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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.

### Keywords

Unprotected sex; Unprotected intercourse; Healthcare professionals

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## 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 1,392 women recruited from 13 family planning clinics across the U.S. 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 (NSFG) show that 11% of women at risk of unintended pregnancy are not using contraception [8].

Many approaches to minimizing 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 for minimizing the risks of STIs and unintended pregnancy described in the U.S. 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 U.S.-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 ten 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 post-menarchal and pre-menopausal 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 pre-ejaculatory fluid with respect to unintended pregnancy risk [16], we enquired about both “full” and “partial” risk 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, [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 examining reasons for unprotected intercourse in the CDC Pregnancy Risk Assessment and Monitoring System (PRAMS) and other smaller surveys [18–19]. Respondents could choose as many reasons as applied and also include other reasons that were not listed as response options. Basic demographic information (age, gender, ethnicity, sexual orientation, and degrees held) was also collected. Please see the online appendix for more detailed information about the questionnaire constructs.

We calculated simple frequencies for the number of respondents who experienced each type of unprotected intercourse (both ever and in the past year), the percentage reporting each type, the mean and mode ages at first time, and the percentage reporting each reason why no protection was used. Data analysis was conducted using Stata version 13.0.

### 3. Results

Characteristics of the sample of SFP members who completed the survey are shown in Table 1. The sample is predominantly female (90%), heterosexual (89%), and white (80%). Just over half (54%) are aged between 35 and 49 years, with a further 29% aged between 25 and 34 years. Seventy percent hold an MD degree, 48% an MPH, and 19% a PhD. No meaningful differences were produced in the results that follow by excluding males, respondents self-identifying with minority racial/ethnic groups, gay/lesbian/bisexual respondents, or those aged 50 years or over from the sample.

The proportions of respondents who have experienced each category of unprotected intercourse ever and in the past year are shown in Figure 1. Across all categories, the proportion of respondents ever experiencing unprotected intercourse is much higher than in the past year. The three most common types of unprotected intercourse are fully or partially unprotected intercourse involving a risk of unintended pregnancy (62% ever; 7% in the past year); fully or partially unprotected intercourse involving a risk of unintended pregnancy including instances where only withdrawal was used (76% ever); and fully or partially unprotected intercourse carrying a potential risk of STIs to self (63% ever; 12% in the past year). The proportions of respondents who have ever or in the past year knowingly taken the risk of contracting STIs from a partner or put a partner at known or potential risk of STIs are much smaller (4% ever; 1% in the past year, and 11% ever; 3% in the past year, respectively). The proportions of respondents reporting full *versus* full or partial intercourse in the past year were virtually identical and thus only full is shown for each category in Figure 1.

Among participants who have ever experienced each type of unprotected intercourse, age at first intercourse carrying a risk of unintended pregnancy and age at first intercourse carrying

a potential risk of STIs to self are similar (mean = 21, mode = 18 and 19, respectively). Age at first intercourse carrying a known risk of STIs to self or a known or potential risk of STIs to a partner tends to be higher (mean = 27 and 23, respectively, mode = 25).

Figure 2 shows the number of times respondents who have experienced each category of unprotected intercourse have engaged in each type ever and in the past year. Both ever and in the past year, the majority of respondents in each category have experienced unprotected intercourse more than once, and over a third more than 10 times.

Figure 3 shows the percentages of respondents who cited each circumstance that applied to their ever having experienced each category of unprotected intercourse. The most common reason for experiencing unprotected intercourse carrying a risk of unintended pregnancy or a potential or known risk of STIs to self is being “swept away in the heat of the moment”. By contrast, among those who have experienced unprotected intercourse conferring a known or potential risk of STIs to a partner, “preferred no method” is the most common reason. Compared to the proportion of respondents who reported being “too young to know better” when they experienced unprotected intercourse conferring a risk of unintended pregnancy or a potential risk of contracting an STI, many fewer respondents cited age as a reason for unprotected intercourse carrying a known risk of STI or a potential risk of passing an STI to a partner. Circumstances surrounding each category of unprotected intercourse in the past year did not differ substantively from the circumstances applicable to ever having experienced each type.

#### 4. Discussion

Among our sample of reproductive health professionals with expertise in family planning, ever having taken a risk with respect to unintended pregnancy and STIs is common, while having taken such risks in the past year is uncommon, but not non-existent.

Those who reported the two most common types of risk-taking—unprotected intercourse carrying a risk of unintended pregnancy or with a partner whose STI status was unknown—tended to experience these risks at younger ages and under circumstances that involved “the heat of the moment”, the influence of alcohol or drugs, having no contraceptive method easily accessible, or being “too young to know better”. These respondents appeared to experience most sexual risk-taking as younger adults, perhaps before they become healthcare professionals or while they were in training. While exactly comparable figures do not exist for the general population, findings are consistent with evidence that the rates of unintended pregnancy and the incidence and prevalence of STIs are especially high among young adults [4, 5, 20], and that unprotected intercourse is common among younger age groups. According to Bayer Healthcare’s 2014 World Contraception Day survey of 13,986 young adults aged 10–30 years across 35 countries, 44% of respondents reported having sex with a new partner without using contraception [21]. Additionally, a study of 326 college students in the U.S. found that 23% of sexually active women did not use contraception in the past 12 months [22]. Imperfect method use (as measured through “partially unprotected” intercourse) was also prevalent among respondents taking risks with respect to unintended pregnancy. It is also possible that some respondents felt ambivalence about avoiding

conception [23] and while not actively trying to get pregnant, they may not have been explicitly trying to avoid pregnancy either [24].

The smaller proportions who reported risk-taking with a known infected partner or who put a partner at risk of an STI experienced these risks at older ages, and for reasons that more often appeared to involve a deliberate choice, such as not wanting to use a method or perceiving that risk of STI transmission was very low. Candidate explanations for these patterns among respondents in our sample include the possibility that such scenarios might more commonly occur within relationships where partners are aware of each other's STI status and/or that most these events involved STIs where the risk of transmission is reduced at certain times (*e.g.* herpes simplex virus). It is also possible that having undergone STI testing and being aware of one's own or a partner's STI status is more common at older ages or that given their demographic characteristics, respondents in our sample perceived a relatively low risk of STI transmission among their sexual contacts [25].

Our study was based upon a sample of reproductive healthcare providers and researchers from a single professional society in the US and thus may not be generalizable to reproductive healthcare professionals nationally or in other settings. Moreover, our sample is a select group with a special interest in family planning, who self-selected into the survey. The sample was also overwhelmingly white, female, and heterosexual, and under-represents minorities, further limiting the extension of our results to other settings. Our study relied upon self-reports of experiences regarding personal and potentially sensitive topics and thus results may be affected by social desirability bias, recall bias, or other self-reporting biases.

Despite these limitations, the findings of our study represent a novel contribution to knowledge of the behavioral patterns surrounding unprotected intercourse. Such behaviors have not previously been studied among healthcare professionals, and while few of the respondents in our sample have engaged in sexual risk-taking behaviors or found themselves in a risky sexual situation in the past year, the proportion ever having taken risks with regard to sexual behavior is substantial. Our results suggest that when counseling patients about safe sex or designing education programs to reduce unintended pregnancy and STIs, clinicians and researchers could reflect and draw upon their own past experiences of unprotected sex and imperfect use of contraception. Such reflection might already occur among some healthcare professionals, and this would be useful to document. Drawing upon such experiences might help bridge the gap between what is ideally expected in guidelines and what tends to happen in real life, creating avenues for better measurement of behaviors and boosting the development of strategies involving harm reduction, motivational interviewing, and other practices intended to encourage safe sex.

## Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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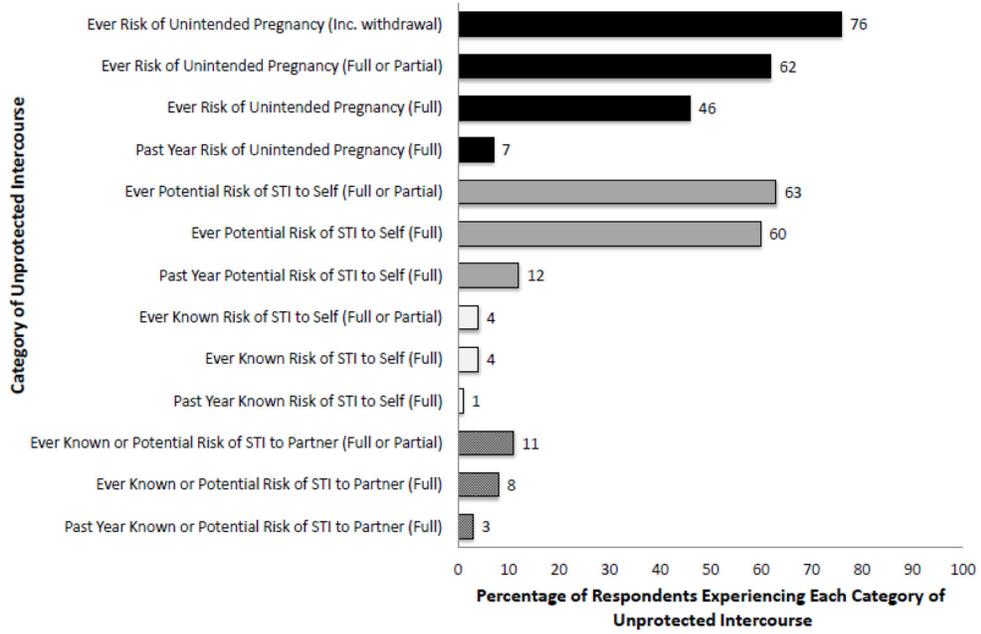
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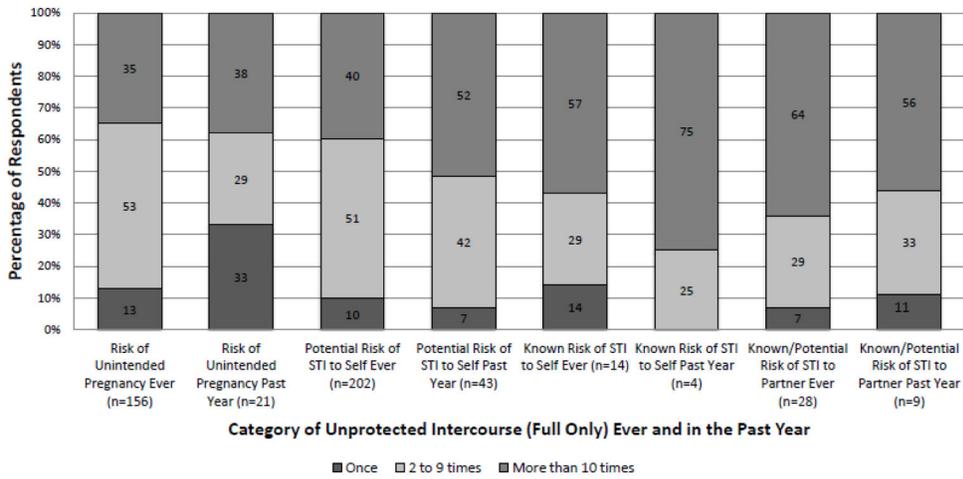
### Implications

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.



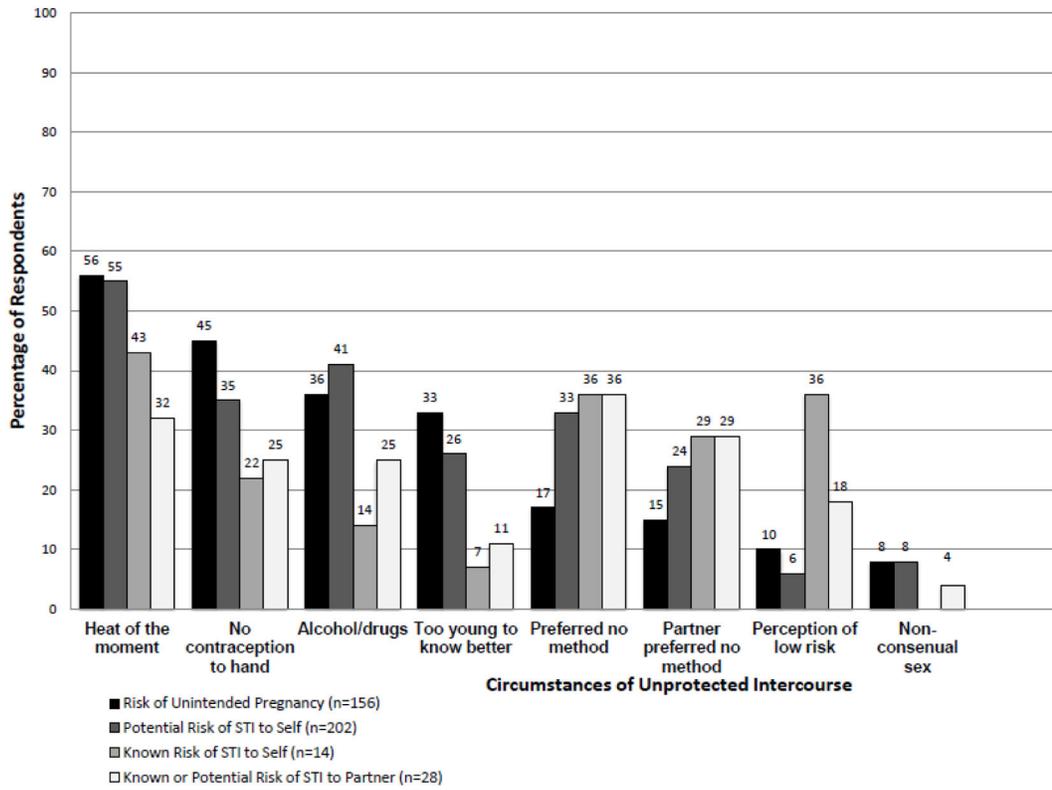
**Figure 1. Percentage of Respondents Experiencing Each Category of Unprotected Intercourse Ever and in the Past Year (n=340)**

“Full” means intercourse without using any method of protection at any time. “Partial” means intercourse that is begun without using any method of protection but a method is subsequently used. Risk of unintended pregnancy refers to vaginal intercourse where the female partner is post-menarchal and pre-menopausal without using any method of contraception when not intending a pregnancy. Potential risk of STI transmission refers to vaginal, anal, or oral intercourse using no method of protection where either the respondent’s or her/his partner’s STI status is unknown. Known risk of STI transmission refers to vaginal, anal, or oral intercourse using no method of protection where the respondent or her/his partner is known to have an STI.



**Figure 2. Percentage of Respondents in Each Frequency Category Among Those Who Have Experienced Type of Unprotected Intercourse Ever and in the Past Year**

“Full” means intercourse without using any method of protection at any time. Risk of unintended pregnancy refers to vaginal intercourse where the female partner is post-menarchal and pre-menopausal without using any method of contraception when not intending a pregnancy. Potential risk of STI transmission refers to vaginal, anal, or oral intercourse using no method of protection when the respondent’s or her/his partner’s STI status is unknown. Known risk of STI transmission refers to vaginal, anal, or oral intercourse using no method of protection where the respondent or her/his partner is known to have an STI. Some percentages add to greater than 100 due to rounding.



**Figure 3. Percentage of Respondents Citing Each Reason Why Unprotected Intercourse Occurred Among Those Ever Experiencing Each Category**

Risk of unintended pregnancy refers to vaginal intercourse where the female partner is post-menarchal and pre-menopausal without using any method of contraception when not intending a pregnancy. Potential risk of STI transmission refers to vaginal, anal, or oral intercourse using no method of protection where the respondent’s or her/his partner’s STI status is unknown. Known risk of STI transmission refers to vaginal, anal, or oral intercourse using no method of protection where the respondent or her/his partner is known to have an STI.

**Table 1**

Characteristics of SFP Members who Participated in the Survey (n=340)

| Characteristic            | Frequency (%) |
|---------------------------|---------------|
| <b>Gender</b>             |               |
| Female                    | 305 (89.7)    |
| Male                      | 34 (10.0)     |
| Gender Queer              | 1 (0.3)       |
| <b>Sexual Orientation</b> |               |
| Heterosexual              | 303 (89.1)    |
| Gay or lesbian            | 16 (4.7)      |
| Bisexual                  | 17 (5.0)      |
| Other                     | 4 (1.2)       |
| <b>Age</b>                |               |
| <25                       | 7 (2.1)       |
| 25–34                     | 97 (28.5)     |
| 35–49                     | 183 (53.8)    |
| 50                        | 53 (15.6)     |
| <b>Degrees Held*</b>      |               |
| MD                        | 239 (70.3)    |
| NP, NM, DNP, MSN          | 14 (4.1)      |
| PhD                       | 64 (18.8)     |
| MPH                       | 163 (48.0)    |
| DrPH                      | 3 (1.0)       |
| MS, MSc, MHSc             | 31 (9.1)      |
| Other Master's            | 29 (8.5)      |
| Other                     | 3 (1.0)       |
| <b>Race/Ethnicity*</b>    |               |
| Hispanic origin/Latino/a  | 17 (5.0)      |
| African-American          | 13 (3.8)      |
| White, non-Hispanic       | 273 (80.3)    |
| Indian/South Asian        | 17 (5.0)      |
| Asian-American            | 25 (7.4)      |
| Native American           | 1 (0.3)       |
| Other                     | 8 (2.4)       |

\* Participants were allowed to choose as many categories as applicable and thus percentages add to greater than 100.0