WHO'S THE DECIDER?:

HOW DIFFERENT DIMENSIONS OF POWER ARE RELATED TO PARTNER BELIEF ABOUT CONTROL OVER THE COUPLE'S METHOD CHOICE*

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A defining characteristic of most existing research on fertility regulation is "an assumption of women's primacy in fertility and contraceptive use" (Greene & Biddlecom 2000, p. 81). However, with the growth of the HIV/AIDS epidemic, there has been an increased emphasis on understanding men's roles in the reproductive health of couples involved in intimate relationships. This shift has led to a developing body of research directed at men, but has been less successful in generating research based on couples, where reports are obtained from both partners. Understanding how contraceptive decisions are made in heterosexual couples requires consideration of the role of *both* male and female partners in the decision making process, as well as what factors affect the relative influence of each partner over the final decision.

In this paper, we use data from a new, large survey of both partners from over 1,000 married, cohabiting, and dating heterosexual couples in the United States. Our study investigates how perceptions about who makes the final contraceptive choice are related to partners' absolute and relative characteristics along various dimensions of power, including structural status (age, education, and personal income), sexual experience and knowledge of contraceptives, gender role ideology, relationship commitment, and perceived relationship alternatives. Our findings show that men and women differ in their perceptions of who has the final say in contraceptive decisions, as well as differ in the factors influencing these perceptions.

GENDER AND REPRODUCTIVE HEALTH

The narrow focus of past research on women's perspective as the way to understand fertility and its proximate determinants likely arises from four factors. First, women were chosen as the primary target of study because births can be unambiguously attributed to women, though men may be unaware of children they may have fathered. Due to their role in childbearing, women are assumed to have greater ability to recall reproductive events than are men (Becker 1996). Second, researchers perceive the need for data from only one partner due to an "assumption of consonance between men's and women's interest within marriage" (Greene and Biddlecom 2000, p. 830). Third, many researchers have assumed that partners in a couple operate in or are responsible for separate spheres, with men having primary responsibility for the economic needs of the family and women's responsibility being focused on home-production and related reproductive roles (Watkins 1993; Becker 1996). Fourth, the introduction of the pill and other coitus-independent female methods (e.g., IUD, Norplant) allowed women to make independent contraceptive decisions without necessarily involving (or convincing) a partner and even without partner knowledge (Becker 1996).

However, over the past two decades, there has been a growing recognition of the limitations of restricting contraceptive research to women. Attempts to limit the spread of HIV/AIDS through condom use require the explicit consent and cooperation of male partners in heterosexual relationships if such efforts are to be successful. In addition, researchers and policy makers began recognizing that men likely do influence in contraceptive decisions, thus affecting women's ability to meet their reproductive goals, as well as protect their own health and the health of their children. Further, studies have provided evidence that the majority of men, whether married or unmarried, believe that family planning is a joint responsibility for partners

in a couple (Grady et al. 1996; Marsiglio 1985; Marsiglio and Menaghan 1987; Sheean et al. 1986). The new focus emphasizes "reproductive health" that includes men *and* women rather than women alone. This new direction was made explicit in the 1994 International Conference on Population and Development (ICPD) that emphasized the need to promote men's involvement in parenthood and sexual and reproductive behavior, including family planning (United Nations 1995).

The recognition of men's contributions to reproductive health has generated several studies that focus on how couple dynamics and the distribution of influence and power within heterosexual relationships are related to reductive health decisions and outcomes. Few studies have addressed specifically who makes the final contraceptive decisions in a couple which is the focus of the present study. However, recent research on power in intimate heterosexual relationships and its consequences for fertility and disease-avoidance behaviors provides important clues as to what factors likely determine the contraceptive decision-making process among heterosexual couples. For example, male dominance or the lack of power by women is a recurring theme in the literatures on condom use (e.g., Campbell 1995; Schneider 1988; Stein 1990) and microbicide acceptability (e.g., Elias & Heise 1994; Gupta & Weiss 1993; Scarlett et al. 1998; Wulf et al. 1999). Gomez and Marin (1996) examined male and female influences on the ability of Latinas to use condoms for disease protection. They report that the women in their sample felt powerless in the condom-use decision within their sexual relationships. However, since both women and their partners tended to view contraception as being a woman's responsibility, they felt more able to negotiate condom use if they identified it as their sole method of contraception. This suggests that at least some groups define contraception as a woman's "sphere of influence," giving women primacy in this decision-making area. A study by

Bean et al. (1983) also found that wives' attitudes were more important than husbands' in the choice of male or female sterilization, and a study by Miller, Shain and Pasta (1991) shows that wives' traditionalism and role segregation were important for this same choice.

THEORETICAL PERSPECTIVE

Based on their characteristics and the nature of their relationship, partners likely bring differing levels of influence or power over the contraceptive decision. To explain how partners' relative characteristics may influence who has the final say on what contraceptive methods are used, we draw on Social Exchange theory (Emerson 1962, 1972, 1981) because it deals directly with the dyadic relationship, examining the structure of interpersonal exchange and its consequences. The theory develops from the assumption that power rests not in the individual but rather in the relationship or exchange between two (or more) individuals. Although the exchange relationship is assumed to confer some degree of power on each member of the relationship, the relative distribution of power in a relationship is based on the distribution of and access to resources that are valued by the individuals in the relationship. Within a relationship, the partners' relative power depends on: the quantity of valued resources (e.g., money, affection) one partner has to exchange relative to what the other partner has; the level of dependence of one partner on the other for the valued resources; and, the partners' perceptions of the extent of alternative sources for the valued resources outside of the relationship. So, for example, a woman's power relative to her partner is higher when: (a) she has more of the valued resources to exchange compared to what her partner has; (b) she is less dependent on the relationship (that is, her partner) for the valued resources; or, (c) she perceives many other sources or alternatives for getting the resources she values (thus reducing her dependence on the relationship as the only source for the valued resource). An actor's relative power in a relationship is expressed or

observed in decision-making dominance (such as in having the final say in decisions), in the ability to take actions even against a partner's desires, and in the ability to control a partner's behavior. Importantly, the preferences and desires of the more powerful partner will have a greater impact in the decision-making process than will those of the less powerful partner.

Based on Social Exchange theory, we identify multiple factors that will affect how power is distributed in couple relationships. *Structural power* arises from individual characteristics that are linked to inequality in the larger social structure, such as age, education, or income. If a woman earns less than her husband or partner, she will be more dependent on him for financial support or assistance, and he will have greater influence over her actions and the couple's decision-making. The partner who is older or more highly educated may have more experience, knowledge, or material resources than the alternate partner, contributing to greater power in the relationship. Similarly, partners with *greater sexual experience or knowledge of contraceptives* may be more likely to make the method choice because the less experienceD or knowledgeable partner may rely on them for their knowledge in avoiding pregnancy and/or sexually transmitted diseases.

Power imbalances also emerge from differences between partners in their *level of commitment to the relationship* since how committed individuals are will affect their dependency on the relationship. The more highly committed partner will be relatively more dependent, and thus less powerful in contraceptive decision-making. Similarly the distribution of power is likely affected by how much individuals believe they would have little trouble in attracting potential partners or even how happy they would be if they were not in a relationship. To the extent that an individual perceives more *alternatives to their current partnership*, the less he or she will be

dependent on the relationship, and thus have greater power over decision-making, including contraceptive choices.

We also expect that dependency, and thus power, in a relationship may vary by one's *gender-role orientation*. Individuals who have liberal gender-role orientations are more likely to adopt traits and behaviors that are non-traditional for their gender (Presser 1994; Ross 1987). As such, partners who have a liberal gender-role orientation will have more balanced dependencies in their relationships, with partners being more likely to share contraceptive decision-making. In contrast, the traditional gender-role orientation holds that women are by nature passive and sensitive which makes them dependent on men and best suited for family care roles, whereas traditionally oriented men are likely to assume family roles (e.g., economic provider) that increase their relative power. Therefore, men may have a greater say in contraceptive decisions when partners have a traditional gender-role orientation. Alternatively, it is possible that a traditional gender-role orientation will increase women's decision-making power. Due to the emphasis on gender-specific domains in family life, a traditional gender-role orientation may lead to gender-typed spheres of influence (Thomson 1989) in which women have dominion over reproductive-related decisions, including contraceptive use.

In investigating the influence of partners' individual and relative characteristics on who decides on contraception, we include controls for three other potential effects. First, we control for race/ethnicity because past research suggest that there may be cultural differences (e.g., gender-role orientation) that may affect who has primacy in contraceptive choice (Bowleg et al. 2000; Gomez and Marin 1996; Pulerwitz et al. 2000; Quadagno et al. 1998). Second, we take into account the use of physical violence in conflicts given that such violence may elicit compliance due to the threat of physical harm if there are any disagreements on method use.

Third, we control for relationship type because partners in married, cohabiting, and dating couples are likely to differ in important ways (e.g., level of commitment, economic exchanges) that may affect how decision-making occurs in the relationship.

METHODS

Data

To examine the influence of personal, partner, and relationship characteristics on perceptions of couples' contraceptive decision making, we use data we collected through the NICHD-funded study referred to as the National Couples Survey, of 1,009 couples (2,018 individuals) throughout the United States where: the female partner is between the ages of 20 to 35 years: the male partner is age 18 or older; the couple has been in a married, cohabiting, or (non-marital, non-cohabiting) dating sexual relationship for one month or longer; the female partner is not currently pregnant or trying to get pregnant (at risk of unintended pregnancy and making contraceptive decisions); and, neither partners is medically or surgically sterile. The survey used computer-assisted self interviewing (CASI) to collect data from an area probability sample of households in four cities and the county subdivisions immediately adjacent to them: Baltimore, MD, Durham, NC, St. Louis, MO, and Seattle, WA. The four cities were chosen for substantive and pragmatic reasons. On the pragmatic side, these are cities where Battelle has survey research offices making the survey more cost efficient. On the substantive side, these sites provide diverse populations with respect to race/ethnicity, economic status, and other factors that may influence contraceptive decision-making.

During the survey effort, 65% of households were successfully rostered for eligibles. Where more than one age-eligible couple and/or unattached adult was present, we randomly selected a couple or unattached adult and screened them for eligibility. The screener completion

rate was 83%. For daters, the focal respondent was randomly selected from among the male and female adults in the household. The selected (focal) respondent was screened first, and then we screened his/her nonresident partner prior to establishing the couple's eligibility. Eligibility screening was completed for 86% of focal respondents. If the focal dating respondent met the eligibility criteria, field interviewers then asked the focal respondent to recruit his/her dating partner. Due to human subjects concerns, dating partners were recruited indirectly, by the focal respondent and not by us. If the focal respondent's dating partner agreed to be contacted, the field interviewer administered an eligibility screener, which was completed with 77% of the focal respondents' partners. Overall, 70% of eligible married/cohabitating couples completed the survey, and 94% of eligible dating couples completed the survey. The full sample consists of 2,018 male and female partners from 413 married, 261 cohabiting, and 335 dating heterosexual couples. After excluding cases due to missing data, our final sample includes 800 female respondents (337 married, 218 cohabiting, 245 dating) and 811 male respondents (346 married, 216 cohabiting, 249 dating).

At the interviewing stage, partners were scheduled to take the survey contemporaneously, usually at their residence. The questionnaires for males and females were nearly identical. Field interviewers took two laptop computers to the home and set up the partners in separate spaces for the interview. Respondents were restricted from communicating with each other about their answers. The computer-assisted survey allowed us to capture and resolve many data inconsistencies during the interview process. Overall, the rostering, screening, and interview response rates are respectable, given the heavy burden of the survey on the participants, in that, each member of the couple was asked to provide rather sensitive information about their private lives. Further, the requirement that both partners had to agree to participate also increased the

chances for refusal, particularly among daters who had to recruit their non-resident partner for us, telling that person that s/he wanted to provide us with information about their sexual relationship and convincing the partner to do the same.

Measures

We used self-report data from each partner in constructing the dependent and predictor variables. The dependent variable is based on the respondents' response to the question, "Who usually makes the final decision about what kind of birth control to use?" Response categories were: *I always decide*, *I decide more than he/she does*, *we decide together*, *he/she decides more than I do*, and *he/she always decides*. We combined the *always decide* and *decide more than* responses to form a three-category outcome measure indicating whether the final decision is usually made by the woman, the man, or both together.

As related to the power-dependency theory, we constructed measures for the partners' structural characteristics (age, education, and personal income), sexual experience and awareness of contraceptive methods, gender-role orientation, relationship commitment, and relationship alternatives. Age is measured in years based on the respondents' reported birth date. Education is measured as the number of years of education completed. The measure of personal income is based on the respondents' self-reported gross annual personal income in the past year converted to $1,000 units.

We used self-report data on the lifetime number of sex partners and the number of birth control methods the respondents knew about as indicators of their sexual experience and general contraceptive knowledge. Lifetime number of sex partners is treated as a continuous measure with the upper value set to 100 partners. The number of birth control methods is based on the respondents report of how many of ten listed methods the respondent knows about: birth control

pill; condom; diaphragm; IUD, coil, or loop; implant such as Norplant; injectable such as Depo-Provera; "morning after" pill; rhythm method or natural family planning; withdrawal or pulling out; and, sterilization.

Our measure of relationship commitment is based on responses to the question, "What is the percent chance that you will end your [marriage/relationship] in the near future?" Respondents were instructed to report any number between zero and 100. We reverse coded the response so that higher values indicate the respondent is less likely to end the relationship, and thus more committed to or invested in the relationship.

To measure respondents' perceived alternatives to the current relationship, we used factor analysis to create a summary measure (factor scores) of perceived relationship alternatives. The summary measure is based on responses (impossible, possible, probable, and certain) to four questions asking if they broke up this month, how likely it is that during the next year: (a) they could get a better spouse/partner, (b) they could get a spouse/partner as good as their current one, (c) they would be sad but would get over it, and (d) there are many other men/women they could be happy with. The four items were factor analyzed using Principal Component Analysis and Varimax orthogonal rotation with minimum eigenvalues set to one. The Cronbach's alpha for the summary measure of perceived relationship alternatives is .704. Higher values on the summary measure indicate perceiving more alternatives.

We also used the factor analysis procedures described above to create an indicator of gender-role orientation. The summary measure (factor score) is based on responses to eight questions on level of agreement with statements related to roles of husbands and wives in raising children, major spending decisions, sharing housework, importance of wife's career relative to husband's, decisions on food spending, responsibility for birth control, who should initiate

sexual encounters, and who should choose the couple's sexual activity. The Cronbach's alpha for the summary measure of gender-role orientation is .636. Higher values indicate a more traditional gender-role orientation.

Following our theoretical approach, we also constructed indicators of the partners' relative dependency based on their relative statuses in terms of age, education, personal income, sexual experience (lifetime number of sex partners), knowledge of contraceptives, relationship commitment, and perceived alternatives to the current relationship. We also created a relative gender-role orientation measure to account for partners who may be more or less traditional in terms of gender roles. In each case, the indicators of the partners' relative status, experience, knowledge, commitment, alternatives, or gender-role orientation were calculated as the value on the respondent's measure minus the value on his/her partner's measure. Thus, for all the measures of the partners' relative characteristics, high values indicate the respondent is higher on the variable of interest compared to his or her partners and vice versa for lower values. So, for example, when analyzing women's perception of who has the final say on birth control decisions, a higher value on the relative partner measures indicates that the woman is higher than her partner on that indicator. For the analysis of the men's perceptions, a higher value on the relative partner measure indicates the man's characteristic is higher than that of his partner.

For the control variables, race/ethnicity is measured with three categories, indicating whether the respondent is Hispanic, non-Hispanic Black, or non-Hispanic White or other race/ethnic group. The measure, relationship type, indicates whether the couple is married, not married and cohabiting, or dating. In the analysis, we take into account the intensity of couples' arguments through a dichotomous measure (yes/no) based on whether either respondent reports

that their arguments have included physical violence (e.g., pushing, shoving, biting, hitting, throwing things, or use of weapons).

Data analysis

For the data analysis, we first conducted descriptive analyses on the dependent, main predictor, and control measures separately for male and female respondents. We next used multinomial logistic regression to predict the three-category outcome, who decides what birth control to use (man, woman, or both). In the preliminary analyses, we estimated separate models for male and female respondents to identify factors significant within sex groups. We first tested models including the control variables (race/ethnicity, relationship type, arguments with violence) and the partners' relative difference measures (e.g., relative age, relative relationship alternatives). We then added the respondent's and then the partner's individual characteristics (e.g., respondent's income, partner's education). At each stage we dropped variables that did not significantly affect the dependent variable. From these preliminary analyses, we determined which predictor variables had significant effects on the dependent variable within sex groups.

We then estimated a final model that included all the predictor and control variables with significant effects for either the male or female partners, as well as interaction terms between respondent's sex and each of the predictor and control variables. The final model was estimated a second time after reversing the reference category for the sex measure. Through these analyses we were able to estimate sex-specific effects for each of the predictor and control variables included in the final model. It should be noted that the sex-specific coefficients and standard errors generated by the final model analysis are identical to what one would find with separate analyses by sex; the full sample analysis with sex interactions provides additional information on whether the coefficients for men and women significantly differ.

In estimating the final model analysis that included all partners (men and women), we adjusted for the non-independence of cases coming from the same couple. Although all statistics were weighted to take into account sampling procedures, we normalized the final weight so as not to inflate the size of the sample or increase the risk of making a Type 1 error in our significance tests. Finally, to provide easier interpretation of the results, especially those involving relative partner effects, we calculated separately for the male and female partners predicted probabilities for the dependent variable across categories or values of the predictor variables.

FINDINGS

Descriptive statistics

Table 1 provides the percent distributions for the dependent variable and the control variables separately for men and women in the sample. Although the distributions of the control variables do not differ by sex, perceptions of who has the final say in birth control decisions does vary significantly between men and women. Women perceive themselves as having the final say substantially more than men believe is the case. In contrast, a higher proportion of men than women perceive that either men alone or both partners together make the final decision on birth control.

In Table 2, we provide means and standard deviations on the eight main predictor variables separately by sex, as well as mean difference tests by sex and correlations between partners' characteristics. As shown, there are significant mean differences between men and women for nearly all the predictor variables, except relationship commitment and perceived relationship alternatives. Compared to women, men are on average significantly older, earn more, have had more sexual partners, and are more traditional in their gender-role orientation.

Women have more education and know more types of contraceptive methods than men, on average. The paired sample correlations provide some indication of the level of concordance or similarity between partners on the main predictor variables. All the correlations are significant and are positive, indicating that partners tend to vary together on these characteristics (i.e., both partners are high or low relative to other couples in the sample). However, the strength of association differs considerably across the predictor variables. While there is a strong association between partners' age, there is only a moderate association between partners' education level, how many contraceptive they know, and gender-role orientation. Partners' personal income, lifetime number of sex partners, relationship commitment, and relationship alternatives are relatively weakly associated, which suggests that the partners' relative difference in these factors is somewhat higher.

Multivariate analysis

In our multivariate analysis of perception of who has the final say in birth control decisions, we found that only two of the relative difference measures (relative knowledge of contraceptives and relative relationship alternatives) had significant effects for either male or female partners. Of the individual characteristics, only lifetime number of sex partners, relationship commitment, relationship alternatives, and gender-role orientation were significant. In none of the analyses did we find significant effects for the partners' absolute or relative age, education, or income. In the final multinomial logistic regression model using the full sample of male and female partners, we included only those measures of relative difference and individual characteristics found to be significant for either men or women, along with the control variables. As noted above, this model also included interaction terms between sex and each of the other main predictor and control variables, as well as the main effect for respondent's sex, allowing us

to report sex-specific findings. These are shown in Table 3 for female partners and Table 4 for male partners. Each table provides sex-specific coefficients (log odds), standard errors, and predicted odds. As indicated by superscripted *D* in Tables 3 and 4, we found that several of the predictor and control variables had significant sex interactions indicating that the effect significantly differed for men and women: lifetime number of sex partners, own and partner's relationship commitment, relationship alternatives, partner's gender-role attitudes, argument include violence, and relationship type.

As shown by the female-specific results in Table 3, significant effects were found for women's lifetime number of sex partners, the difference between women's and their partner's knowledge of contraceptives, partner's relationship commitment, perceptions of relationship alternatives, and both the women's and their partner's gender role attitudes. Among women, the only significant effects are those contrasting the likelihood that women perceive the man versus the woman or the man versus both partners as making the final birth control decision. As we expected the more sex partners women have had in their lifetime, the more likely they are to perceive themselves rather than their partner as making the final decision on birth control. Similarly, the more contraceptives women know about compared to what their partner knows, the more likely they are to perceive themselves or both they and their partners as making the final contraceptive decision rather than their male partner alone. Further, even though women's relationship commitment has no effect, the more committed the male partner is to the relationship, the more likely women are to perceive that both partners make the final decision rather than the man alone. However, controlling for the partner's relative relationship alternatives, the more alternatives women see to their current relationship, the more likely they are to perceive the man making the final decisions on birth control than either her or both

partners together. Finally, the more traditional a woman is in her gender-role orientation, the more likely she is to perceive her partner rather than herself as making the final birth control decision. The same pattern of influence is found for partner's gender-role orientation, with a male partner's more traditional attitudes increasing the likelihood that a woman perceives her partner rather than herself or both partners as making the final decision.

In Table 4, we present the results for men's perceptions of who has the final say in birth control decisions. For men, significant effects were found only for relationship commitment, difference in partners' relationship alternatives, and gender-role orientation, as well as for the control variables, arguments include violence and relationship type. The stronger is men's commitment to the relationship, the more likely they are to perceive themselves as having the final say in contraceptive decisions compared to the woman or (opposite to the finding for women) both partners deciding. Controlling for his own perceived relationship alternatives, the more the man's relationship alternatives exceeds his partner's perceived alternatives, the less likely he believes he has the final say compared to the woman or both partners. The effect of men's gender-role orientation on their perception of who has the final say is essentially the same as found in the analysis for female partners. As shown in Table 4, the more traditional men are in their gender-role orientation, the more likely they are to perceive themselves, rather than the woman or both partners, as making the final decisions on contraceptive use.

In addition two of the control variables have significant effects for male partners. Men in relationships that have involved violent arguments are more likely to perceive that either the woman or the man make the final decision regarding birth control (rather than both together) compared to other men in relationships without violent arguments. Compared to dating men, married men are more likely to perceive their female partner as having the final say rather than

the man or both partners. Similarly, cohabiting men are more likely than men in dating relationships to perceive the female rather than male partner as deciding on birth control.

In Table 5 we present predicted probabilities for perceptions of who has the final say in contraceptive decisions separately for men and women respondents. We include notation to indicate whether in the analyses shown in Tables 3 and 4 the variables had significant effects on perceptions for female (*W*) or male partners (*M*), and whether a sex difference in the effects (*D*) were found. In calculating the predicted probabilities, we varied values on the variable of interest, setting all the other predictor and control variables to their sex-specific mean value. The predicted probabilities illustrate the overall pattern of effect rather than the relative likelihood of one outcome versus another.

Lifetime number of vaginal sex partners had a significant effect only for female partners. Differing from our expectations, the more sex partners a woman has had, there was an increase in the probability of her perceiving contraceptive decisions being made by both partners and a declining probability that she perceived herself as having the final say. However, the greater was her knowledge of contraceptive methods compared to what her partner knew clearly shifts the probability of her perceptions of who has the final say to herself away from the decision being made by or with her partner.

Own relationship commitment was significant only for male partners, and partner's relationship commitment was significant only for female partners. So, effectively, these results show the impact of male partner's relationship commitment on the women's perception and men's perception of who has the final say. Female partner's relationship commitment had no effect for either partner's perception of who makes contraceptive decisions. The pattern of the predicted probabilities shown in Table 5 indicates that the more committed were male partners to

their relationship, the more male partners perceived that they were making the contraceptive decisions, as opposed to the female partner in particular or both partners. In contrast, greater commitment from a male partner appears to shift female partners' perception of who has final say away from herself and toward both partners deciding together.

Like male partner's relationship commitment, the effect of relationship alternatives (including partners' relative alternatives) significantly differed by sex. Own relationship alternatives had a significant effect for female partners (non-significant for male partners), and partners' relative relationship alternatives was significant for male partners (non-significant for female partners). To provide the overall pattern of influence for relationship alternatives, our calculation of the predicted probabilities allowed values to vary on own, partner's, and relative partners' relationship alternatives. Low and high values on relationship alternatives were set respectively to –1.5 or +1.5, which are approximately equivalent to one and a half standard deviations below and above the mean.

As shown in Table 5, we used these values to calculate predicted probabilities when both partners had low, both high, or opposite levels of relationship alternatives. For both male and female partners, when both partners were low on relationship alternatives, there was a higher probability of perceiving contraceptive decisions being made jointly. There was a 50 percent or greater chance the women perceived themselves as having the final say when either or both partners had a high level on relationship alternatives. Women perceived the highest probability for men having the final say (at less than an 8 percent chance) when both partners had high values on relationship alternatives. Similarly, the highest probability that men perceived themselves as having the final say (slightly less than 10 percent chance) is when both partners were high on relationship alternatives, though this was also somewhat the case when only the

woman had a high value. The highest probability that men perceived contraceptive decisions being made jointly (72 percent chance) was when the man was high and the woman low on relationship alternatives. In contrast, the highest probability of men perceiving the female partner as having the final say was when she had a higher value on relationship alternatives than he did.

Gender-role orientation had a significant effect on perceptions of final say for both men and women, and the effect differed by sex. Partner's gender-role orientation, though, was significant only for women. The predicted probabilities indicate that women were only slightly more likely to perceive that the male partner or both partners had the final say when they were more traditional in gender roles. Similarly, though with a larger effect, having a more traditional partner increased the probability of women perceiving that the man or both partners made final decision.

Although race/ethnicity had no effect for either men or women, the other two control variables were significant in predicting men's perceptions, and their effects were significantly different from the non-significant relationships observed for women. The percent chance that men perceive that there was joint decision-making about contraceptives was substantially lower, and a slightly higher chance that men perceived they had the final say, if violent arguments had occurred in the relationship. Further, men were most likely to perceive that the final say was made by them or with their partner when they were in a dating relationship.

DISCUSSION

In this study we considered how factors that may contribute to differential power in heterosexual relationships contribute to perceptions of who has the final say in decisions regarding contraception. We analyzed recent data from a large sample of heterosexual married,

cohabiting, and dating couples that included self-report data from each partner in a couple on a range of characteristics related to power and dependency in intimate relationships. Our results showed that partners in heterosexual relationships differ in their perceptions of who has the final say on contraceptive decisions, and these perceptions are shaped by different factors for men and women. In addressing the question of who has the final say birth control decisions, the modal category was both partners for men and woman for women. None of the structural measures of power (age, education, and income) had significant effects, though several of the other indicators of the power-dependency relationship in couples appear to be related to perceived final say in birth control decisions.

Although we did not find a relative partner effect for sexual experience, we did find that women who had more sexual experience (i.e., more sex partners than other women) seems to contribute to their sharing contraceptive decisions with their male partner. Consistent with our expectations, when women had relatively greater knowledge of contraceptives than their partner, their perceived decision-making power over contraceptive use increased. However, this finding did not reach significance for male partners' perceptions.

Male partner's commitment had very different consequences for men's perceptions and women's perceptions of who makes the contraceptive decision in a couple. For women, greater male commitment appeared to shift some of the power over contraceptive decision-making away from her to both partners together. For men, the probability that they alone made the decision increases with relationship commitment, at the cost of women's singular decision-making. In both cases, men appeared to increase their influence over contraceptive decisions the more committed they were to a relationship. Variation in women's relationship commitment, though, appears to have no effect on perceptions of final say for male or female partners.

To a large extent, the effect of relationship alternatives depended on the relative status of the partners, though the pattern influence differed by sex and was unexpected. Women perceived themselves as being most likely to have the final say when at least one of the partners had high relationship alternatives. Women's perception of shared decision-making was most likely when both partners had low relationship alternatives. Men, though, were most likely to perceive joint decision-making as occurring when there was an imbalance in relationship alternatives in favor of the man. In addition, men perceived their own decision-making power over contraception to be greater when their female partner had high relationship alternatives, regardless of the level of his relationship alternatives.

Although partners' relative gender-role orientation had no effect, the respondents' or their partner's (for women only) orientation did contribute to who has final say. Overall, the likelihood that women perceived themselves as having the final say declined somewhat when either she or her partner had a more traditional gender-role orientation. Men, though, were more likely to perceive themselves as having the final say the more traditional they were in their gender-role attitudes. Female partner's gender-role orientation had no impact on men's perception of final say on contraception. Our control variable analysis also indicated that men perceived joint decision-making as being *least* likely to occur in relationships in which couples have had a violent argument and *most* likely to occur in dating relationships.

These results provide very limited support for a power-dependency model of who makes contraceptive decisions in heterosexual couples. We did find that women perceived their decision-making was more dominant when they knew more contraceptives than their partner. Also, gender-role traditionalism was linked to a more prominent influence of men over birth control decisions, either in terms of men perceiving they have the final say or their greater

involvement through joint decision-making. However, the remaining relative partner influences were either not significant (e.g., relative education) or operated in an unexpected manner (e.g., relative relationship alternatives).

Among our next steps for this research, we will be testing for whether partners' absolute and relative characteristics explain concordance in partners' perceptions of who has the final say. We also are looking at how perceptions of who makes contraceptive decisions in a couple affects actual methods used. Along with the current study, this research will provide a fuller view of how couple dynamics contribute to pregnancy and disease risks.

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Table 1: Percentage Distributions of Categorical Measures by Sex

	Men Percent	Women Percent	Chi-square (df)
Perceptions of final say on birth control			
Both decide	56.13	43.71	55.51**
Man decides	8.89	4.12	(2)
Women decides	34.98	52.18	
Race/ethnicity			
Hispanic	7.93	7.26	2.88
Non-Hispanic Black	34.98	31.56	(2)
Non-Hispanic White	57.09	61.19	
Arguments include violence			
Yes	26.89	26.96	.001
No	73.11	73.04	(1)
Relationship type			
Married	42.84	42.45	.058
Cohabiting	29.82	30.39	(2)
Dating	27.34	27.16	

NOTE: All statistics are based on weighted data. Values may not sum to 100 percent with gender group due to rounding. For women, unweighted N = 800; for men, unweighted N = 811.
** $p < .01$

Table 2: Means and Standard Deviations on Main Predictors Separately by Sex

	Men		Women		Significant Mean difference	Paired sample correlation
	Mean	(*sd*)	Mean	(*sd*)		*r*
Age	30.148	(5.922)	28.069	(4.548)	**	.730**
Years of education	13.944	(3.155)	14.167	(3.012)	*	.581**
Personal income ($1K units)	31.787	(25.665)	21.376	(19.363)	**	.324**
Lifetime number of vaginal sex partners	18.572	(22.523)	11.227	(15.936)	**	.258**
Number of contraceptives know	6.058	(3.155)	7.080	(3.239)	**	.541**
Relationship commitment	85.075	(23.900)	84.246	(25.387)	ns	.292**
Relationship alternatives	-.069	(.89)	-.111	(.77)	ns	.222**
Gender-role orientation	-.069	(1.004)	-.218	(.920)	**	.380**

NOTE: All statistics are based on weighted data. For women, unweighted N = 800; for men, unweighted N = 811. Significant mean differences between male and female partners were determined using paired samples t-tests.
* $p < .05$
** $p < .01$
ns = not significant

Table 3: Results from Multinomial Logistic Regression Predicting Perception of Who Has Final Say in Birth Control Decisions for Female Partners

	Both decide vs. woman decides			Man decides vs. woman decides			Man decides vs. both decide		
	b	(*se*)	exp(*b*)	*b*	(*se*)	exp(*b*)	*b*	(*se*)	exp(*b*)
Lifetime number of vaginal sex partners	.013^{D}	(.007)	1.013	-.025**	(.009)	1.025	.012	(.009)	1.012
Difference in partners' knowledge of contraceptives	-.009	(.027)	.991	-.144*	(.060)	.866	-.135*	(.061)	.874
Relationship commitment	.008	(.004)	1.008	.004	(.006)	1.004	-.004^{D}	(.007)	.996
Partner's relationship commitment	.008	(.005)	1.008	-.011	(.006)	.989	-.019**^{D}	(.006)	.981
Relationship alternatives	-.203	(.171)	.816	.932**^{D}	(.296)	2.539	1.135**^{D}	(.307)	3.110
Difference in partners' relationship alternatives	.073	(.150)	1.076	-.290	(.217)	.748	-.364	(.230)	.695
Gender-role orientation	.024	(.107)	1.024	.414*	(.210)	1.512	.390	(.215)	1.476
Partner's gender-role orientation	.110	(.104)	1.117	.670**^{D}	(.243)	1.953	.559*	(.249)	1.749
Race/ethnicity									
Hispanic	-.332	(.329)	1.277	-.347	(.543)	.707	-.015	(.560)	.985
Non-Hispanic Black	.245	(.212)	.717	-.285	(.416)	.752	-.529	(.427)	.589
Arguments include violence	.211^{D}	(.222)	1.235	-.095	(.401)	.910	-.306^{D}	(.406)	.737

Table 3: Results from Multinomial Logistic Regression Predicting Perception of Who Has Final Say in Birth Control Decisions for Female Partners (continued)

	Both decide vs. woman decides			Man decides vs. woman decides			Man decides vs. both decide		
	b	(*se*)	exp(*b*)	*b*	(*se*)	exp(*b*)	*b*	(*se*)	exp(*b*)
Relationship type									
Married	-.192[D]	(.271)	.825	.687[D]	(.540)	1.989	.880	(.557)	2.410
Cohabiting	-.453[D]	(.264)	.636	-.336	(.484)	.714	.116	(.494)	1.123
Constant	-1.540**	(.516)		-2.842**	(.746)		-1.302	(.754)	
Model chi-square (*df*)	214.31** (54)								

NOTE: Multinomial logistic regression coefficients and predicted odds are shown, with standard errors in parentheses. Significant sex differences are based on sex-interactions with all predictor variables using full sample of male and female partners. All statistics are based on weighted data. Total unweighted N is 1,611 (800 female partners and 811 male partners).

* $p < .05$

** $p < .01$

[D]Significant sex difference in coefficient

Table 4: Results from Multinomial Logistic Regression Predicting Perception of Who Has Final Say in Birth Control Decisions for Male Partners

	Both decide vs. woman decides			Man decides vs. woman decides			Man decides vs. both decide		
	b	(*se*)	exp(*b*)	*b*	(*se*)	exp(*b*)	*b*	(*se*)	exp(*b*)
Lifetime number of vaginal sex partners	-.004^{D}	(.005)	.996	.006	(.006)	1.006	.010	(.006)	1.010
Difference in partners' knowledge of contraceptives	-.003	(.028)	.997	.011	(.046)	1.011	.014	(.044)	1.014
Relationship commitment	.001	(.004)	1.001	.016*	(.007)	1.016	.015*^{D}	(.007)	1.015
Partner's relationship commitment	-.003	(.004)	.997	-.001	(.006)	.999	.001^{D}	(.005)	1.001
Relationship alternatives	-.044	(.156)	.957	.256^{D}	(.206)	1.292	.300^{D}	(.201)	1.349
Difference in partners' relationship alternatives	.198	(.131)	1.219	-.321*	(.140)	.725	-.519**	(.156)	.595
Gender-role orientation	.038	(.104)	1.039	.591**	(.171)	1.805	.553**	(.171)	1.738
Partner's gender-role orientation	-.154	(.111)	.857	-.015^{D}	(.151)	.985	.138	(.148)	1.148
Race/ethnicity									
Hispanic	.276	(.353)	1.318	-.056	(.591)	.945	-.332	(.557)	.717
Non-Hispanic Black	.364	(.222)	1.439	.284	(.349)	1.328	-.080	(.345)	.923
Arguments include violence	-.507*^{D}	(.215)	.602	.287	(.312)	1.332	.794*^{D}	(.311)	2.211

Table 4: Results from Multinomial Logistic Regression Predicting Perception of Who Has Final Say in Birth Control Decisions for Male Partners (continued)

	Both decide vs. woman decides			Man decides vs. woman decides			Man decides vs. both decide		
	b	(*se*)	exp(*b*)	*b*	(*se*)	exp(*b*)	*b*	(*se*)	exp(*b*)
Relationship type									
Married	-.968**[D]	(.265)	.380	-1.041*[D]	(.475)	.353	-.073	(.461)	.930
Cohabiting	-1.132[G]	(.266)	.322	-1.091**	(.418)	.336	.042	(.403)	1.042
Constant	1.394**	(.459)		-2.368**	(.885)		-3.762**	(.853)	
Model chi-square (*df*)	214.31** (54)								

NOTE: Multinomial logistic regression coefficients and predicted odds are shown, with standard errors in parentheses. Significant sex differences are based on sex-interactions with all predictor variables using full sample of male and female partners. All statistics are based on weighted data. Total unweighted N is 1,611 (800 female partners and 811 male partners).

* $p < .05$

** $p < .01$

[D]Significant sex difference in coefficient

Table 5: Predicted Probabilities on Perception of Who Has the Final Say on Birth Control Decisions by Sex

	Women's Perceptions			Men's Perceptions		
	Both decide	Man decides	Woman decides	Both decide	Man decides	Woman decides
Lifetime number of vaginal sex partners[W, D]						
One partner	.417	.013	.570	.606	.056	.338
10 partners	.443	.016	.541	.595	.061	.344
20 partners	.472	.019	.509	.582	.066	.352
30 partners	.501	.023	.476	.570	.071	.359
Difference in partners' knowledge of contraceptives[W]						
Knows of 7 fewer methods than partner	.451	.049	.501	.591	.060	.349
Knows of 2 fewer methods than partner	.450	.025	.525	.585	.064	.351
Knows of 2 more methods than partner	.446	.014	.540	.581	.067	.352
Knows of 7 more methods than partner	.438	.007	.555	.575	.071	.353
Relationship commitment[M, D]						
Less committed (1 *sd* below mean)	.400	.016	.584	.590	.046	.364
More committed (1 *sd* above mean)	.496	.016	.488	.574	.091	.335
Partner's relationship commitment[W, D]						
Less committed (1 *sd* below mean)	.400	.023	.577	.599	.064	.337
More committed (1 *sd* above mean)	.495	.012	.493	.570	.065	.365
Partners' relative relationship alternatives[W, M, D]						
Woman low, man low	.524	.004	.472	.609	.045	.346
Woman high, man low	.416	.031	.553	.519	.084	.397
Woman low, man high	.466	.010	.524	.716	.027	.257
Woman high, man high	.347	.078	.575	.546	.099	.354
Gender-role orientation[W, M]						
Less traditional (1 *sd* below mean)	.444	.011	.545	.593	.038	.370
More traditional (1 *sd* above mean)	.449	.024	.527	.564	.109	.326

Table 5: Predicted Probabilities on Perception of Who Has the Final Say on Birth Control Decisions by Gender (continued)

	Women's Perceptions			Men's Perceptions		
	Both decide	Man decides	Woman decides	Both decide	Man decides	Woman decides
Partner's gender-role orientation[W, D]						
Less traditional (1 *sd* below mean)	.424	.009	.568	.618	.060	.322
More traditional (1 *sd* above mean)	.468	.030	.502	.550	.069	.381
Race/ethnicity						
Hispanic	.356	.015	.629	.619	.052	.329
Non-Hispanic Black	.495	.013	.492	.627	.068	.305
Non-Hispanic White	.433	.019	.549	.550	.065	.385
Arguments include violence[M, D]						
Yes	.486	.014	.500	.483	.096	.421
No	.433	.017	.550	.620	.056	.325
Relationship type[M, D]						
Married	.449	.026	.524	.540	.057	.403
Cohabiting	.393	.011	.596	.501	.059	.440
Dating	.503	.012	.485	.716	.081	.203
Overall	.447	.016	.536	.584	.065	.351

NOTE: All statistics are based on weighted data. For women, unweighted N = 800; for men, unweighted N = 811. Predicted probabilities are calculated from coefficients shown in Tables 3 and 4 varying values on the predictor variable of interest and using sex-specific means for the other predictor variables. For partners' relative relationship alternatives, low and high alternatives were scored as -1.5 and +1.5, respectively; these are values approximately one and a half standard deviations below and above the mean.

[W]Significant variable ($p < .05$) for women based on findings shown in Table 3.

[M]Significant variable ($p < .05$) for men based on findings shown in Table 4.

[D]Significant sex difference in effect of variable ($p < .05$) based on findings shown in Tables 3 and 4.