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Do as we say, not as we do: experiences of unprotected intercourse reported by members of the Society of Family Planning

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Abstract

Objectives: We examine the lifetime and past-year prevalence and circumstances of unprotected intercourse among members of the Society of Family Planning (SFP), a professional reproductive health organization in the United States.
Study design: We invited the membership of SFP (n=477) via email to participate in an anonymous online survey. The response rate was 70% (n=340). We asked whether respondents had *ever* and *in the past year* had unprotected vaginal intercourse when not intending a pregnancy and, if so, how many times, under what circumstances, and at what age the first time. We then asked about unprotected vaginal, anal, or oral intercourse *ever* and *in the past year* under three different scenarios relating to sexually transmitted infections (STIs): (1) partner STI status unknown, respondent STI-free; (2) partner known infected, respondent STI-free; (3) partner STI-free, respondent STI status unknown or known infected. Each scenario included questions about the number of times, applicable circumstances, and age at first time.
Results: Forty-six percent of respondents had ever had unprotected vaginal intercourse when not intending pregnancy, 7% within the past year. Sixty percent had ever had unprotected vaginal, anal, or oral intercourse with a partner whose STI status was unknown, 12% within the past year. Four percent had ever had unprotected intercourse with a partner known to have STI, and 8%, with an STI-free partner when they themselves either had an STI or did not know their STI status.
Conclusions: Ever having taken a risk with respect to pregnancy and/or STIs is common among our sample of reproductive health professionals.
Implications: Most reproductive healthcare professionals in our sample have taken sexual risks in their lifetime and a small proportion has done so in the past year. These findings could inform counseling by encouraging healthcare professionals to reflect upon their own experiences when developing strategies to promote safe sex among their patients.

Keywords: Unprotected sex; Unprotected intercourse; Healthcare professionals; Unintended pregnancy; Sexually transmitted infections

1. Introduction

Despite reproductive health professionals' role in preventing unintended pregnancy and sexually transmitted infections (STIs), no published studies document their own experiences of sexual risk-taking behavior. Previous research from family medicine and psychiatry focusing on the lifestyle determinants of illness and preventative strategies involving health behavior change has demonstrated frequent discrepancies between healthcare professionals' recommendations to their patients and their own personal behaviors [1–3]. In light of these documented gaps between actions and advice, we sought to examine unprotected intercourse among reproductive health providers and researchers.

In the United States, just over half (51%) of all pregnancies occurring each year are unintended [4] and around 20 million new STIs are diagnosed each year [5]. Studies attempting to directly measure the prevalence of unprotected intercourse vary widely in sample size, timeframe, and sample characteristics [6]. A study of 1392 women recruited from 13 family planning clinics across the US found that 46% had engaged in unprotected intercourse within the past 3 months [7]. Moreover, data from the 2006–2010 National Survey of Family Growth show that 11% of women at risk of unintended pregnancy are not using contraception [8].

Many approaches to minimize the risks of sexual behavior, including harm reduction strategies [9], are recognized by the Centers for Disease Control and Prevention (CDC). In this paper, we focus on the guidance

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for minimizing the risks of STIs and unintended pregnancy described in the US Selected Practice Recommendations for Contraceptive Use [10–12]. To prevent STIs, correct and consistent use of condoms (or other barriers such as dental dams) with all partners is recommended for every episode of vaginal, anal, or oral sex outside of a mutually monogamous relationship with an uninfected partner [10,11]. To prevent unintended pregnancy, correct and consistent use of an appropriate contraceptive method is recommended at every act of intercourse where the female partner is at risk of unintended conception [12].

The specific objective of this study is to explore recent and past experiences of unprotected intercourse among a sample of reproductive healthcare professionals with expertise in family planning. We examine both unprotected intercourse carrying a risk of unintended pregnancy and unprotected intercourse carrying a known or potential risk of STIs to either the respondent or to a partner. We assess the prevalence of each type of unprotected intercourse ever and in the past year (i.e. the lifetime prevalence and the period prevalence over the past 12 months), how frequently each type occurred among those who have experienced it, the age at first occurrence, and the reasons for why such risks are taken.

2. Materials and methods

During May and June 2014, we invited the 477 then members of the Society of Family Planning (SFP), a US-based society of reproductive healthcare professionals, to participate in an anonymous online survey examining their lifetime and past-year experiences of unprotected intercourse. Members of SFP are either clinical healthcare professionals or academics whose careers are dedicated to the scientific study of family planning. Both those who have completed training and those in training programs are eligible. Full membership requires scholarly research activity in the form of academic publications and presentation of research findings. The survey was piloted among a group of 10 expert colleagues. The institutional review board at the University of Texas at Austin (where the lead author was based at the time of initial data collection) approved the study.

We administered the survey using Qualtrics survey software and sent invitations via email, with an informed consent document and link to the online survey included. After reviewing the study information, participants consented electronically. We obtained responses from 70% of members (340/477). Because SFP does not collect detailed demographic information on its members, comparison of the demographics of the study population to the SFP membership was not possible.

Participants were asked whether they had ever and in the past year experienced four different types of unprotected intercourse: (1) intercourse carrying a risk of unintended pregnancy; (2) intercourse carrying a potential risk of STIs to self; (3) intercourse carrying a known risk of STIs to self; (4) intercourse carrying a known or potential risk of STIs to a partner. The first category is motivated by the Healthy People 2020 national goal of preventing unintended pregnancy [13] and in our study refers to vaginal sex where the female partner is postmenarchal and premenopausal without using any method of contraception when not intending pregnancy. To account for well-documented practices such as starting intercourse without any method of contraception and then stopping to start using a method [14,15] and the potential sperm content of preejaculatory fluid with respect to unintended pregnancy risk [16], we enquired about both "full" and "partial" risks for each category of unprotected intercourse. "Full" risk of unintended pregnancy was defined as having had vaginal intercourse with ejaculation without using any method of contraception, when not intending a pregnancy. "Partial" refers to the situation where vaginal intercourse is begun without using any method of protection before stopping to start using a method, when not intending pregnancy (e.g. beginning sex without a condom and then putting one on prior to ejaculation). Because withdrawal is considered a method of contraception yet also fits the definition of beginning vaginal intercourse without using protection, we asked an additional question about having had vaginal intercourse using withdrawal as the only method of protection when not intending pregnancy.

The latter three categories are based upon standard epidemiological categorization of partners as discordant, unknown, or concordant with respect to STI status (see, for example, Ref. [17]). We did not study concordance since our interest is in STI risk. Because we relied upon self-reporting, we were not able to verify whether respondents' perceptions of their own or a partners' status were accurate reflections of actual status. Potential risk of STIs to self was defined as having had vaginal, anal, or oral sex using no method of protection when the respondent was STI-free but the partner's STI status was unknown (i.e. partner unknown). Known risk of STIs to self was defined as vaginal, anal, or oral intercourse using no method of protection when the respondent was STI-free but the partner was known to have an STI (i.e. partner discordant infected). Known or potential risk of STIs to a partner was defined as having had vaginal, anal, or oral sex using no method of protection when the respondent either had an STI or did not know her/his STI status while the partner was STI-free (i.e. self-discordant infected or unknown). Again, we distinguished between "full" unprotected intercourse, where no method of protection was used at all, and "full or partial" unprotected intercourse, where either no method was used at all or a method was introduced at a later stage, having begun intercourse without one.

Among participants who had experienced each type of full unprotected intercourse, we asked how many times each had occurred both ever and in the past year, the participant's age at first time, and the reasons why no protection was used, with response categories based upon prior research