹¹ Men’s contraceptive preferences have also been shown to predict what method his partner uses, independent of

the woman's own preference.¹² Future research is needed to determine if partners similarly influence adolescents' postpartum contraceptive use and if adolescents are especially vulnerable to the contraceptive opinions and attitudes of their partners.

Our research also demonstrates how partner involvement in contraceptive decisions has the potential to be a detriment to an adolescent's uptake or continuation of a given method. A handful of partners had misconceptions about birth control—particularly the IUD and hormonal methods; previous studies have documented some of these fears among young men.⁹ Partner confusion about safety and side effects can inhibit their ability to encourage effective contraceptive methods.¹³ Misconceptions about the IUD are especially important to note, as failure to initiate long-acting, reversible contraception within three months of delivery has been shown to be a strong predictor of unintended repeat pregnancy for adolescent mothers.¹⁴ This highlights a need for strategies that engage male partners in education about highly effective methods of contraception, not just condoms.

This study has a number of implications for future research and clinical interventions. Partners have the potential to influence contraceptive use and, ultimately, rates of repeat pregnancy. Attempts to engage partners in discussions about contraception may largely benefit postpartum adolescents, as their partners are most often supportive of contraceptive use. Best practices for engaging young male partners in contraception—e.g., through education, outreach, or joint-clinic visits – are elusive but will provide critical guidance for interventions seeking to reduce repeat adolescent pregnancy. Partner support for contraception may be particularly important in the later postpartum period, when adolescents' use of newly adopted methods begins to wane.⁷ Continuing to engage partners in contraceptive clinic visits (during follow-up appointments, for example) may help maintain partner encouragement for contraception and prevent declining support described by participants over the course of the study.

As we move towards increasing partner involvement in contraceptive decision-making, we must also work to understand what predicts whether partner engagement will positively impact the adolescent mother, given the unsupportive roles played by some partners. Understanding what made some participants resilient to discouraging attitudes by their partners may also help educators and clinicians encourage contraceptive use among patients with unsupportive partners. Clinicians should keep in mind that rarely, increasing partner involvement in contraception may also serve to increase a male's reproductive control over his female partner.¹⁵ While the role of reproductive coercion within postpartum adolescent relationships was not explored in depth in our study, almost a fifth of participants reported physical abuse by their partner during the postpartum year and a few adolescent reported their partners' strong desires to have another child. Recent research suggests that contraceptive sabotage—e.g. hiding OCs, removing the patch or the ring—may explain some of the observed association between unintended pregnancy and intimate partner violence.¹⁶ In addition, we learned of one case in which a partner threatened the adolescent mother with violence if she forgot to take her OCs. Male partners who are highly motivated to prevent repeat pregnancy should be taught about appropriate ways to encourage contraceptive use, such as picking up prescriptions and reminding and encouraging contraceptive visits. Role-playing may be a way to model healthy behavior while discouraging reproductive control, threats, and violence.¹⁷

One limitation of this study is that qualitative interviews were conducted with the adolescent mothers themselves, and not with their partners, preventing us from verifying participant reports. Yet, an adolescent's perceived support from her partner, rather than objective levels of support, is what ultimately affects her contraceptive decisions. Additionally, our research was conducted with a homogeneous population, perhaps limiting the generalizability of our

themes to other populations. At the same time, our focus on African American adolescents provides rich and unique insight to a population at especially high risk of rapid repeat pregnancy. Ultimately, this study adds to the incredibly sparse literature on the dynamics of contraceptive decision-making within adolescent dyads in the postpartum period, highlighting the varying roles played by males during contraceptive uptake and continuation. Sustained use of highly effective contraception is the most powerful prevention strategy for repeat adolescent pregnancy.^{18, 19} Thus, an increased understanding of partners' roles in contraceptive decisions could make an important contribution to pregnancy prevention interventions for adolescent mothers.

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TABLE 1

Demographic and relationship characteristics of sample

	% (n) ^a
Age at childbirth (years)	
15	10.0 (4)
16	22.5 (9)
17	30.0 (12)
18	37.5 (15)
Age at first intercourse (years)	
12 or 13	15.0 (6)
14 or 15	52.5 (21)
16 or 17	32.5 (13)
Lifetime sexual partners at baseline	
1	27.5 (11)
2-3	40.0 (16)
4-5	22.5 (9)
>5	10.0 (4)
Experiences during the postpartum year	
Broke up with a partner	40.6 (13)
Felt rejected by partner	21.9 (7)
Moved in with partner	18.8 (6)
Got hit by partner	18.8 (6)
Relationship trajectories in the first postpartum year	
Baby's father most of the time	59.4 (19)
Another steady partner most of the time	15.6 (5)
Multiple partners	21.9 (7)
Not sexually active	3.1 (1)

^aDenominator is 40 for all variables except "Experiences" and "Relationship trajectories," where only 32 participants completed 12-month visits that captured this information.

Table 2

Supportive themes relating to partner roles in participants' contraceptive use

Partner attitude/behavior	Representative participant quotations
Supports participant's decision to use contraception	<p>"He's okay with [DMPA]. He say whatever is best, whatever I think is best." (<i>age 17</i>)</p> <p>"I asked him like do you think I should go get this prescription [for OCs]...Of course he agreed and everything. We're not looking for any more kids at this time...It was just pretty much a conversation that just came up that we agreed on." (<i>age 16</i>)</p>
Insists participant use contraception	<p>"He was just like, you know you gonna get on birth control right? Cause we was reading a book and I ain't know that you could get pregnant within 6 weeks after having a baby. I didn't know that. And he like, well if we gonna be having sex, you gonna get on the birth control." (<i>age 18</i>)</p> <p>"Birth control was basically his idea as soon as he found out I was pregnant. He said after I had my child I was getting on birth control so ...he was the person who basically talked me into getting birth control." (<i>age 17</i>)</p>
Advocates for a longer acting contraceptive method	<p>"He said that he knew I wouldn't remember the pill, I knew I wouldn't remember the pill. So he said the shot would be the best thing cause it's like every three months, like that." (<i>age 18</i>)</p> <p>"He saw how I was taking birth control pills and I wasn't taking them how I was supposed to. So he put the idea in my head [to get the IUD] so I did." (<i>age 18</i>)</p>
Plays a role in method continuation	<p>"He try and remind me [to take OCs] and everything. Every night when he get off work, he'll call." (<i>age 18</i>)</p> <p>"He just kind of try to remind me or ask me did I make my appointment or did I get my shot." (<i>age 17</i>)</p>

Table 3

Unsupportive themes relating to partner roles in participants' contraceptive use

Partner attitude/behavior	Representative participant quotations
Dislikes side effects	<p>"He was telling me that I need to get off the shot for a minute cause it keep making my hair come out." (<i>age 18</i>)</p> <p>"He was saying if it keep making me lose weight he want me to get off the shot." (<i>age 18</i>)</p>
Expresses concerns about safety of contraception	<p>"He just felt as though that I shouldn't be using [combined hormonal methods] 'cause if you know what was going around at college, blood clots and all that, he just didn't want me using that." (<i>age 18</i>)</p> <p>"...We talked about the IUD before I had got it and he didn't want me to get it because the fact that something being in there, you never know what can happen." (<i>age 16</i>)</p>
Desires another child	<p>"It was all my idea to [to get on DMPA]. He didn't want me to get on nothing...He say he want another baby. But I'm, I'm not ready. I don't want one...I'm not having no more kids." (<i>age 18</i>)</p> <p>"We talked about [birth control] after I had my baby...he was the one that was telling me that I should be using birth control and you know putting the pressure on me. But by him being around my baby so much, he figured that he want a baby...so we never talked about it after that." (<i>age 17</i>)</p>