

Spring 2005

## Pregnancy Intendedness in a High Risk Group: Reassessing its Meaning

Mary Miller

Follow this and additional works at: <https://digitalcommons.georgiasouthern.edu/etd>

---

### **Recommended Citation**

Miller, Mary, "Pregnancy Intendedness in a High Risk Group: Reassessing its Meaning" (2005). *Electronic Theses and Dissertations*. 630.  
<https://digitalcommons.georgiasouthern.edu/etd/630>

This thesis (open access) is brought to you for free and open access by the Graduate Studies, Jack N. Averitt College of at Digital Commons@Georgia Southern. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Digital Commons@Georgia Southern. For more information, please contact [digitalcommons@georgiasouthern.edu](mailto:digitalcommons@georgiasouthern.edu).

PREGNANCY INTENDEDNESS IN A HIGH RISK GROUP: REASSESSING  
ITS MEANING

by

MARY MILLER

(Under the Direction of Helen Graf)

ABSTRACT

The traditional framework of the National Survey of Family Growth classification scheme works well for most married couples, but is less plausible for minority women who are labeled as high-risk. Surveys that are being used to assess the National Family Growth are limited classification schemes because they have failed to reveal the complex nature associated with defining pregnancies in high-risk groups. This research was designed as a qualitative study, which used semi-structured, open-ended interviews to explore concepts of pregnancy. Five qualitative dimensions of pregnancy intendedness emerged: socioconception desire for pregnancy, forced preparation, fertility behavior and expectation, post-socioconception desire for pregnancy, and dealing with the pregnancy. The relationships of these qualitative dimensions exhibited complex and varied relationships. Future research should focus on asking questions regarding pregnancy categorization in the presence of both partners in order to

elucidate the relationship between pregnancy desire for both the woman and the partner.

INDEX WORDS: Socioconception desire for pregnancy, Post socioconception desire for pregnancy, Fertility behaviors and expectations, Dealing with pregnancy, Forced preparation, High-risk groups, Pregnancy intendedness, Unwanted pregnancy, Mistimed pregnancy, Intendedness, National Survey of Family Growth, Unplanned pregnancy, Unintended pregnancy, Pregnancy

PREGNANCY INTENDEDNESS IN A HIGH RISK GROUP: REASSESSING  
ITS MEANING

by

MARY MILLER

B.S., Armstrong Atlantic State University, 2002

A Thesis Submitted to the Graduate Faculty of Georgia  
Southern University in Partial Fulfillment of the  
Requirements for the Degree

MASTER OF PUBLIC HEALTH

STATESBORO, GEORGIA

2005

© 2005

Mary Miller

All Rights Reserved

PREGNANCY INTENDEDNESS IN A HIGH RISK GROUP: REASSESSING  
ITS MEANING

by

MARY MILLER

Major Professor: Helen Graf

Committee: Stuart Tedders  
Joanne Chopak-  
Foss

Electronic Version Approved:  
May 2005

## DEDICATION

To my husband Ron, thanks for the many sacrifices that were made, both here and away in far away lands. You are my driving force and continued support. You saw what I see now.

## ACKNOWLEDGEMENTS

I wish to thank my husband for his unwavering support and patience because without him I would have stopped many months ago. Also, I would like to express sincere appreciation and gratitude to Dr. Stanford and his team for his original research. Sincere thanks to Dr. Graf and the other members of my thesis committee for the valuable guidance and assistance that they provided in the preparation of this manuscript. I thank all the ladies who let me in their lives, who let me experience parts of their lives, and who let me tell their story. Thanks to Dr. Robert Vogel for providing me with statistical insight for sampling my data. Finally, I would like to make grateful acknowledgments to the Jiann-Ping Hsu School of Public Health.



## TABLE OF CONTENTS

	Page
ABSTRACT.....	i
TITLE PAGE.....	iii
COPYRIGHT.....	iv
APPROVAL PAGE.....	v
ACKNOWLEDGEMENTS.....	vii
LIST OF TABLES.....	xi
LIST OF FIGURES.....	xii
CHAPTER	
1 INTRODUCTION .....	1
Background of the Problem .....	2
Statement of the Problem .....	6
Purpose of the Study .....	7
Research Questions .....	8
Theoretical Construct .....	8
Research Design .....	14
Significance of the Study .....	15
Limitations .....	17
Delimitations .....	17
Assumptions .....	18
Definitions .....	18
Summary .....	21
2 LITERATURE REVIEW .....	24

	Non-Traditional Measures .....	26
	Evolution of Childbearing .....	29
	Pregnancy Distinctions .....	34
	Psychosocial Barriers .....	39
	High Risk .....	41
	Recall Bias .....	43
	Partner's Influence .....	46
	Contraceptive Use .....	49
	Gaps in the Literature .....	51
	Conclusion .....	54
3	METHODOLOGY .....	59
	Purpose of the Study .....	59
	Research Design .....	61
	Sampling Methodology .....	62
	Instrumentation .....	63
	Data Collection Procedures .....	64
	Data Analysis Procedures .....	65
	Summary .....	68
4	RESULTS .....	69
	Findings .....	73
	Socioconception Desire .....	73
	Forced Preparation .....	80
	Fertility Behaviors and Expectation .....	83
	Post-socioconception Desire .....	85

Dealing with the Pregnancy .....	86
Qualitative Dimensions in Relation to the NSFG ..	89
Summary .....	92
5 CONCLUSIONS .....	94
Analysis of the Findings .....	95
Discussion of Research Findings .....	98
Implications for Future Research .....	103
REFERENCES.....	107
APPENDICES.....	126
A Survey Instrument .....	127
B Informed Consent .....	138
C Institutional Review Board Approval Page .....	141
D Copyright Permission .....	143

## LIST OF TABLES

	Page
Table 1: Age, Residence, and Educational Attainment.....	71
Table 2: Pregnancy and Birth History.....	72

LIST OF FIGURES

	Page
Figure 1: Theory of Planned Behavior.....	12

## CHAPTER 1

### INTRODUCTION

"For this, their promise, and for their hard past, I honor the women of my race." (W.E.B. DuBois, 1969).

For much of the 20<sup>th</sup> century, researchers have analyzed the complex concept of pregnancy intendedness. Since methods to assess pregnancy intentions were first established, the definition of pregnancy intendedness, a woman's attitude toward her pregnancy, which implies wanted, unwanted, planned, unplanned, intended, and unintended, has greatly changed over time (Zabin, 1999; Trussell, Vaugn, & Stanford, 1999; Mosher & Bachrach, 1996). In particular, the last decade has experienced a major reassessment in measuring the meaning of pregnancy intendedness (Zabin, 1999).

Factors such as the decline in stigma attached to illegitimacy, the significant increase in out-of-wedlock births, an increase in sexual activity outside of marriage, and the earlier onset of sexual activity have contributed to the need to reassess current instruments that are being used to define pregnancy intentions (Edin, 2000). According to Klerman (2000), these aforementioned factors should be used to reinforce the need to redevelop or redefine questions and definitions that embody today's concept of intendedness. This redevelopment should help aid policy

makers and program managers who initiate or evaluate programs associated with pregnancy intentions (Klerman, 2000). Developing a more accurate measurement that is relevant for today's meaning of pregnancy intendedness is essential in understanding fertility-related behaviors, forecasting fertility, estimating the unmet needs for contraception, implementing family planning programs, and, most of all, evaluating community-based programs aimed at preventing or reducing unintended pregnancies (Santelli et al., 2003).

#### Background of the Problem

The clinical relevancy of the National Survey of Family Growth (NSFG) classification scheme is uncertain even though it has been well established as a system for defining pregnancy fertility (Stanford, Hobbs, Jameson, Dewitt, & Fischer, 2000). Surveys that are being used to assess national family growth are limited classification schemes because they have failed to reveal the complex nature associated with defining unintended pregnancies (Sable & Libbus, 2000). Pregnancy intention is coupled with both emotional and psychological factors which may not be captured by current measures such as the NSFG and the Pregnancy Risk Assessment Monitoring System (PRAMS), another standard research tool for tracking childbirth trends

(Santelli et al., 2003). As a result, researchers have started to question the meaning of pregnancy intendedness since both the NSFG and PRAMS have reported women being happy even after experiencing unintended pregnancies resulting from contraceptive failures are (O'Campo, Faden, Gieien, Kass, & Anderson, 1993; Green, Gazmararian, Mahoney, & Davis, 2002; Hellerstedt et al., 1998).

Researchers continue to show how vital it is to plan conception as studies show the negative association of unintended childbirths and health education (Cubbin et al., 2002; Hulsey, 2001; Faghihzadeh, Rochee, Lmyian, Mansourian, & Rezasoltani, 2003). Unintended planning status of a mother's pregnancy can affect prenatal behaviors and prenatal care (Kost, Landry, & Darroch, 1998). Live births resulting from unintended pregnancies are the highest among African-American women who are poor, single, poorly educated, and who are between the ages of 15 and 24 years of age (Dietz, Adams, Spitz, Morris, & Johnson, 1998). Mayer (1997) reported that women who experience unintended childbirths have an increased risk of delivering adverse births, an increased risk of alcohol and tobacco use, and an increased risk of abortion.

Despite the wide array and efficacy of available contraceptives, unintended pregnancies propose serious



problems (Denton & Scott, 1994). As a result of unplanned births, unintended live births have been associated with increased risk of adverse outcomes such as premature births, low birth weights, or small-for-gestational-age fetuses (Cubbin et al., 2002; Mayer, 1997; Dietz et al., 1999). In the United States alone, approximately 3.1 million pregnancies are categorized as unintended, and 1.6 million of these unintended pregnancies are aborted (Grimes & Gallo, 2001; Fischer, Stanford, Jameson, & DeWitt, 2000). When compared to other industrialized nations, the United States has reported the highest rates of unwanted pregnancies (Faghihzadeh et al., 2003). Preventing unwanted births is considered the most effective method of preventing child neglect and abuse (Zuravin, 1987; 1991).

Although the way women have defined pregnancy intendedness has changed, the NSFG has continued to use the following sequences of questioning to assess a mother's feelings about a particular pregnancy: is the pregnancy wanted, unwanted, or mistimed; and what type of contraceptive practice was being used (Hulsey, 2001). Stanford et al. (2000) implied that while it is imperfect for measuring current childbearing trends, the National Survey of Family Growth (NSFG) is currently being used as an instrument for classifying pregnancy intentions. The NSFG is

a noted successor to the 1965 National Fertility Study, which directed its questions toward married women who had completed their intended family size (Campbell & Mosher, 2000). Traditional methods for measuring pregnancy intentions are less effective when applied to unmarried teenagers and unmarried adults who do not exemplify the stereotypical 1960s mother or family; these groups may provide different responses to pregnancy intentions due to their current partners' devotion to relationships, marriage intentions, and socioeconomic status (Peterson & Mosher, 1999).

Regardless of traditional methods of measurements, pregnancy intention should not be constructed on the basis of wantedness and timing, but rather on the basis of psychological and emotional factors, something the NSFG has failed to implement (Poole, Flowers, Goldenberg, Cliver, & McNeal, 2000). Developing a more accurate definition for understanding pregnancy intendedness may increase efforts to promote contraceptive use, decrease unintended pregnancies, and may help decrease the gap between socioeconomic and racial/ethnic disparities in unintended pregnancies (Mortality & Morbidity Weekly Report, 1999). The critical problem of defining and measuring intendedness must be resolved in order to develop more beneficial

instruments when reporting (1) why women fail to use contraceptives even though contraceptives are easily accessible and (2) why children resulting from the lack of contraceptive use are considered unintended (Trussell, Vaughn, et al., 1999).

#### Statement of the Problem

Pregnancy intendedness questions developed in the 1970s or earlier may no longer be adequate to describe antecedents of births and pregnancies in today's society (Zabin, Huggins, Emerson, & Cullins, 2000). According to a past NSFG survey, unlike pregnancies in the 1970s, proportions of unintended births between 1982 and 1988 had not decreased even though fertility barriers had been removed in order to allow easier access to contraceptives, sterilization, and the liberalization of abortion laws (Sable, 1999). This same survey also reported that a large percentage of teenagers answered that they did not want to be pregnant at any point in their life; this answer implies that a large number of women misunderstood what was being asked, or that intendedness cannot be measured as a dichotomy but as a continuum (Bachrach & Newcomer, 1999).

Unlike factors that previously determined fertility rates and contraceptive use among married couples, unmarried teenagers and unmarried adults are affected by completely

different factors (Kroelinger & Oths, 2000). Today's definitions of pregnancy intendedness may be valid when used at aggregate levels, but are considered weak when used at individual levels, particularly in social contexts where childbearing and pregnancy often occur in casual or transient relationships (Zabin, 1999). As opposed to measuring intention according to reproductive ability and contraceptive availability, Green, Gazmararian, Mahoney, and Davis (2002) reported that social circumstance, limited access to reproductive health services, and a partner's attitude may ultimately influence how a woman defines her pregnancy intentions.

#### Purpose of the Study

The purpose of this study was to explore how high-risk women conceptualized the intention status of their pregnancies and how their concepts related to the National Survey of Family Growth classification scheme. Research from this study may help demonstrate that intendedness is a continuum involving intentionality or planning in addition to an affective dimension expressing happiness or dismay. The aforementioned study is designed to investigate how high-risk women relate the concepts of intendedness to the intendedness category used by the National Survey of Family Growth.

### Research Questions

1. Among high-risk groups, does the meaning of pregnancy intendedness exist as a dichotomy as measured by the National Survey of Family Growth, or does a continuum exist for unintended pregnancy?
2. Does culture affect how pregnancy intendedness is defined when assessing high-risk women?
3. How do the concepts of intendedness as expressed by high-risk women correlate to intendedness categories used by the National Survey of Family Growth?

### Theoretical Construct

The concept of attitude continues to play an important part in the history of social psychology and has had a significant impact on explaining behavioral intention in public health (Ajzen & Fishbein, 1980). Fishbein and Ajzen's Theory of Reasoned Action (TRA) and Planned Behavior present a conceptual framework for studying the relationship among attitude, behavioral intention, belief, and behavior (Fishbein & Ajzen, 1975). Historically, differences regarding the complexity of attitudes and its effect on behavior support the theory that attitudes are comprised of a multi-component view (affect, cognition, and conation), which dominates views concerning attitudes (Ajzen & Fishbein, 1980, p 17).

A measurement of attitudes may not always be a predictor of behavior, but knowledge of the determinants of intention is both necessary and sufficient for influencing and understanding human actions (Ajzen & Fishbein, 1980; Ajzen & Fishbein, 1974; Fishbein & Ajzen, 1974). Attitudes are multidimensional (cognitive, affective, conative) and it follows that single attitude scores cannot accurately predict behavior because they cannot represent the three components adequately (Ajzen & Fishbein, 1974). In search of better predictors of social actions when traditional individual-difference variables have failed to predict behavior, some researchers have turned to models of behavioral intention (BI) (Kashima & Kashima, 2001; Davis & Warshaw, 1992).

The Theory of Reasoned Action and Planned Behavior, a behavioral intention model, has been used to predict intentions to engage in premarital sexual intercourse, intentions to practice contraception, and intentions concerning family size (Fishbein, Jaccard, Davidson, Ajzen, & Loken, 1980). Ajzen and Fishbein's 1980 TRA implies that most actions of social relevance are under volitional control and views a person's intention to not perform or perform a behavior as the immediate determinant of the action. Also, Ajzen & Fishbein (1980) have argued that

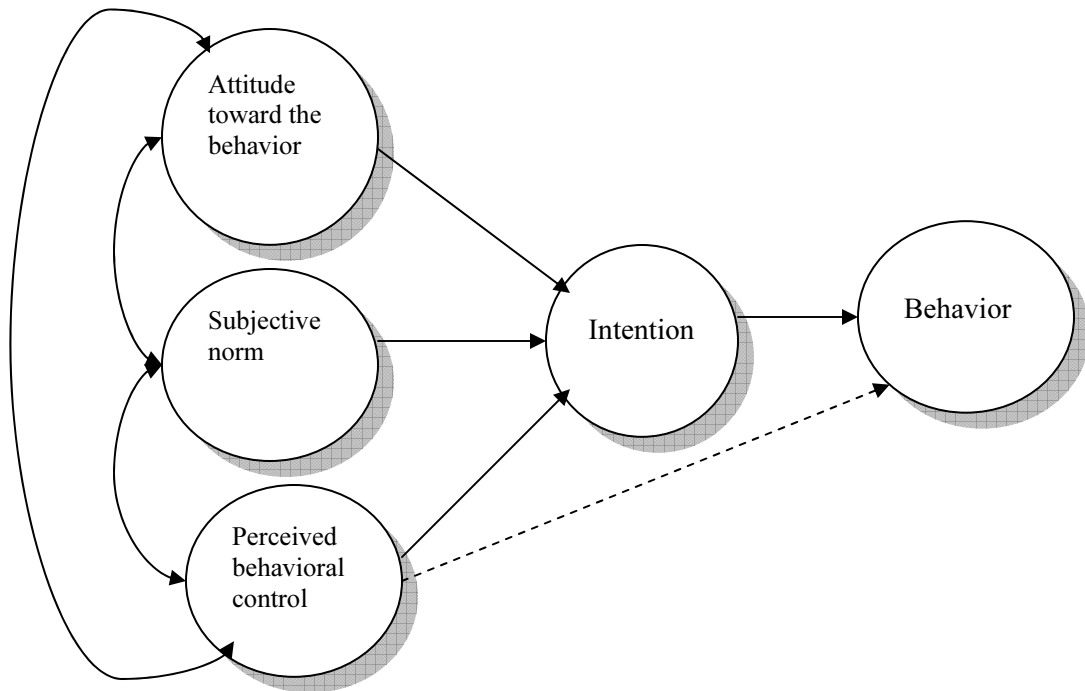
people consider the consequences of their actions before they decide to perform or not perform a behavior.

According to TRA and Planned Behavior, intention depends on two independent factors: attitude and subjective norm (Ajzen & Fishbein, 1980, chap. 5). As the Theory of Reasoned Action and Planned Behavior implies, a person's attitude is a function of two basic determinants, one personal in nature and the other reflecting social influence (Ajzen & Fishbein, 1980). In turn, behavioral intention is determined by a person's attitude toward the behavior, while deliberating the consequences and perceptions of significant others (subjective norms) (Ajzen & Fishbein, 1980; Park, 2000).

Ajzen & Fishbein (1980) have postulated that as long as intention (attitude) and behavior have a strong empirical relation, the factors that determine intentions also provide an explanation for behavior. As a result attitudes are dependent on beliefs regarding the outcomes of performing these behaviors and values attributed to these outcomes (Davis & Warshaw, 1992). A person's perceived social pressures (subjective norms) are a function of the person's normative beliefs (how they feel "important others" expect them to behave) and the person's motivation to comply

with these "important others" (Ajzen & Fishbein, 1980, chap. 6). Figure 1 depicts the Theory of Planned Behavior.





---

Note: From "The Theory of Planned Behavior," by I. Ajzen, 1991, *Organizational Behavior and Human Decision Processes*, 50, p. 182. Reprinted with permission from Elsevier.

## Figure Caption

Figure 1. Arrows indicate the direction of influence when determining a person's behavior.

According to Ajzen (1991), explaining human behaviour and all its complexities is a difficult task. The performance of most individuals is largely dependent on the degree of non-motivational factors, which include availability of requisite opportunities and resources (e.g. time, money, skills, cooperation of others) (Ajzen, 1988). Most actions of social relevance are under volitional control and consistent with a person's intention to perform or not perform a behaviour (Ajzen & Fishbein, 1980).

#### Research Design

A qualitative study was used to relate concepts of intendedness given by participants to intendedness categories used by the NSFG. This study used in-depth, recorded, semi-structured interviews with open-ended questions that helped to foster a meaningful dialogue and to elicit an informal conversation between the interviewer and subjects (Rothe, 1993). To explore what meanings these women attached to their pregnancies as well as how these meanings related to specific terms commonly used to describe pregnancy intendedness (wanted, unwanted, planned, unplanned, intended, and unintended); the researcher used interviews rather than questions with predetermined response categories. In addition, questions were taken

verbatim from the 2001 NSFG pregnancy classification instrument (Stanford et al., 2000). The study focused only on past conditions instead of present or future conditions while trying to reveal relationships between non-manipulated variables. Qualitative dimensions delineated in this study may offer some insights for other researchers who are trying to define the many facets of intendedness and how high-risk groups relate to the terms used to describe pregnancy intendedness. Cultural as well generational factors were taken into consideration when developing inclusion criteria.

#### Significance of the Study

Both the NSFG and PRAMS measure pregnancy intendedness as a simple dichotomy instead of as a continuum (Moos, Petersen, Meadows, Melvin, & Spitz, 1997). A continuum, however, not only distinguishes between unintended and intended pregnancies, but also includes an affective dimension (the desire for a baby) and a planning dimension (preparation for the baby) (Moos, Petersen, Meadows, Melvin, & Spitz, 1997). When questioned about their pregnancy intendedness, according to the 1985 NSFG, a large number of teenagers reported that they did not want to have any number of children in the future; this answer implies that a large number of women possibly misunderstood the

question being asked or that the NSFG measurement of intendedness is flawed (Mosher & Bachrach, 1996). Pregnancy intendedness is a complex concept and current methodological critiques that are being used to assess intendedness have been under scrutiny (Pulley, Klerman, Tang & Baker, 2002).

Previous qualitative studies that were used to define dimensions of pregnancy intendedness failed to include the fact that women who are poor, with less than a high school education, and who are unmarried account for the majority of unintended pregnancies (Fischer et al., 1999; Stanford et al., 2000). This research focused on high-risk women who fit into the category described above. Qualitative dimensions identified by this research will help delineate how high-risk groups define pregnancy intendedness and how the NSFG and PRAMS can develop instruments that measure pregnancy intendedness as a psychological, emotional, and active continuum instead of a dichotomy. While the NSFG has been a significant tool for providing continuity to past data and further research, a more accurate instrument may be needed to measure today's definition of pregnancy intendedness (Klerman, 2000).

### Limitations

1. Participants were less diverse than the United States population.
2. Lack of cooperation from hosting facilities.
3. Participants may start the interview, but refuse to continue the interview.
4. Participants hastily answering questions because they do not want to be disturbed.
5. Low participation rate.
6. Questions regarding validity and reliability involving qualitative studies.
7. Failure to of women to divulge total number of pregnancies, both aborted and carried to term.

### Delimitations

1. Only high-risk women were included in the study.
2. Women were interviewed many years after gestation.
3. Study did not include women who were pregnant.
4. All interviews were conducted in English.
5. Study did not include married high-risk women.
6. Researcher failed to find enough participants to carry out the study.
7. Researcher failed to collect the required amount of data during a specified time frame.
8. This Study is a retrospective study.

9. Study did not have enough qualified help to record dialogue.

#### Assumptions

1. Participants will answer questions honestly.
2. Previous studies reported correct data.
3. All selection categories will be filled.
4. Primary investigator will be objective when conducting analysis.
5. Theoretical saturation will occur when defining all terms.
6. Software designed for qualitative research will be culturally sensitive.

#### Definitions

1. Pregnancy intendedness - planning status of a pregnancy or a construct based on questions that ask only about wantedness or timing (Klerman, 2000; Campbell & Mosher, 2000).
2. Unintended pregnancy - a pregnancy that is reported as being unwanted or mistimed (Santeili et al., 2003; Morbidity & Mortality Weekly Report, 1999).
3. Intended pregnancy - a pregnancy that is reported to have happened at the right time or later than desired (due to infertility or difficulties in conceiving) (Klerman, 2000; Ahluwalia et al., 1999).

4. Planned pregnancy - when a woman thinks about becoming pregnant, discontinues contraceptive use and decides that she is ready to have a child; planning a pregnancy takes place before intercourse (Kroelinger & Oths; 2000; Musick, 2002; Santelli et al., 2003).
5. Unplanned pregnancy - a pregnancy conceived while a woman was using birth control consistently and correctly (Klerman, 2000).
6. High-risk groups - women who have less than a high school education, who maybe teenagers, unmarried, of minority status, and less likely to initiate early prenatal care (Johnson et al., 2003).
7. Pregnancy attitude - the degree of happiness about a suspected pregnancy (Sable & Libbus, 2000).
8. Inadequate prenatal care - prenatal care initiated after the first trimester while attending less than 50% of recommended visits or foregoing prenatal care throughout a pregnancy (Egarter, Braveman, & Marchi, 2002; Mikhail, 2000).
9. Late prenatal care - prenatal care that is initiated after the first trimester, but before the third trimester (Kogan, Kotelchuck, Alexander, & Johnson, 1994).
10. Low birth weight - infants weighing less than 2500 grams when born (Alexander, Kogan, & Nabukera, 2002).



11. Affective dimension - expressing happiness or dismay over being pregnant (Bachrach & Newcomer, 1999).
12. Planning dimension - preparation for a pregnancy, life goals, and education (Santelli et al., 2003).
13. Mistimed pregnancy - a conception that is unwanted at the time the pregnancy occurred, although the mother wanted to have an additional child or children in the future (Kost et al., 1998; Klerman, 2000; Sable, 1999).
14. Fertility - actual reproduction (Campbell & Mosher, 2000; Mosher & Bachrach, 1996).
15. Fecundity - the ability to reproduce (Campbell & Mosher, 2000; Mosher & Bachrach, 1996).
16. Ambivalence - indifferent attitudes toward a pregnancy in addition to the timing of the pregnancy (Sable & Libbus, 2000).
17. Intention status - process that occurs around the time of conception and involves the physical act of prevention or non-prevention of pregnancy (Kroelinger & Oths, 2000).
18. Unwanted pregnancy - a negative attitude on the part of an expecting mother toward the pregnancy when she first finds out that she is pregnant or a pregnancy that has occurred when no children or no more children were desired (Denton & Scott, 1994; Stanford et al., 2000).

19. Intentionality - pregnancy planning status (Bachrach & Newcomer, 1999).

20. Wanted pregnancy - any pregnancy that occurred at the right time, along with all pregnancies that occurred later than wanted, and all pregnancies where the respondent stated ambivalence in response to the timing question (London, Petterson, & Piccinino, 1995).

#### Summary

Research continues to support the view that becoming pregnant is a rational behavior centered on planning and forethought (Henshaw, 1998). In addition, both the NSFG and PRAMS intention instruments have continued to demonstrate this by asking questions in terms of the relationship of contraceptive use and pregnancy (Klerman, 2000). Pregnancy planning along with forethought may be applied to some couples that choose to give birth, but for the majority of high-risk groups, where unintended pregnancy is a serious problem, this rationale may not be applicable (Fischer et al., 2000).

Many women believe that pregnancy timing holds little significance and they believe that one to three children should be expected (Stanford et al., 2000). Even if unexpected births happen, certain groups of women still accept these births as the will of a higher power and no

future plans will be adversely affected by these pregnancies or births (Zabin, 1999). The previous statement is a reflection of a lack of concern about timing and numbers of pregnancies and these attitudes are more common among the less educated and adolescents (Cowley & Farley, 2001).

Stanford et al. (2000) suggested that intendedness questions proposed by the NSFG and PRAMS are not applicable to women who espouse the above attitudes, but instead these instruments foster an unmodified concept of timing as a basis for differentiating types of pregnancies. For this reason, a reformulation or reassessment of intendedness questions is needed to identify these women and to inform these women of advantages and disadvantages associated with pregnancy planning, though ultimately the choice not to plan pregnancies remains theirs to make (Klerman, 2000).

Current and future research should formulate new questions that will provide a better understanding of how unintended pregnancies are a result of complex, multiple, interrelated social and economic influences as well as how contextual determinants such as poverty, racism, partner's influence, and health service structures constrain many women's options for and access to health care (Cubbin et al., 2002). This research will address these concerns by

using a qualitative method to compare intendedness categories from both NSFG and NUD\*IST qualitative dimensions.

Chapter two reviews the literature for this study. Chapter three delineates the purpose of the study and setting, research design, sample, instrumentations, data collection, and data analysis procedures. The remaining two chapters include a discussion of the findings and recommendations for future research.

## CHAPTER 2

### LITERATURE REVIEW

"Do I contradict myself? Very well then I contradict myself (I am large, I contain multitudes.") Walt Whitman (as cited in Bartlett, 1992, p. 489).

The National Survey of Family Growth (NSFG) is considered a well-established instrument for determining fertility rates and predicting birth rates, but researchers have begun to question its validity when it comes to measuring intendedness (Klerman, 2000; Sable, 1999). Conventional measures of intendedness were designed to capture a snapshot of how an expectant mother felt about being pregnant, but these questions are asked many months after the baby has been delivered, miscarried, or aborted (Santelli et al., 2003). Furthermore, current measures have focused only on questions that assess the timing of pregnancies and contraceptive methods to categorize pregnancies as intended, mistimed, or unintended (Williams & Alma, 1999).

Sable (1999) reported that pregnancy intendedness should be considered a complex concept because it involves the added emotions of two people and how and when two individuals practiced contraception. Ajzen & Fishbein (1980) theorized that intention is a function of

multiplicity, one that involves two determinants- social influence and personal influence. For this reason, Bachrach and Newcomer (1999) proposed that the extremes of pregnancy intendedness should be measured as a continuous sequence and not as a simple separation between two extremes as suggested by the National Survey of Family Growth.

Healthy People 2010 has proposed that all pregnancies should espouse a planning method and that all pregnancies should be wanted pregnancies, but over half of all pregnancies in the United States are unintended pregnancies because of inconsistent contraceptive methods (Fischer et al., 1999). A planning method that supports a continuum, Stanford et al. (2000) revealed that according to their study this continuum contains the following two dimensions: an affective dimension, which is related to the partner, community, and personal values concerning childbearing and a planning dimension, which involves preparation for pregnancy, life goals, and education. Inconsistency in contraceptive use may be associated with a partner's influence on this continuum, because even though women know how to use contraceptives effectively, they may not have the power within their relationship to act on this knowledge (Sable & Libbus, 2000). According to Stanford et al. (2000),

males' or partners' influence can directly affect a woman's attitude towards her pregnancy.

#### Non-Traditional Measures

Since there has been a dramatic increase in out-of-wedlock births, a decline in stigmas attached to illegitimacy, earlier initiation of sexual activity, and later marriages, questions that were used to assess pregnancy intention during the 1960s may not be appropriate to delineate antecedents of pregnancies and births during the twenty-first century (Klerman, 2000). Since the 1920s, earlier measures of intendedness have been defined in terms of a married couple's fertility history, and since the early 1970s, the National Survey of Family Growth has classified pregnancies based on two sequences of questioning that have focused on contraceptive history and the method in which they are being used in order to assess whether a married woman, who had completed her ideal family size, wanted to have additional children in the future and whether or not a pregnancy occurred sooner than she wished (Kaufmann, Morris, & Spitz, 1997). Later, while trying to compensate for large portions of unintended births to unwed mothers, past researchers failed to identify non-demographic factors that influence fertility-related behaviors which could have been used to define pregnancy intendedness, but,

instead, issues were further complicated by changing the definition of intendedness to include pregnancies and births as units of measurements (Campbell & Mosher, 2000).

For over half a century, the NSFG has used questions regarding contraceptive history and contraceptive methods to assess pregnancy intendedness and these same questions have been used to influence policies that are purported to reduce the number of unintended births (Melvin et al., 2000). Trussell, Vaughan, and Stanford (1999) study suggested that more than just an area of variation exists between unintended and intended, but rather a wide spectrum from truly unintended, through unplanned, to intended and, finally, to deliberately planned. Current surveys have continued to treat intendedness as a fixed variable in which women are supposed to unequivocally maintain the same feelings before, during, and after their pregnancy (Poole et al., 2000). Meanwhile, information involving fertility-related behavior revealed that, according to the 1988 National Survey of Family Growth, despite the efficacy and availability of contraceptives, unwanted and unintended births have increased (Williams, 1991). The 1988 NSFG reported that more than 85% of births to never-married teenagers are unwanted at anytime in their life; this phenomenal response to the NSFG questionnaire may suggest



that respondents misunderstood questions, or that fertility-related behaviors were being impacted by other determinants (Mosher & Bachrach, 1996).

According to Abma and Mott (1994), motivational incentives for limiting childbearing for high-risk women are less pronounced; their perception of future employment is limited and constrained by society. Sable's 1999 study implied that certain women are more inclined to give socially acceptable answers for questions that are being used to assess intendedness regarding out-of-wedlock births; therefore this may explain why high-risk groups have a higher propensity for answering "unintended" when asked questions regarding their methods and history of contraceptive use. Zabin (1999) reported that when asked yes or no questions regarding pregnancy intention, women in high-risk groups or who are disadvantaged and living in unstable environments may say their pregnancy is unintended when in actuality it is intended. These views and relationships may offer an explanation as to why childbearing and fertility intention differ by stages of demographic transition and societal status context (Zabin, 1999). Attitudes and behaviors concerning fertility intention involve a complex theory that describes the

behavior of not one but both partners (Ajzen & Fishbein, 1980).

#### Evolution of Childbearing

One of the most dramatic changes in postwar American family-formation patterns has been a dramatic increase of childbearing outside of wedlock (Parnell, Swicegood, & Stevens, 1994). According to a 1976 survey performed by the NSFG Cycle I, Anderson (1981) reported that 94% of second births were wanted and 72% were planned. When compared to the above figures, in 1982 10% of all births to ever-married women were unwanted and 28% were mistimed (Abma & Mott, 1994). Among never-married women 25% of all births were unwanted, and nearly half of the remaining births were mistimed (Abma & Mott, 1994). However, in recent years, declining levels of unwanted pregnancies have been observed, but in spite of this progress, according to the NSFG, high-risk women continue to have serious problems avoiding unintended pregnancies (Williams, 1991).

Luker (1999) has suggested that unintended pregnancies have shifted from the end of completed family sizes to the initial stages of planning a family or when to become a mother. As the tie between marriage and childbearing has progressively unraveled, women have become accustomed to planning their families outside of legal marriages (Musik,

2002). The 1992 Ortho Birth Control Study revealed that sexual activity among unmarried women has continued to increase and as a result the proportion of women experiencing unintended pregnancies has also increased (Forrest & Fordyce, 1993). In 1998, Henshaw estimated that the 1995 NSFG underreported unintended births and by his calculations the correct estimations are as follows: total number of unintended births during 1994 was 3.04 million which includes induced abortions, spontaneous abortions, and unintended births. According to Henshaw (1998), these numbers are higher than the 1995 NSFG because he assumed that all abortions are unintended pregnancies.

Klerman's (2000) study implied that current measures have failed to capture the diverse meaning of intendedness when assessing the underserved and high-risk population. Traditional measures have juxtaposed marriage and childbearing; when one existed, the other followed closely behind (Bumpass & Westoff, 1970). For much of recorded time, all births that occurred during wedlock were considered wanted, all births outside of wedlock were considered unwanted, and a large number of births to a single family were considered the norm because contraceptive practice was in an infantile stage (Kertzer, 1991). Sable (1999) reported that in a society (underserved) where stable marriages and

two-parent households are considered only part of the mainstream, high-risk groups assign different degrees of value to concepts and circumstances used to determine the meaning of intendedness. Stanford et al. (2000) reported that certain groups of women viewed pregnancy intention from five dimensions (preconception desire for pregnancy, steps taken to prepare for pregnancy, fertility behavior and expectation, post-conception desire for pregnancy, and adaptation to pregnancy and child) and these dimensions are more precise but still concordant with Fischer et al. 1999 study.

Every pregnancy conceived outside of marriage is not considered an unintended pregnancy, even though current pregnancy intendedness measures report them as unintended (Bachrach & Newcomer, 1999). Many high-risk or disadvantaged women are inclined to have pregnancies out of wedlock with a casual partner because of structural family problems that exist within the African American community (Wu & Martinson, 1993). For example, experiences among poor women, whose unintended pregnancies are often related to their social circumstances and limited access to reproductive health services, differ significantly from middle-class women, for whom an unintended pregnancy may

represent ambivalence about sexuality (Santelli et al., 2003).

Researchers have reported that instability of pregnancy intentions is associated with identifiable risk factors such as low socioeconomic status and being single (Joyce, et al., 2002; Hulsey, 2001; Mayer, 1997). America has continued to hold Moynihan's (1965) view on African American families, which suggested that the pathological nature of African American communities can be traced to the deterioration of African American family life. On the contrary, Ruggles (1994) has argued that disadvantaged positions of African Americans are the cause of single-parent families, which are often associated with unintended childbearing.

Since the 1970s and the 1980s, people in the U.S. have continued to strongly criticize welfare for African American social injustices such as decreasing marriage rates, increasing poverty, and increasing out-of-wedlock births, even though these injustices existed as far back as the 1850s even among free African Americans (Ruggles, 1994; Edin, 2000). Due to welfare's complex rules regarding benefits to the married working poor, many African Americans believed they were being sanctioned for marrying because government agencies allotted them a lesser amount

of money even though both parents' qualifying wages were below the poverty level (Hoffman & Duncan, 1994; McAllister & Boyle, 1998; McAllister, 1997). Although researchers have failed to come to an agreement on what causes single-parent homes, they do agree on the following: African American women who reside in poverty-stricken neighborhoods, who live below the federal poverty level, and who are raised in single parent homes are more likely to have births out of wedlock (Wu & Martinson, 1993; Klima, 1998; Wu, 1996; Hogan & Kitagawa, 1985).

When it comes to marriage and African Americans, economic hardships have presented substantial risk factors for African Americans, and, as a result, out-of-wedlock births have continued to increase substantially (Roberts, 1997). In Edin's (2000) qualitative study on low-income single mothers and marriage, she reported that mothers in her study considered marriage to be a burden for them. Women in Edin's (2000) study reported that because of abuse and the lack of financial contribution from male partners, they saw no reason to marry. In a 1994 wantedness study, Abma and Mott reported that only 14% of African Americans were married when compared to 29% of Hispanics and 48% of Whites. Cubbin et al. (2002) reported that even after adjusting for education, ethnicity, marital status, and

other factors that were likely to confound differences in wealth, poverty status remained statistically significant for minority postpartum women with incomes below the federal poverty level and these same women had about a 60% likelihood of having an unintended pregnancy. Surprisingly, at its best, stratification at the societal level has continued to dictate which mothers possess necessary resources to have a traditional family life (Wu, 1996).

#### Pregnancy Distinctions

Since 1973, based on married women' answers to questions that assessed whether they wanted to bear children in the future and whether or not a pregnancy happened sooner than wanted, the National Survey of Family Growth has categorized intendedness in the United States as wanted, mistimed, or unwanted (Hulsey, 2001). Pregnancy intendedness has been classified as the following: a pregnancy that was not wanted at any point in time is classified as unwanted; if a pregnancy was wanted, but wanted at a different point in time, the pregnancy is classified as mistimed; and if a pregnancy was wanted, regardless of the point in time, the pregnancy is classified as intended wanted (Stanford et al., 2000; Melvin et al., 2000). Mistimed and unwanted pregnancies may be classified as unintended pregnancies; these pregnancies are often

associated with elective abortions, inadequate prenatal care, poor health behavior, and child abuse, and these are the cause of concern when addressing solutions for Healthy People 2010 (Grimes & Gallo, 2001).

Despite living in a technological-based era in which couples should have considerable control over their reproduction, researchers have reported that nearly half of all pregnancies in America are unintended (Lee & Stewart, 1995; Hellerstedt et al., 1998). Emphasizing personal choice and intent, Healthy People 2010 has recommended that the nation adopt the following social norm in which all pregnancies are intended pregnancies instead of unintended pregnancies (U.S. Department of Health and Human Services, 2000). However, for over half a century, surveys used to measure pregnancy intention have failed to use the term unintended because among all ever-married women all conceptions were perceived to be wanted (Campbell & Mosher, 2000).

Females of all socioeconomic levels, marital status, and age groups are affected by unintended pregnancies, but certain females who are young, unmarried, less educated, and poor are reported to be more prone to unintended pregnancies (U.S. Department of Health and Human Services, 2000; Forrest, 1987; Forrest, 1994). According to data from



the 1982, 1988, and 1995 cycles of the National Survey of Family Growth, high-risk women had an unintended pregnancy rate that was three times higher than that of Caucasians (Henshaw, 1998). Cubbin et al. (2002) reported that according to a California study, women with less education are more likely to have unprotected sex, to have decreased use of abortion services, and decreased knowledge of effective contraceptive use when compared to educated women.

Unintended pregnancies can be further classified as unwanted or mistimed pregnancies (Dietz et al., 1998). A pregnancy is termed mistimed if a woman answered that she wanted a pregnancy, but not at a particular point in time and although mistimed pregnancies are classified as unintended, mistimed pregnancies pose less of a problem when compared to unintended unwanted births (Kost et al., 1998). The extent of mistimed pregnancies becomes important when considering their health impact (Santelli et al., 2003). Although negative associations of mistimed pregnancies are minimal when compared to unwanted pregnancies, mistimed pregnancies are considered unwanted pregnancies and they continue to be an important problem for health care providers and public health professionals (Abma & Mott, 1994). Seriously mistimed pregnancies (by more than 24 months) pose a problem if they are carried to term and

these types of unintended mistimed pregnancies are at a higher risk of being delivered before gestational age, of being of low birth weight, and not being breast fed, when compared to pregnancies that are mistimed by less than 24 months (Joyce & Grossman, 1990). Currently, additional research is needed before the importance of the mistimed category can be fully assessed and, therefore, all pregnancies that are considered to be grossly mistimed, according to the NSFG, are labeled as intended (Pulley, Klerman, Tang, & Baker, 2002).

Unintended unwanted pregnancies have been recognized as the most problematic pregnancies because they are often associated with abortions, late prenatal care, and negative maternal behavior (Trussell, Stewart, Guest, & Hatcher, 1992). According to the National Survey of Family Growth, when compared to mistimed pregnancies, unintended unwanted pregnancies are reported most often; these pregnancies are defined as pregnancies that are not wanted at any time and they may or may not be carried to term (Stanford et al., 2000). Although contraceptives are easily available, abortion is sought as a frequent solution for unintended unwanted pregnancies (Sulak, 1993). In America, for every three live births, one abortion occurs annually and with a ratio of two to four, the United States has continued to

surpass other industrialized countries such as Canada, Great Britain, and Australia in abortions performed (U.S. Department of Health and Human Services, 2000). According to data reported by the 1988 NSFG, 3.1 million pregnancies were reported as unplanned, 1.6 million ended in abortion, and 1.5 million were carried to term (Sable et al., 1997).

In the United States, nearly 40% of newborns are unintended unwanted pregnancies that are carried to term and these pregnancies are often associated with adverse prenatal outcomes resulting from inadequate or no prenatal care (Forrest & Fordyce, 2001). A recent report documented that when compared to women with intended pregnancies, women with unintended unwanted pregnancies are more likely to consume alcohol, abuse drugs, and smoke cigarettes in their first trimester when child development is considered most critical (Santelli et al., 2003). Also unintended unwanted pregnancies have been linked to negative behaviors such as delivering low birth weight infants and initiating late prenatal care (Abma & Mott, 1994).

A disproportionate number of African American infants have died in part because their mothers have failed to initiate early prenatal care when compared to non-high-risk women (McAllister, 1997). Concomitantly, during their first months after birth, African American infants are two times

more likely than non-Hispanic white infants to die of complications resulting from low birth weight (Lu & Halfon, 2003). Morbidity and Mortality Weekly Report (2002) has reported that low birth weight percentages increased to 11.8% from 1980-2000 due to inadequate prenatal care; this sharp increase in low birth weight is attributed to women who are labeled as high-risk groups or belong to an ethnic minority group, with low income, low educational attainment, no spouse, multiparous, and little or no insurance (Zayas, Cunningham, McKee, & Jankowski, 2002). Although Medicaid and other state plans have been made available and accessible, researchers have continued to report late prenatal care initiation and unintended pregnancies among these groups of women (Klerman, et al., 2001; Meikle, Orleans, Leff, Shain, & Gibbs, 1995; Newes-Adeyi & Maxwell, 2000).

#### Psychosocial Barriers

Sable and Wilkinson (2000) reported that certain major life events combined with a lack of social support can negatively affect or alter how women view their pregnancies. Also, emotional distress may be associated with how a mother describes her pregnancy, how a mother feels about her pregnancy and, as a result, influence pregnancy related behaviors and maternal beliefs (Nuckolls,

Cassel, & Kaplan, 1972). Lu and Halfon (2003) reported that typical maternal psychological stress is associated with stressful life events that can lead to low birth weight infants or preterm deliveries.

Until recently, very little research has shown how psychological and emotional behaviors affect mother-child relationships because most studies resulted from retrospective record reviews where little reliable psychosocial information is available (Sagrestano et al., 2002). Research has theorized that during their first trimester, women go through a period of oscillation when trying to accept or reject the idea of being pregnant; when the quickening stage is reached during the second trimester, women work toward the idea of accepting the pregnancy; and a woman's feeling about wanting the pregnancy may change as the pregnancy has progressed and the woman has worked through maternal tasks (Hulsey, 2001). Joyce, Kaestner, and Koreman (2002) reported that the National Longitudinal Survey of Labor Market Experiences revealed the following statistics: 10.1% of pregnancies reported during pregnancy as intended were reported unintended after the birth, and 29.2% of unintended pregnancies were reported intended after delivery. In other words, mothers were three times more likely to switch pregnancy intention from unintended to

intended than from intended to unintended, but women whose pregnancy was intended did not switch pregnancy classification (Joyce et al., 2000). Women whose pregnancies were intended initiated earlier prenatal care, smoked less during their pregnancy, and were more likely to breast feed their infants when compared to women whose pregnancies were unintended (Mayer 1997). Women with unintended pregnancies often live in dysfunctional environments and are exposed to physical and sexual abuse during their childhood (Santelli et al., 2003).

#### High Risk

The positive benefits associated with adequate prenatal care during pregnancy has been well documented, supporting the case for universal maternity care in the United States (Millard, Beerman, Massey, Shilz, & Heiss, 1999). Certain populations of women are considered to be at a greater risk for poor birth outcomes than other women (Frisbie, Echevarria, & Hummer, 2001). According to Millard et al. (1999), these women are termed high-risk because they usually are young, poor, undereducated, of minority status, and without a spouse or support system. According to Johnson et al. (2003), women who are labeled high risk are less likely to initiate early or no prenatal care and

experience higher infant mortality rates when compared to women who initiate early prenatal care.

There is a substantial body of literature correlating women who receive little, late, or no prenatal care with increased risks of poor pregnancy outcomes; many studies have linked decreased prenatal care visits with adverse birth deliveries or low birth weight (Alexander & Kotelchuck, 2001; Handler, Rosenberg, Raube, & Lyons, 2003; Frisbie, Echevarria, & Hummer, 2001; Power & Matthews, 1997; Newes-Adeyi & Maxwell, 2000). The magnitude of low birth weight infants and infant mortality is of considerable size (Roberts, 1997). Also, Roberts (1997) reported that low birth weight and infant mortality rates for women with late and no prenatal care were 7.6% and 10.7 per 1000, respectively, for the State of Illinois and 19.5% and 31.9 per 1000 for certain neighborhoods in Chicago. A major reason for these differences was an interlinked system of social, environmental, and biological factors that are unique to high-risk women (Roberts, 1997).

Sociodemographically, researchers have delineated populations which have an increased risk for inadequate or no prenatal care; this group is characterized as being of ethnic descent, mainly African American, of low income status, multiparous, unmarried, and with less than a high

school education (Stout, 1999; Pagnini & Reichman, 2000). The National Center for Health Statistics reported that high-risk women who are socially and economically disadvantaged were 12% more likely to initiate late prenatal care when compared to only 5% of whites who initiated late prenatal care (Meikle, et al., 1995). Lu and Halfon (2003) reported that during the first months of birth, infants of high-risk mothers are two times more likely than non-Hispanic white infants to die of complications resulting from low birth weight.

Cost, organization, transportation, and delivery of care have also been associated with structural barriers. Medicaid has been instrumental in reducing structural and financial barriers for disadvantaged women, but numerous women fail to receive prenatal care even when financial and structural barriers are controlled (Pagnini & Reichman, 2000). Additional research is needed to improve prenatal care utilization (PNC) among high-risk women, but in order to improve PNC utilization, providers need to gain a better understanding of factors influencing prenatal care initiation (Johnson, et al., 2003).

#### Recall Bias

The fact that a large number of teenagers reported that they did not want to become pregnant at any time in



the future when asked to assess their pregnancy intendedness has encouraged demographers and researchers to question the validity of the National Survey of Family Growth questionnaire (Klerman, 2000). The National Survey of Family Growth has relied on two sequences of questioning that ask mothers to recall how they felt or what they did before they became pregnant (Trussell, Vaughan, et al., 2001). Retrospective studies have been prone to recall bias and as a result many women who experience adverse births may report negative feelings about their pregnancy in order to explain negative outcomes, and women with healthy births may be less likely to express their initial feelings about their pregnancy (Sable & Wilkinson, 2000).

At an NSFG interview, a respondent's state of mind is being captured and many events could have transpired that may have an effect on how the respondent felt at a particular point in time during her pregnancy (Musick, 2002). In theory, instead of measuring pregnancy intendedness, the NSFG has been measuring the extent to which a respondent can account for past actions and behavior and ways to explain or rationalize such behavior (Ryder, 1973). As a result of post hoc rationalization, feelings about a healthy child and the unwillingness to admit to a socially unacceptable answer, many unintended

pregnancies may be underreported and intended pregnancies may be overreported (Trussell Vaughan, et al., 2001; Williams et al., 1999).

Another explanation for recall bias is increased pressure to offer a socially acceptable response that could explain how or why an illegitimate birth is considered intended when adverse social and environmental conditions abound or how these pregnancies are considered unintended when incorrect or no contraception was being practiced (Bachrach & Newcomer, 1999; Sable, 1999). Clearly, not all unintended pregnancies are contraceptive failures (Sable, 1999). According to the NSFG, the following classification is used when reporting unintended pregnancies: unintended pregnancies have occurred when safe contraceptive use was not being practiced; nearly 50% of unintended pregnancies have resulted from women not using a form of contraception when they conceived; of pregnancies classified as contraceptive failures, under the NSFG's definition, only 68% were unintended, which resulted in a 94% abortion rate; 59% of women with an unintended pregnancy resulting from contraceptive failures reported being unhappy, while 90% of those with a contraceptive failure were classified as intended (Trussell & Vaughn, 1999). For most high-risk women, intendedness status is not fixed, but instead is

dynamic, and it is clear that this status changes in terms of feelings at a particular point in time (Poole et al., 2000).

#### Partner's Influence

Qualitative studies have reported that many women define their pregnancy intentions according to their partner's attitude (Stanford et al., 2000; Fischer et al., 1999). Ajzen and Fishbein (1980) theorized that on the normative side, women are influenced mostly by their husbands, boyfriends, current partner, and care givers. Even when effective contraceptive methods are known, some women may not have the power within their relationship to act upon what they want because of a threat of violence (Donovan, 1995; Sable & Libbus, 2000). For traditional married couples, a simple schema may suffice in which partners select a family size and then pursue it or periodically revise it; however, at any given moment they agree on the targeted family size. Such a schema is less plausible for unmarried couples, momentarily cohabitating couples, and unmarried teenagers (Stevens-Simon, Kelly, & Singer, 1996).

Most women are inclined to change their intendedness status based on their current partner's expressed or unexpressed feelings of wantedness even if no marital bond

exists (Parnell et al., 1994). In an economically inferior environment where men are scarce and means are inferior, a partner's influence is considered significant (May, 1980). Kroelinger and Oths' 2000 study revealed the following determinants are associated with unwanted pregnancies: unwantedness was significantly influenced by the stability (emotional, financial, or support) of a partner (father of the child or current partner).

When Kroelinger and Oths (2000) surveyed their participants, the following results emerged: (1) women who had partners who implied or said they were unhappy about their pregnancy said their pregnancies were unwanted, (2) more women said their pregnancy was unwanted if their partner was not reliable when compared to those whose stated their partner was reliable, (3) and women who lacked financial support from their partner were inclined to express feelings of an unwanted pregnancy. Not only can a current partner's attitude affect how a woman describes her pregnancy, but also intention status can be affected by the number of times a woman changes partner (Zabin et al., 2000). Zabin et al. (2000) surveyed 250 low-income women and, 66% of those who changed intention status only once, had experienced a change in partner; among those with two intention status changes, 81% had experienced a change in

partner; and among those who had experienced three or more intention status changes, 94% had experienced a change in partner. Also in 2000, Joyce et al. reported that women who considered their pregnancy to be intended, only 3.3% reported that their partner or spouse did not intend the pregnancy; among women who reported their pregnancy to be unintended, 25% reported that their spouse or partner intended the pregnancy; 56.3% of women who switched from intended to unintended reported that their spouse or partner did not intend the pregnancy, and 95% of women who switched from unintended to intended reported that their spouse or partner intended the pregnancy.

Pregnancy intention is considered an important and extremely complex concept because intendedness involves emotional and psychological factors of both the partner and the expectant mother (Sable, 1999). According to Ajzen & Fishbein's (1980) Theory of Reasoned Action, intention is a function of an individual's positive or negative evaluation of performing a behavior and how one perceives social pressure associated with performing or not performing a particular behavior. Marsiglio's 1993 study reported that young African American males with strong traditional views were more inclined to believe that fathering a child out of wedlock personified being a real man and that these young

men failed to perceive any consequences typically associated with unplanned childbearing. As with most women, having a child out of wedlock is not considered a negative behavior even though negative consequences have been associated with unintended births and a person's intentions to have or not have a child are mostly based on reasonable considerations concerning various consequences that will follow (Ajzen & Fishbein, 1980).

#### Contraceptive Use

According to Trussell et al. (1992), contraceptives are the cornerstone for preventing unintended unwanted pregnancies and in addition to its overall cost analysis, this cornerstone should be of great interest to both policy makers and public health providers. Williams and Alma (1999) reported that according to fertility research, attitudes toward contraception use are instrumental in determining when fertility occurs. Nearly half of all unintended pregnancies have resulted from women not using contraception when they conceive and many resulted from improper and inconsistent use of a particular birth control method (Green et al., 2002).

In Sable and Libbus' (2000) qualitative study, among women who had stated that they had no intentions of becoming pregnant nearly half were inconsistent users of

contraceptives. Green et al. (2002) reported similar findings, which revealed that out of 1173 commercially insured women where contraceptive benefits were universal, only 40% of women with an unintended pregnancy used contraceptives one month before their pregnancy. Of the women with an unintended pregnancy who used contraception, 60% used fewer effective methods such as condoms, diaphragms, sponges, and spermicides (Green et al., 2002).

Correct contraceptive practices continue to have a profound impact on the risk of having an unintended birth (Forrest & Fordyce, 1993). When comparing women who wanted to postpone and women who wanted to forego having children, women who postponed were two to three times more likely to report an unpredicted birth than those women using contraceptives (Williams & Abma, 1999). Intention status varies according to demographic and social characteristics, and the highest rates of unintended pregnancies are noticed among subgroups that are most likely to exhibit negative pregnancy behaviors (Kost et al., 1998).

However, understanding the concept of ambivalence toward contraception is essential in understanding contraceptive practice (Zabin, 1999). According to Santelli et al. (2003), almost half of all pregnancies reported as unintended have resulted from women who failed to use

contraception rather than those who effectively used contraception. Trussell, Vaughan et al. (1999) have theorized that the above actions are contradictory because planning and intending to become pregnant are different than wanting to be pregnant and the intention to avoid unintended pregnancies often does not translate into contraceptive use.

#### Gaps in the Literature

Several gaps exist in the literature regarding African American women and their childbirth practices. While not all factors that contribute to unintended pregnancies among high-risks are known, it is clear that being African American, single, and poor has exacerbated problems associated with unintended pregnancies (McAllister & Boyle, 1998). Because of the highly publicized Moynihan (1965) report, many social psychologists, public health professionals, and the majority of Americans have continued to espouse the theory that African Americans are disadvantaged because of single-parent households and not because of their status in society (Ruggles, 1994). Very little research has been offered to support this theory, and indeed existing research has continued to perpetuate this theory without offering a critical examination of its assumptions.



Research has continued to show the effects of single-parent households on high-risk women, but research has failed to provide a source for such a critical determinant that has been seen as a pattern among high-risk women. Although researchers have surmised that single-parent households headed by African American women resulted from an accumulation of high female labor force participation, a lack of high wage jobs for African American males, and narrow wage differentials among African American men and women, few researchers have studied the effects of these accumulations on African American marriages (Morgan, McDaniel, Miller, & Preston, 1993; Rolison, 1992). According to a qualitative study provided by Edin (2000), low-income mothers receiving government assistance have stated that welfare discourages marrying because they think they are being punished (referring to a reduction of money received from the federal or state government) by welfare for being married even though their combined two-parent income fails to allow them to live a better quality of life or they see no reason to marry because it offers them no positive incentives (upward mobility or economic stability) and because they do not perceive any social stigma attached to out-of-wedlock births. Existing literature offers little insight into such reported claims.

Cultural and cohabitation trends that exist in African American households should be studied in more depth. Effects of social support and kinship networks that operate within geographical areas in which family members are located can be considered a positive determinant when reducing adverse prenatal care (Roberts, 1997). Despite long-standing belief that single-parent households in African American communities have compromised family stability among African Americans, single-parent patterns among African American families date as far back as the 1850s among free African Americans, and generally speaking, these families were stable (Wu & Martinson, 1993). It was not until after the 1960s that these families became unstable (Wu & Martinson, 1993). As a result of instability in the 1960s and plunging marriage rates, public opinion has blamed welfare for discouraging marriages among African Americans, and such discouragements have been blamed for spawning single-parent households (Edin, 2000). Single-parent households are blamed for instituting high poverty rates among African Americans, but Ruggles (1994) argues that poverty should be blamed for single parent households among African Americans.

Roberts' (1997) revealed how income, social status, and marital status are common among pregnancy statistics

regarding African Americans, and how these factors are considered important only for nine months of research. For the rest of an African American woman's life, she is considered a third-tier citizen and nothing can change that important piece of data (Roberts, 1997). Researchers have continued to study African American women from quantitative viewpoints, but few researchers have observed poor African Americans in their own environments (McAllister, 1997). Poverty, unemployment, and socioeconomic status have affected social stratifications between African Americans and Whites (Roberts, 1997). Also, according to Roberts (1997), African American families are being undermined by a lack of resources and unemployment, which erode social fabrics and paternal support. When all variables concerning unintended pregnancies are held constant, race is the only factor that remains unchanged and African American women are subjected to many more factors than those that are commonly listed (Roberts, 1997).

#### Conclusion

Over the past few decades, social psychologists and public health professionals have expended a considerable amount of time investigating how women classify their pregnancy status (Zabin, 1999; Trussell, Vaugn, & Stanford, 1999; Mosher & Bachrach, 1996). In research, policy, and

clinical practice, intendedness measurements have been used ambiguously (Moos et al., 1997). However, with different women, these terms may have totally different connotations and nowhere is this more evident than in a recent study of 110 women who were receiving prenatal care and who when asked if their births were intended, only 35% responded that their births were planned births, and of these, 91% responded with wanted births (Fischer et al., 1999).

As a result of such findings, many researchers have begun to question whether current instruments that are being used to measure intendedness are valid (Klerman, 2000; Trussell, Vaughn, et al., 1999). Although the NSFG is considered a well-established classification scheme for defining fertility rates and intendedness, it needs to be reformulated (Stanford et al., 2000). Unlike when it was initially developed, the demographic focus of pregnancy intendedness has shifted from completed family size (the end of the fertility cycle) to when to start a family or begin motherhood (the beginning of the cycle) (Luker, 1999). Instead of accounting for such an important change, the NSFG has continued to use a simple schema to distinguish between intended and unintended pregnancies (Santelli et al., 2003). However, as a result of increasing complexities associated with pregnancy and parenthood, intendedness and

unintendedness should be measured on opposite ends of a continuum, one which involves two distinct dimensions termed affective and planning (Bachrach & Newcomer, 1999).

According to Klerman (2002), the NSFG has failed to acknowledge the belief that not all women are concerned about the timing and the number of pregnancies. During its earlier measures, demographers used the NSFG to measure pregnancy intendedness during a time when all births were considered wanted, marriages were stable, and nonmarital conceptions were infrequent (Klerman, 2002). Compared to early developments of the NSFG, today more than half of all pregnancies occur out of wedlock, and over half of all pregnancies are considered unintended, and of those, approximately half have resulted in abortions (Cubbin et al., 2002).

When measuring birth and fertility rates, current measurements of intendedness are appropriate on an aggregate level, but are not as useful on an individual level because of the many different stimuli that continue to have an enormous effect on intendedness (Ajzen & Fishbein, 1980). According to the Theory of Reasoned Action, intention is a function of an individual's positive or negative evaluation of performing a behavior and how one perceives social pressure associated with performing or not

performing a particular behavior (Ajzen & Fishbein, 1974). In recent decades, the stigma associated with out-of-wedlock births has diminished, psychosocial barriers have increased, and the cord between marriage and family has unraveled (Klerman, 2000). As a result, America has experienced a surge in out of wedlock births among women who do not see marriage in their future and this may explain why, according to the NSFG, their pregnancies are considered unintended when the expectant mothers themselves see these pregnancies as intended (Zabin, 1999).

Because of such ambiguity, additional research is needed to conceptualize and measure strategies for interpreting pregnancy intendedness. Researchers have structured demographic conceptualizations of the National Survey of Family Growth on the basis of anticipated childbearing and pregnancy intendedness which differs greatly from how and when couples decide to start a family (Trussell, Vaughan, et al., 1999). Research consistently suggests that certain women and couples have multiple traits, intentions, and desires that result from a spectrum of behaviors and attitudes that are aimed at preventing or starting conception, and these behaviors and desires go beyond simply practicing or not practicing contraception (Miller & Pasta, 1995). A growing body of research seems to

support the belief that pregnancy intendedness and pregnancy wantedness are two distinct phenomena and the concept of intendedness holds no meaning for certain groups of women (Miller & Pasta, 1995). Santelli et al. (2003) implied that it is of great importance that the meaning of pregnancy intendedness be reassessed when it pertains to certain groups of women, their partners, their beliefs, and their culture and this reassessment will help healthcare providers and policy makers develop more comprehensive strategies that will be useful in reducing and understanding unintended pregnancies.

Chapter three delineates the purpose, setting, research design, sample, instrumentations, data collection, and data analysis procedures for this study. Chapter four compiles results and findings. Chapter five discusses the findings and recommendations for future research.

## Chapter 3

### METHODOLOGY

"What shall I give my children? Who are poor. Who are adjudged the leastwise of the land." Gwendolyn Brooks, Annie Allen (as cited in Bartlett, 1992, p. 740).

The purpose of this study was to explore how-risk women conceptualize the intention status of their pregnancies and how their concepts relate to the National Survey of Family Growth classification scheme. Research from this study may help further prove that intendedness is a continuum involving intentionality or planning in addition to an affective dimension expressing happiness or dismay (Fischer, et al., 1999). The proposed study was designed to show how high-risk women relate the concepts of intendedness to the intendedness category used by the National Survey of Family Growth.

#### Purpose of the Study

In 2002, Savannah, Georgia, in Chatham County boasted a population of 232,048, which consisted of 128,279 Caucasians, 93,971 African Americans, and almost 10,000 people from other races (Georgia Division of Public Health, 2004). In that year, Chatham County's poverty rate was 15% compared to 13.6% for the state of Georgia; African Americans had a 7.5% unemployment rate compared to a 2.39% unemployment rate for Whites, and almost 100% of families



below Savannah's poverty level were African Americans (US Census Bureau, 2000). According to the Department of Human Resources, Georgia Division of Public Health (2004), the number of live births in Chatham County in 2002 was 3,602 compared to 133,468 in the state of Georgia and Chatham County's percent of late or no prenatal care was 24.7 compared to 13.2 for Georgia. In 2002, Chatham County's percent of live births with less than five prenatal care visits was 12.5 compared to 3.9 for the entire state of Georgia (Georgia Division of Public Health, 2004). Also, Chatham County reported a fetal mortality rate of 11.8 compared to 8.9 for the state of Georgia; the fetal mortality rate for Whites in Chatham was 7.4 versus 14.3 for African Americans (Georgia Division of Public Health, 2004).

A recent survey by the Robert Wood Johnson Foundation reported that one in three Georgians is uninsured and when taken as a percentage, 13% of Georgians under the age of 65, or about one million are uninsured (Bryant, 2003). Among these one million, 29% of males and 24% of females between the ages of 19 and 24 are uninsured (Bryant, 2003). According to Skutch (2004), roughly 73,000 people or 15% of the population in Chatham County are uninsured. The breakdown of uninsured is as follows: 37% male, 63%

females, and most are African Americans or Latinos (Skutch, 2004).

All participants for this study lived in one of three housing projects: Yamacraw Village, Robert Hitch Village, or Fred Wessels Homes. All housing projects in the City of Savannah are entities of the Housing Authority of Savannah (HAS), which was established by the federal government in 1938 to provide decent, safe, and sanitary housing on a temporary basis (Housing Authority of Savannah, 2004). Each housing project consists of a 250-unit community and all are two-story flattop buildings (Housing Authority of Savannah, 2003). Each housing project consists of two-, three-, and four-bedroom units, which are allocated according to family size (Housing Authority of Savannah, 2004). Each housing project mirrored the next with the exception of small decorative touches.

#### Research Design

The research was designed as a qualitative study which used semi-structured, open-ended interviews, with the exception of the NSFG pregnancy classification questions, which were taken verbatim from the 2001 NSFG instrument, to explore concepts of pregnancy intention (Stanford et al., 2000). In order to explore and explain the different meanings women attached to their pregnancies, as well as

how they associated specific terms (wanted, unwanted, planned, unplanned, intended, and unintended) that are commonly used to describe pregnancies, the primary investigator used interviews rather than questionnaires with predetermined responses (Marshall & Rossman, 1995; Rothe, 1993).

### Sampling Methodology

A random probability-sampling scheme was used to recruit participants from each of the three housing projects (Yamacraw Village, Hitch Village, and Fred Wessels Homes). Each participant had to be between the ages of 18-44; of African American descent; with at least one live pregnancy; and able to speak, understand, and read English. The researcher contacted Savannah's Housing Authority and inquired about the number of housing units in each of the housing projects. An over-sampling of the units in each housing complex was generated by using the Statistical Analysis System (SAS). SAS generated 40 random apartment numbers for each individual unit. Each housing project was randomly sampled according to the number of individual unit. Over sampling was used in order to create additional subjects in the event that subjects refused to participate or if potential subjects were absent from their place of

residence. The investigator then visited each apartment complex that the SAS software randomly selected.

#### Instrumentation

The interview instrument, which is located in the appendices, is based on previous research (Fischer et al., 1999), which followed a semi-structured outline of points to cover possible questions to address each point (Stanford et al., 2000). In all cases, the introductory question was "How do you feel about this pregnancy?" Based on the reply to the initial question, the interviewer then asked "Why" that particular response was provided. As the interview progressed and an initial description of the index question pregnancy evolved, the interviewer added questions to clarify issues and concerns as the participants mentioned them, such as past pregnancies, economic circumstances, family and partnership concerns. Also, the interview specifically explored how women defined the terms "wanted," "unwanted," "planned," "unplanned," "intended," and "unintended" in relation to their current pregnancies. Inquiries about these terms were made in the context of responses to previous questions and participants were asked what conditions or circumstances would need to be altered for the pregnancy to be considered the opposite of the answers given. When an inconsistency was expressed about a

pregnancy, the interviewer attempted to clarify the participant's account by further addressing discordant issues. The interviewer asked the participant the question again, restated the participant's previous answer, and asked the participant to elaborate on the answer that was previously given to that particular question.

#### Data Collection Procedures

Women were approached in their respective housing developments and invited to participate in the study. A preliminary questionnaire established eligibility in order to participate. Written informed consent was obtained before the interview, using both a written and an oral explanation of the study, following protocols approved by Georgia Southern University's Institutional Review Board. The remainder of the interview was recorded on audiotapes and at the conclusion of the interview, basic demographic information was obtained.

All interviews were collected by a single interviewer (M.M), who received training and feedback (based on listening to tapes) from an expert qualitative analyzer. The total time for the interview varied between 30 and 45 minutes. Interviews were transcribed by a paid professional transcriber. Transcripts were then corrected by the primary interviewer, who listened again to the tape recordings.

After theoretical saturation occurred, the data was then analyzed by transcribing the data into the NUD\*IST software for students.

#### Data Analysis Procedures

Data analysis was conducted in three stages. First each paragraph of the interview was examined and coded by the primary investigator and then by an expert qualitative analyzer to identify issues and concepts related to pregnancy intendedness. The primary investigator then used the student version of NUD\*IST to code the data. A coding list from previous research was used, which expanded substantially in the process of the present study (Stanford et al., 2000). Second, the primary investigator examined each code and summarized it as its own conceptual entity in light of the paragraphs linked to it and relevant background information from each interview. Third, all interviews were reviewed and each subject was classified based on dimensions of pregnancy intendedness which were newly defined. Differences in independent classification of each subject were resolved by constant review by both the primary investigator and the expert qualitative researcher. The NUD\*IST software for students was used to help with all portions of the thematic content analysis.

Interviews were conducted until theoretical saturation (when information from study participants repeated information obtained from previous studies and fewer new concepts emerged) had occurred. Additional transcribing was completed in order to consolidate themes and review literature for corroborative information. The audiotaped interviews were transcribed directly onto the computer software program NUD\*IST for students. A constant comparative method was used to generate patterns, themes, or descriptive categories in the data.

The next level of analysis involved the formation of code words. Code words are labels that describe a particular category of data. The code book listed various code words used in the data analysis and defined them. If a new word was found and it could not be "coded" or labeled with an existing code, a new code word was defined and entered into the code book. Reliability was established by having an expert researcher check the coded segments. After each interview, text was re-coded; it was then sorted using NUD\*IST, ensuring that all sections with similar codes could be defined. Each coded segment was compared with other coded segments to identify which coded sections fitted together into categories and then to determine how those categories and their relationships between them could be

converged. As this process continued with more interview listening and further analysis, coded segments were "moved" inductively to construct more abstract categories. Categories were transcribed as groups of code words and their accompanying text were abstracted to a "higher" conceptual level. Several codes became conceptualized as one category. Using the constant comparative method, the primary transcriber (M.M.) compared the categories and concepts with each other to inductively form patterns and themes.

For the purpose of comparing women's responses to the new qualitative dimensions of intendedness with their NSFG categories, each qualitative dimension was classified into discrete categories: positive, ambivalent, negative, or unclear from the available data (Stanford et al., 2000). Ambivalent designation was reserved for mixtures of strong positive and strong negative feelings, beyond simple worry or regret. With regard to steps taken to prepare for pregnancy, each answer was dichotomized into any steps taken or not taken. The primary investigator conducted data analysis on an ongoing basis and information sessions were held with the expert qualitative researcher to discuss the findings, to review demonstrated consistencies, and to



identify areas that lacked clarity. Characteristics of the study participants were then reported in table format.

#### Summary

Data analysis began with the first interview and continued throughout the study. Starting with segments of coded data, different definitions were generated. These definitions were accomplished by developing code words from NUD\*IST transcribed interviews which were then abstracted to a higher level of analysis until a category was created. These categories were then examined for related or similar ideas and elevated into concepts.

Concepts were reexamined after theoretical saturation occurred and further abstracted to patterns. Further redefinition and conceptualization were continued until no more new codes resurfaced. Chapter four will define how women defined the terms associated with pregnancy intendedness and compare their meaning of intendedness to the NSFG meaning of intendedness. Chapter five will offer implications and future recommendations.

## Chapter 4

### RESULTS

"Public opinion is a weak tyrant compared with our own private opinion. What a man thinks of himself, that is which determines, or rather, indicates his fate." Henry Thoreau (as cited in Bartlett, 1992, p. 477).

The purpose of this study was to explore how high-risk women conceptualize the intention status of their pregnancies and how their concepts relate to the National Survey of Family Growth classification scheme. A qualitative research framework provided an avenue for exploring variety in how women define the terms "wanted" or "unwanted," "planned" or "unplanned," and "intended" or "unintended" in relation to their past pregnancies. Reviewing the analysis of these terms and the concepts or actions that women have associated with these terms, five additional qualitative distinct concepts were identified: (1) socioconception desire for pregnancy, (2) forced preparational changes, (3) fertility behavior and expectation, (4) post-socioconception desire for pregnancy, (5) and dealing with the pregnancy.

A random probability sampling scheme was used to recruit participants for the study. Originally, 24 women were contacted to participate in the study. Of these contacted, 10 women completed the full interview,

eight decided not to continue the interview for various reasons (five of these related that the questions were too invasive), and six closed the door in the primary investigator's face. The sample consisted of 10 high-risk women living in one of the three housing projects (Yamacraw Village, Fred Wessels, or Hitch Village) all in Savannah, Georgia.

As shown in the following table the mean age of the participants was 26.5 years (range of 20-35 years). The Participants had an average of 2.4 live pregnancies (range of 1-4). According to the participants, none of them were married or had a live-in mate. The mean annual household income for all 10 participants was \$6800 (range \$4,000-10,000). At the time of the study, none of the participants were employed outside of their residence. Four of the women had graduated from high school; two had a year of college; all others had less than a high school education. All of the participants received welfare or Aid to Families with Dependent Children (AFDC) as their major source of income.

Table 1

## Age, Residence, and Educational Attainment

---

Participants	Women (N=10)
Age range (years)	Number of Women
20-24	2
25-29	5
30-34	3
Residence (Housing Projects)	
Yamacraw Village	2
Hitch Village	5
Fred Wessels Homes	3
Educational Attainment	
Some High School	6
Graduated High School	2
Some College	2

---

Table 2

## Pregnancy and Birth History

---

Participant	Number of Total Pregnancies	Current Age of Live Births
1	3	5y, 2y, 15y
2	2	10y, 7y
3	2	3m, 1y
4	1	3y
5	2	10m, 2y
6	3	15y, 8y, 4y
7	4	18y, 15y, 5y, 3y
8	2	10y, 3y
9	2	6y, 3m
10	3	8y, 4y, 2m

---

Note. Number of pregnancies does not include aborted, adopted, or miscarriages.

## Findings

The interview was devised to capture a broad view of how high-risk women conceptualize pregnancy intentions and to compare how their concepts related to current measures of pregnancy intendedness. Substantial variety was found in how these women described the terms "wanted" or "unwanted," "planned" or "unplanned," and "intended" or "unintended" Questions were loosely centered on topics such as a woman's contraceptive history, life desires before and after the pregnancy, ideal family size, and partner involvement. Participants described certain experiences continually, including partner support, active involvements, lack of involvements, contraceptive history, and setbacks. The following concepts emerged after achieving thematic saturation: (a) socioconception desire for pregnancy, (b) forced preparation, (c) fertility behavior and expectation, (d) post-socioconception desire for pregnancy, and (e) dealing with the pregnancy.

### Socioconception Desire

Socioconception desire for pregnancy was related to situation and surroundings (including making a connection, problem partners, and never having enough) and being alone (including absentee partner, isolation and uninvolved

mates). It was found that socioconception desire for pregnancy arises from a complex interaction between stages of partner influence, demographic transition, and societal circumstances and therefore it changes over time. There was substantial evidence in a number of interviews of such change having occurred, but, for this analysis, the research focused on the socioconception desire for pregnancy many years after the pregnancy. Socioconception desire for pregnancy had both positive and negative components, and frequently both were evident in each participant.

Participants in this study were very poor and their lives seemed very complex. In order to understand their attitudes towards conception, it is imperative to understand their many complexities, how these women lived, and how they viewed relationships and family. Also, it is important to understand the system that discourages the poor from marrying. Although this instrument did not necessarily probe governmental systems that discouraged marrying, many women willingly voiced their opinions about why they chose not to marry but to conceive. Thematic analysis was used to code these opinions and revealed that relational problems did influence how women viewed and labeled their pregnancies.

Since socioconception desire for pregnancy focuses on how these women viewed partner involvement, their future, and their environment, many women voiced attitudes towards partner involvement and future plans. Jnaie (pseudo name) recounted an involvement with her once live-in-male friend that plagued many of these women's lives:

"With my first pregnancies, I was stupid and didn't know any better. I thought that he'd stay with me when I had a baby for him. He was around for a while, but then he started gettin [sic] into trouble and gettin [sic] locked up. Now he is in prison for armed robbery; no tellin [sic] when he gon [sic] get out. My youngest baby is hises [sic]. I just thought that it would be okay to have a child by him since he took care of what was hises [sic]."

For some of these women, the actions and responses of their partner to their pregnancies reinforced societal stigmas associated with African-American males who father children. "That's the way Black men are" many are quoted as saying. Many of the participants said their mates' responses ran the gamut from being okay, ambivalent, upset, and happy. Some fathers even denied paternity even though they had encouraged the mother to have their baby. In these situations, the mother claimed that the only thing he {the



father} wanted to do was to not see me get away from here {the projects}.

As a result, many painful and difficult lessons were learned when many of the partners involved in this study proved to be unfaithful. For many respondents this experience was so common that they did not believe that men could be faithful partners or involved fathers. The phrase "Black men ain't [sic] good for nothing, but getting women pregnant and leaving them" impregnated their views when it came to African American male involvement with their children. The above view did not mean that women were not willing to have children by these men, but they just didn't expect a committed relationship. One of the respondents told of her acceptance of having a non-committed relationship:

"I couldn't believe it. I knew it wasn't his baby {current partner}, but my ex's. I had to tell my boyfriend. He tried to stick around, but he ended up leaving us and never coming back. I wish my last baby was his. You know, he was a good baby daddy. He gave me money and he ain't [sic] out all night of the week. Plus he got a car and a job and he lets me drive his car when I need it."

Another respondent told how she was involved with a partner for many years and after learning that he was cheating on her after she got pregnant, she could have died. Below is her story regarding an unfaithful mate:

"He was not happy after he found out I was pregnant. I could tell because he stopped wanting to have sex and be around me. And that's when I found out that he was with another woman. You ought to know a person after years of living together, but sometimes you don't. He came back after a couple months, but it ain't [sic] the same the way it was before."

Constantly resurfacing was the factor that was readily apparent among many of the relationships described by the participants in the study, which involved the transient nature of their relationships with men. Women told about their increased isolation by the absence of an involved partner. Instead, according to participants in this study, they were faced with raising all of their kids without a father, but with the person they happen to be involved with at the moment.

Many women talked about how their baby's father wanted to help, but could not help because of incarceration. Some men lived with women who had children from previous relationships, which posed a greater problem resulting from

blended families. Some of the participants expressed their desire for the fathers of their children to be involved with their child. Having an involved father gave many of the women disposable income, increased emotional support, and provided social support. For many women this desire proved to be the opposite of what they experienced. Below are two participants' different accounts of partner involvement:

"They won't be around most of the time anyway. They just come by and give a little money so I can buy things before the baby gets here and keep giving that same amount of money when the baby comes. Sometimes it's hard to raise kids with two people and raising them with just one person is even harder. You just have to know if he gon [sic] be there and not leave you even when the baby is born."

"My baby's daddy still gives us things every now and then, but he moved on with his life. I mean, he had run-ins with jail and I didn't want that around me and my children. I ain't [sic] got but so much, but I'm making it. His {the baby's daddy} mom come by and get 'em [sic] when I beg her to, but other than that, I have no help since my aunt's health turned on her."

Many mothers expressed both positive and negative sides of having and wanting male involvement with their child and with them. Having the father involved fostered a sense of increased social support and also provided assistance with child rearing. However, many of the fathers manipulated their situation of not having a man around. Although there was a lack of male involvement resulting from many reasons, participants in this study relied on social support from family {mothers and sisters} and girlfriends.

The majority of the participants in this study relied on girlfriends or mother or mother and sister combination to help them with tasks that they could not perform themselves. For instance, if mothers had more than two children, they depended on their social support system to go buy food for them when their food-stamps were spent for the month or to pick up prescriptions at the local drug store. Some of the women received money from their mothers and sisters. Extra money was always needed at the end of the month to carry them to the beginning of the next month. But, for some, a girlfriend was needed to catch them up on what was happening in the old neighborhood, to baby-sit, and to let the mother enjoy a day away from the house without kids in tow. Many women described how they depended

on girlfriends as their media for what was happening outside of the projects. Besides the father, many women in this study confided in their girlfriends about being pregnant well before they told any family member.

Mothers, sisters, and friends not only offered physical support for these women, but they also provided emotional support. Emotional support came in the form of encouragement such as telling them to finish school or get your GED and "you will be okay." Mother, sister, and girlfriend support compensated for the support that many of these women lacked in male companionship.

#### Forced Preparation

Forced preparations are connected with dealing with the pregnancy. Force preparations are active steps (whether direct or indirect) taken to begin life as a mother (including getting on government assistance, moving into the projects, quitting school, or becoming a single head of household). These steps are most critical when studying when, why, and how women initiate prenatal care. The instrument used in this study did not necessarily focus on these items, although many women volunteered the aforementioned information in the context of discussing how they felt about the pregnancy.

Unlike, Stanford et al's 2000 study, women in this study did not mention personal health (such as a preconception visit to the doctor) in relation to steps taken to prepare for pregnancy. Instead, they spoke of how they had to quit school, or they were forced out, or they had to move out of their parents or relatives' homes due to their fault or no fault of their own. For others, after having a child of their own, they saw the need to establish their own independence by getting on the housing list and moving into the projects. One of the women explained the situation that led to her moving out of her grandmother's house:

"She didn't like the fact that he was sneaking in my bedroom at night, but at least she knew where I was, but she was always nagging me about stuff. When she told me that he couldn't come to her house again, me and a friend went to the housing authority to apply for section eight."

Many of the participants dropped out of school after having more than one child because family members became less supportive of their predicament. Many said that people viewed their first child as a mistake, but subsequent pregnancies were not viewed as a mistake. Two of the participants told about how their life was affected after

having a second child before they dropped out of high school.

"I dropped out after my second child because it got even harder after having two. I moved in with him and his family and that's how I got out here. My mom still comes around to get them when she don't [sic] have to work. She just tells me don't have no more babies."

"I never got a chance to finish school and I only had one year left. With no one helping me, I doubt if I will ever finish that, plus money is tight and I have to watch what I spend things on."

After getting pregnant and having more than one child many of the women implied that they had to stop everything that they were doing because it was hard to find someone who would take care of a baby. After the baby was out of diapers many felt that it was too late to go back to school because all of their friends were past them. Although many of these women aspired to finish school and go to a technical college or university, only two were close to reaching these goals while the others gave many reasons for not following through with their dreams. One commented that it wouldn't be her getting herself out of here {the projects}, but rather one of her kids. Since many of these women did not believe that they themselves could leave the

projects they relied on others to help them find away out the projects.

#### Fertility Behavior and Expectation

Fertility behavior and expectations emerged from participants as they described how their pregnancies occurred. Just as with Stanford et al's (2000) study, fertility behavior and expectation was divided up into three main categories: (a) active proceptive behavior, (b) passive proceptive behavior, and (c) avoiding pregnancy. In this study, it was found that a range of proceptive behavior can exist within these categories and within the same woman. Although fertility can change from one societal context to the next, fertility behavior and expectation were reported retrospectively for all the women in this study.

Active proceptive behavior was associated with discontinuing birth control for the sole purpose of getting pregnant, timing sexual intercourse, taking fertility drugs, and or artificial insemination (Stanford et al., 2000). Participants often responded that it is not uncommon for a woman to stop taking the pills and not tell the mate if her intentions are to entrap him. The majority of the younger women in this study chose to stop using contraceptives if their conquest seemed as if he had ends



{money}. A man's income and how he took care of prior pregnancies played a significant role when deciding whether or not to use contraception. Many of the participants who wanted to get away from a life of paucity and out of the projects specifically targeted these men to father their children with the hopes of these men taking care of them and their children from previous relationships. Passive proceptive behavior focused on discontinuing birth control methods without an express purpose of getting pregnant (Stanford et al., 2000). Women in this study practiced passive proceptive behavior when they felt they could not get pregnant after having sex many times without getting pregnant. Silvia (pseudo name) gives her account of how she accidentally became pregnant:

"I had sex many times before, but we'd never get pregnant. I mean we got together and broke up so many times until nothing really ever happened. I think just because we were not in a serious relationship we didn't think about getting pregnant. As soon as we got serious that's when I became pregnant. I think, I got jinxed was when we started getting serious because before that I never worried about getting pregnant."

The last stage of fertility and expressed expectation was defined as actively avoiding behavior, which included

using contraception or believing that one can get pregnant. Actively avoiding pregnancy involved both intention and behavior and not just the attitude these women held about using condoms. However, this study was not designed to focus on the relation between attitude, intention, and behavior. As described by Ajzen and Fishbein (1980), attitudes alone do not always predict intentions, because there exist a wide-range of attitudes that do not conform to behavior, but do conform to intentions.

#### Post-socioconception Desire

Postconception desire for pregnancy was associated with the same factors that were connected to socioconception desire for pregnancy. Many of the participants had to come to terms with their being pregnant and that they had to raise a child with or without social, emotional, or financial support. In addition, many came to realize, that in their own way, there existed an affective component after giving birth to a child. In the individual, such an affective response involved a multitude of people, which included her baby's father and current and past male companions, relatives, friends, and all others that were closely associated with her life.

Although the affective component differed with each participant, it kept changing from negative socioconception

desire for pregnancy to positive post-socioconception desire for pregnancy and positive socioconception desire for pregnancy to negative post-socioconception desire for pregnancy. The affective component may explain why many women were ecstatic about learning that they were the first to bare a partner's child, but became angry at giving birth, when they learned that he had other children that were never discussed. Also, the desire to abort, or to adopt seemed to be based on religious values or social stigmas that were based on the affective component as well. Like its affective component, post-socioconception desire showed to have changed over time depending on how mothers chose to deal with their pregnancy.

#### Dealing with the Pregnancy

In spite of having no involved partner, dropping out of high school, and having to move out of their parents' home, many women were forced to deal with their pregnancies. The majority of these women did not believe in abortions and viewed adoptions negatively; they thought it was unnatural, that it was ungodly, and that it was sacrilegious. Just as with abortions, many of these women did not look favorably upon adoption. To many of these women, adoption was a negative avenue because of the way the state treated foster children. Many women held the view

that if a mother could not care for her children, it is the job of both parents' parents to intervene before the state intervened.

When participants were asked about their reactions towards an unexpected pregnancy, many simply stated that they would deal with it just like all the other unexpected things in their life. For some, if the pregnancy happened, they thought it was meant to happen and there was nothing they could do about it. According to this retrospective study, dealing with the pregnancy was related to finding ways to provide for both the mother and her children, as unexpected life events. Although many women did not support abortion or adoptions except in rare circumstances, many believed that regardless of how many children they had, the child was not to blame and should not be punished because of errors made by the parents.

Many of these women had only themselves to rely on, and, unlike most women, they did not view their pregnancies as a happy occasion. For many, it was another person that depended on them for food and for both emotional and physical support. The very items they needed to give the children, they lacked. Perhaps this is why for the majority of these women taking time to adapt to their pregnancy did not include actively preparing a child's room, but using

the first available room. With so many other problems, such as having multiple children, no money, scarce food, and living in crime-infested neighborhoods, many women voiced that having another child only compounded their situational and emotional problems.

As noted, a particular component of socioconception desire for pregnancy, post-socioconception desire for pregnancy, and dealing with pregnancy, was a women's life riddled with emotional and social and economic paucity. Unlike some women, in this particular group, the motivation to not get pregnant paled in comparison to the motivation of getting pregnant. Women in this study saw no reason to temporarily suspend pregnancy until marriage because they did not see a social {marriage} and economical future beyond the projects. Ultimately, to these women, having a pregnancy by someone with money was their means of ending life in the projects. This may explain why so many of these women purposely chose to get pregnant by men with money, chose to deal with their pregnancies instead of aborting their pregnancies, and chose not to actively participate in preventing their pregnancies. Possibly, this lack of importance may dispel the myth of these pregnancies being unintended (as researchers expect), but as intended.

Each dimensions of pregnancy intendedness was related to the others, but remained distinct on qualitative analysis. Socioconception desire for pregnancy and dealing with the pregnancy was associated with whether to give the baby to family members or to abort. Partner's influence and involvement played a significant role in how women viewed socioconception desire for pregnancy, post-socioconception desire for pregnancy, and how women dealt with their pregnancy. Although the majority of these women yielded fertility behavior and expectation, the partner's influences on forced preparation was reported through many of the women's conversation. For many of the women, if the partner expressed that he would help with the pregnancy these women were more likely to apply for housing in order to be with the partner.

#### Qualitative Dimensions in Relation to the NSFG

When classifying each participant's pregnancy according to the National Survey of Family Growth, the results were as follows: four intended, five mistimed, and one unwanted. After reviewing the concepts of wanted or unwanted, planned or unplanned, intended or unintended, in relation to the qualitative dimensions that were discovered after thematic analysis, substantial variety was noted

while comparing each classification scheme. Different women used similar terms for different underlying concepts.

In relationship of the NSFG intendedness categories (intended, mistimed, and unwanted) with qualitative dimension categories (socioconception desire for pregnancy, forced preparation, fertility behavior and expectation, post-socioconception desire for pregnancy, and dealing with pregnancy), each qualitative dimension category remained distinct when classifying pregnancy intendedness, but the NSFG's dimension of pregnancy intendedness was related to other intendedness categories. Socioconception desire and post-socioconception desire for pregnancy was associated with the NSFG unwanted and intended category. Dealing with the pregnancy was noticed throughout the NSFG category of intended, mistimed, and unwanted. Most distinctly, all qualitative dimension categories were affected by the NSFG's mistimed category.

The complex nature of fertility behavior and expectation along with contraceptive intentions became more entwined when relating socioconception and post-socioconception desire for pregnancy. Planning steps after conception had taken place reflected attitudes of behavior and fertility expectation. For many of the women the desire of the mate to want to be with them or around them was

enough to create both active and passive proceptive behaviors. The complex nature of fertility behavior and expectation along with contraceptive intentions became more entwined when relating socioconception and post-socioconception desire for pregnancy.

According to Ajzen and Fishbein (1980), determinants of fertility intention have centered around situational and demographic determinants and people consider the consequences of their actions before and after the action have been engaged. The assumption can be made that most social actions (positive, negative) should be considered before an action is engaged. Dealing with the pregnancy (continuing or aborting) is centered on this social action. Although the women in this study chose to not abort their pregnancies, many failed to think that leaving their surroundings was under their control because the intentions associated with many of their pregnancies were constant social involvement with their mates and the hopes of leaving their environment.

The decision to deal with a pregnancy has significant clinical and public health implications. Although all of the women in this study chose to deal with their pregnancies, additional steps that involved forced preparation affected how all of the women viewed their



pregnancies. The decision to remain with or leave their prior residence significantly affected their support system. For many, after being forced to move into the project environment and away from their support system, their safety and children's safety became their first priority. This may help to explain why prenatal care is not a primary concern for many of these women. The majority of these women were concerned with surviving from day to day and from night to night. The night life of crime and uncertainty surrounded their concerns for both them and their children.

#### Summary

Contextual themes were formulated and discussed in Chapter Four. Themes such as socioconception desire for pregnancy, forced preparation, post-socioconception desire for pregnancy, and dealing with pregnancy were developed after coding each participant's response to various questions. While these women used the terms "intended," "unintended," "planned," "unplanned," "wanted," and "unwanted," in a variety of ways, their words held separate meanings when compared to the NSFG's concept of intendedness. Interviewing participants in this study helped to explore many underlying issues of pregnancy intendedness and how these women related to these

pregnancies. The primary analysis of this study was not to disprove the use of the NSFG, but to show how relatively large and heterogeneous pregnancy intendedness can be classified. The analysis showed that much of what poor mothers say supports existing theories, though mothers' accounts reveal a far greater degree of complexity than these theories realize. Chapter Five will discuss these findings and their implications.

## Chapter 5

### CONCLUSIONS

"Herein lies the tragedy of the age: not that men are poor- all men know something of poverty; not that men are wicked- who is good? Not that men are ignorant- what is truth? Nay, that men know so little of men." (W.E.B. Du Bois, *The Souls Of Black Folk*, 1903).

Contrary to what traditional pregnancy intendedness dichotomized tools may show, this study revealed that there exists a complex continuum when assessing pregnancy intendedness among high-risk women just as in non-high-risk groups. While going beyond traditional terms (wanted, unwanted, planned, unplanned, intended, and unintended) that are often used by the NSFG, this research showed that women in this study related to their pregnancy in five dimensions of intendedness. These qualitative components are more precise than, but do not detract from, current intendedness measures.

While many factors can alter these components, for the most part, these components remain true to the original work studied by Stanford et al. (2000). However, this study added three additional components - socioconception desire for pregnancy, post-socioconception desire for pregnancy, and dealing with the pregnancy were generated with participants involved with this study. For this group, preconception desire for a pregnancy was not a part of

their every-day life. In previous studies preconception desire for pregnancy was related to employment, career development, financial preparation, and emotional preparation. All the women in this study were dependent on the government (AFDC) and odd jobs to help them survive momentarily from week to week and month to month. In light of these findings, socioconception desire for pregnancy replaced preconception desire for pregnancy; post-socioconception desire for pregnancy was replaced by postconception desire for pregnancy; forced preparation was used instead of steps taken to prepare for pregnancy; and dealing with the pregnancy was used instead of adapting to the pregnancy.

#### Analysis of the Findings

The purpose of this study was to reassess how high-risk women conceptualized their pregnancy intentions and to compare how their concepts related to the NSFG classification scheme. After developing a codebook and establishing subsets of codes, thematic saturation was achieved. The five thematic themes that reoccurred were socioconception desire for pregnancy, forced preparation, fertility behavior and expectation, post-socioconception desire for pregnancy, and dealing with the pregnancy.

Socioconception desire for pregnancy was related to a woman's relationship goals with a partner (including goals for being with a partner, having a quasi-relationship with her partner, and financial support from her partner) and dealing her pregnancy. In most of the cases, many of these women viewed their pregnancy as a social means of material gains and of having and keeping communication with their partners. Unlike, the preconception desire for pregnancy, the socioconception desire involved no long-term goals and values, but instead it involved a complex interaction of non-male commitment, transient relationships, finding someone to take care of them and their children from previous relationships, and having intended pregnancies with the intention of getting out of the projects.

As many of the participants related, they were forced to leave their current place of residence and compelled to apply for government housing in order to have a place for their family. These forced moves without planning seemed to cause a great deal of stress in their lives. In addition, to the stress of their personal lives, many had to deal with the stress of living in an area that provided no aspiration and no motivation.

Fertility behavior and expectation emerged spontaneously as each woman told about how her pregnancy

transpired. Fertility behavior and expectation was divided into the following three categories that were used by Stanford et al. (2000): active proceptive, passive proceptive, and avoiding pregnancy. Depending on each woman's partner, fertility behavior, and expectation changed over time.

Post-socioconception desire for pregnancy was associated with the same factors that were connected to socioconception desire for pregnancy, reinterpreted in the face of reality of an elusive partner in addition to having to deal with a pregnancy on their own. For many of the participants, having to deal with this pregnancy created both negative and positive behaviors. Like socioconception desire for pregnancy, post-socioconception desire for pregnancy changed over time.

Finally, dealing with the pregnancy consisted of an affective dimension. This affective dimension was greatly impacted by financial support from a partner, involvement by a partner, and emotional support from the partner. Some participants even mentioned ways of attracting another partner in order to support them and their family. These women's needs of getting away from the projects proved to be a motivational factor for continuing in unintended pregnancies. Contrary to what many researchers may think

and write these pregnancies for this particular group of women are intended pregnancies.

#### Discussion of Research Findings

Stanford (2000) described components of child bearing as desire for pregnancy by a complex value system, personality traits, childbearing motivations, life-cycle factors, and situational factors. This corresponds well with most of this study, but it failed to include social and environmental factors. Preconception and postconception desire for pregnancy focused on wantedness being influenced by prior child bearing desires, but women in this study associated wantedness with social desires that were manifested in having an active relationship with a mate. Unlike women in previous studies, these women felt that society offered them no future plans of leaving their situations. Instead of having future goals and marital relationships to deter unintended pregnancies, the desire to achieve closeness with someone to give them monetary and emotional support was their motivation to continue getting pregnant.

Participants in this study held the view that if they had a child by their partner, then he, the partner, would stay around. The aforementioned corresponds well with Zabin's (1999) study on the motivation to avoid pregnancy.

Zabin (1999) reported that women who expected to marry in the future placed greater importance on avoiding pregnancy with casual partners than women in similar alliance who do not see marriage in their future. The aforementioned statement supports the idea of a socioconception desire for pregnancy. Socioconception desire for pregnancy is supported by Trussell and Vaughn (1999) who suggested that there exist heterogeneous ranges from truly unintended, through unplanned, to intended, and finally deliberately planned. Although women living in the projects represented a non-traditional society, even the concept of childbearing and intention is foreign in more traditional societies. Trussell and Vaughn (1999) reported that some Americans may describe a child as being intended even when its conception was not consciously planned.

Socioconception for pregnancy and post-socioconception for pregnancy reflect primarily behavioral intentions to avoid pregnancies. Actively engaging and passively engaging in contraception are important because they deal with volitional control of an individual. With these being under the control of individuals, one would assume that these behaviors can be controlled. More research may be needed to better understand why attitudinal and behavioral intentions



regarding pregnancy intentions have a significant effect on "intended" and "unintended" pregnancies.

Many women in this study commonly referred to the idea of dealing with their pregnancies instead of adapting to their pregnancies. Most of the participants reported that they were forced to leave their parents' or relatives' homes and move into the projects. They reiterated that because they were allowed to only make a certain amount of income before they were penalized (rent raised and decreased government money), they chose not to work. Living on a fixed income and their lack of employment caused many of them and their children to do without necessities. Besides worrying about not having money, many worried about getting shot or robbed while living in the projects. The great risk posed by their surroundings at the moment may explain why a lot of these women fail to initiate prenatal care or why planning a pregnancy was meaningless to them. For all of these women, planning a pregnancy meant steps that were taken to prepare for a pregnancy after conception occurred instead of before conception occurred.

Also, in this study, women's fertility behaviors were more likely to be influenced by partner involvement and how he felt about using or not using contraceptives. Although males played significant roles in how a woman viewed post-

socioconception desire for pregnancy, their influenced seemed to be weak when it came to fertility behavior and expectation. A partner's emotional and financial support determined how a woman dealt with her pregnancy. Women with more disposable income near the end of the month were less stressed because they had additional money beyond what the government supplied to them monthly. For this reason, more research may be needed to characterize the effects of male influence on maternal and child health.

Because traditional methods for measuring pregnancy intentions are less plausible for unmarried teenagers and unmarried adults who do not exemplify the stereotypic 1960s mother or family, these latter groups may provide different responses because of a current partner's devotion to relationships, marriage intentions, and socioeconomic status (Peterson & Mosher, 1999). The NSFG categorization emphasizes the dichotomized concept of timing as the basis for discriminating between intended and mistimed pregnancies. Results from this study may lead researchers to question the relevance of this simplified concept when discussing women's lives. Many strong components such as lack of commitment, family desire and partner support should not be considered as two-dimensional concepts but as multidimensional concepts.

Also, the NSFG categorizes pregnancies as unwanted only on the basis of whether or not a woman ever wanted a pregnancy in her life. A number of women who have had abortions have children later. In this study, the most relevant issues for women with regard to desiring pregnancy were not related to the number of children, but instead to partner involvement and financial support. Focusing on a woman's attitude towards her desire for pregnancy, instead of the NSFG categories of intendedness, may provide more explanatory power in regards to pregnancy outcomes and perhaps prenatal care. For instance, Sabel and Wilkinson (2000) reported that being unhappy about a pregnancy or denying the pregnancy is more strongly associated with measures of inadequate prenatal care than were the NSFG categories.

Although many of the women in this study used pregnancy as a means of constant social interaction with their partners, the majority of the women in this study were resigned to the idea on lack thereof partner commitment. According to Ruggles (1994), evasive fathers in the African American community can be traced back to the 1880s, which may suggest that even though these children are born out of wedlock, they may be considered intended. A high incidence of evasive male partners is not a recent

phenomenon in the African American community; instead it is a behavior that has existed over 200 years (Ruggles, 1994). Perhaps this phenomenon may explain why many high-risk women say that they deal with their pregnancy and expect little involvement from their partners, other than financial support.

#### Implications for Future Research

There were four significant limitations in this study. First, participants were less diverse than the American population. This research focused only on high-risk African American women living in the projects and other high-risk groups were not involved in this study. African American women who are not considered to be high-risk were not represented in this study. Second, all interviews were conducted in English and this severely limited our ability to attract non-English speaking African Americans. Third, women were asked to recall their feeling many years after their pregnancy and many had multiple numbers of pregnancies to choose from. Attitudes and recall bias may have impaired some of their judgments. Fourth, many potential women decided against being interviewed for various reasons (including fear that they would be reported to the housing authority for having their partner living with them, reservations about being tape recorded, and the

fear of not knowing what was going to be done with the information that was being gathered).

The qualitative dimensions identified by this study coincide with past researchers who have attempted to define the meaning of pregnancy intendedness. Attitudes, ambivalence, and the motivation to avoid pregnancy need to be studied more from a social and cultural reference point. It may be valuable to research the relationship of how individuals' living arrangements and environments impact their views on defining attitudes and behaviors toward pregnancy desires. This study revealed the centrality of how a woman viewed her significant relationships, particularly her relationship with her partner, as playing a key role in certain dimensions of her pregnancy desires. Also, how a woman dealt with her socioeconomic arrangement needs to be researched further in hopes of understanding whether or not these pregnancies are truly unintended pregnancies. Public health educators need to develop pregnancy prevention programs that are culturally sensitive when addressing reasons as to why pregnancy is widespread in certain groups of women. Additionally, public health educators may want to focus on the qualitative dimension of dealing with pregnancy and how the environment affects prenatal care initiation.

Research is needed which addresses the male's perspective on how they classify these pregnancies. Partner involved research should focus on both the woman's view and the view of her partner. Future research should focus on asking questions regarding pregnancy categorization in the presence of both partners in order to elucidate the relationship between pregnancy desire for both the woman and the partner.

Further work is needed, not only to develop measures that capture other concepts but also to assess the power of these domains in predicting and exploring intendedness and related behaviors among specific cultures. Such concepts need to be explored both qualitatively and quantitatively in samples of non-pregnant women and non-high-risk women and users and nonusers of contraceptives in order to obtain information on how multiple dimensions influence women's pregnancy desires and means and motivations for preventing pregnancies. Also, future researcher should involve high-risk teenagers, since many of the participants were first and foremost teenage mothers.

The significance of this research is not to discontinue the use of the NSFG or PRAMS, because both have provided the field of health and social science fields with invaluable data when researching fertility and demographic

data, quantitative studies, and pregnancy intendedness, but to help expand the categories that are being used to assess pregnancy intendedness. Hopefully, findings from this research can be used to persuade those determining public policy to establish programs that are targeted at reducing negative outcomes that are often associated with unintended pregnancies. The ultimate importance of this research was to understand how high-risk groups related their concepts of pregnancy intendedness to the NSFG concepts.

**REFERENCES**

- Abma, J. C, & Mott, F. L. (1994). Determinants of pregnancy wantedness. *Policy Studies Review, 13(1)*, 39-62.
- Ahluwalia, I. B., Johnson, C, Rogers, M., Melvin, C, Henderson, N., Perham-Hester, K., et al. (1999). Pregnancy risk assessment monitoring system (PRAMS): Unintended pregnancy among women having live births. *Journal of Women's Health & Gender-Bias Medicine, 8(5)*, 587-589.
- Ajzen, I. (1988). *Attitudes, personality, and behavior*. Chicago, IL: The Dorsey Press.
- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Process, 50*, 179-211.
- Ajzen, I. & Fishbein, M. (1974). Factors influencing intentions and the intention-behavior relationship. *Human Relations, 27(1)*, 1-15.
- Ajzen, I. & Fishbein, M. (1980). *Understanding attitude and predicting social behavior*. Upper Saddle River, NJ: Prentice-Hall, Inc.
- Alexander, G. R., & Kotelchuck, M. (2001). Assessing the role and effectiveness of prenatal care: History, challenges, and directions for the future. *Public Health Reports, 116*, 306-316.



- Anderson, J. E. (1981). Planning status of marital births, 1975-1976. *Family Planning Perspectives*, 13(2), 62-70.
- Bachrach, C. A., & Newcomer, S. (1999). Intended pregnancies and unintended pregnancies: Distinct categories or opposite ends of a continuum. *Family Planning Perspectives*, 31(5), 251-252.
- Bartlett, J. (1992). Bartlett's Familiar Quotations (Rev. 16<sup>th</sup> ed. H.J. Kaplan). Boston: Little, Brown and Company.
- Byrant, J. (2003, March 6). Study: 1 million Georgians remain uninsured. Atlanta Business Chronicle. Retrieved August 16, 2004, from <http://www.bizjournals.com/atlanta/stories/2003/03/03/daiIy58.html>
- Bumpass, L., & Westoff, C.F. (1970). The "perfect contraceptive" population. *Science*, 169, 1177-1182.
- Campbell, A. A., & Mosher, W. D. (2000). A history of the measurement of unintended pregnancies. *Maternal and Child Health Journal*, 4(3), 163-169.
- Cowley, C, & Farley, T. (2001). Adolescent girls' attitudes toward pregnancy. *The Journal of Family Practice*, 50(7), 603-607.
- Cubbin, C, Braveman, P. A., Marchi, K. S., Chavez, G. F.,

- Santelli, J. S., & Gilbert, B., J., C. (2002). Socioeconomic and racial/ethnic disparities in unintended pregnancy among postpartum women in California. *Maternal and Child Health Journal*, 6(4), 237-246.
- Davis, F.D., & Warshaw, P.R. (1992). What do intention scales measure? *Journal of General Psychology*, 119(4), 391-407.
- Denton, A. B., & Scott, K. E. (1994). Unintended and unwanted pregnancy in Halifax: The rate and associated factors. *Canadian Journal of Public Health*, 85(4), 234-238.
- Dietz, P. M., Adams, M. M., Spitz, A. M., Morns, L. M., & Johnson, C. H. (1998). Live births resulting from unintended pregnancies: An evaluation of synthetic state-based estimates. *Maternal and Child Health Journal*, 2(3), 189-194.
- Dietz, P. M., Adams, M. M., Spitz, A. M., Morris, L, & Johnson, C. H. (1999). Live births resulting from unintended pregnancies: Is there variation among states? *Family Planning Perspectives*, 31(3), 132-136.
- Donovan, P. (1995). Physical violence toward pregnant women is more likely to occur when pregnancy was unintended. *Family Planning Perspectives*, 27(5), 222-223.

- Du Bois, W.E.B. (1969). *Darkwater*, New York: Shocken Books.
- Du Bois, W.E.B. (1903). *The souls of Black folk*. New York: Fine Creative Media.
- Edin, K. (2000). What do low-income single mothers say about marriage? *Social Problems*, 4(1), 112-133.
- Egerter, S., Braveman, P., & Marchi, K. (2002). Timing of insurance coverage and use of prenatal care among low-income women. *American Journal of Public Health*, 92(3), 423-427.
- Faghihzadeh, S., Rochee, G. B., Lmyian, M., Mansourian, F., & Rezasoltani, P. (2003). Factors associated with unwanted pregnancy. *Journal of Sex & Marital Therapy*, 29(2), 157-164.
- Fishbein, M., & Ajzen, I. (1974). Attitudes towards objects as predictors of single and multiple behavioral criteria. *Psychological Review*, 81(1), 59-74.
- Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research*. Reading, MA: Addison-Wesley Publishing Company.
- Fishbein, M., Jaccard, J.J., Davidson, A.R., Ajzen, I., & Loken, B. (1980). Predicting and understanding family planning behaviors: Beliefs, attitudes, and intentions. In Icek Ajzen & Martin Fishbein,

Understanding attitudes and predicting social behavior (pp. 130-147), Upper Saddle River, NJ: Prentice-Hall, Inc.

Fischer, R. C., Stanford, J. B., Jameson, P., & Dewitt, M. J. (1999). Exploring the concepts of intended, planned, and wanted pregnancy. *The Journal of Family Practice*, 48(2), 117-122.

Forrest, J. D. (1994). Epidemiology of unintended pregnancy and contraceptive use. *American Journal of Obstetrics and Gynecology*, 170(5), 1485-1489.

Forrest, J. D. (1987). Unintended pregnancy among American women, 1982-1988. *Family Planning Perspectives*, 19(2), 76-77.

Forrest, J. D., & Fordyce, R. R. (1993). Women's contraceptive attitudes and use in 1992. *Family Planning Perspectives*, 25(4), 175-179.

Frisbie, P., Echevarria, S., & Hummer, R. A. (2001). Prenatal care utilization among non-Hispanic Whites, African Americans, and Mexican Americans. *Maternal and Child Health Journal*, 5(1), 21-33.

Georgia Division of Public Health. (2004). Health data and information. Retrieved August 16, 2004, from <http://health.state.ga.us/healthdata/perinatal.asp>

- Green, D. C, Gazmararian, J. A., Mahoney, L. D., & Davis, N. A. (2002). Unintended pregnancy in a commercially insured population. *Maternal and Child Health Journal*, 6(3), 181-187.
- Grimes, D. A., & Gallo, M. F. (2001). Counseling to prevent unintended pregnancies: Measuring its value. *Women's Health Issues*, 11(5), 397- 400.
- Handler, A., Rosenberg, D., Raube, K., & Lyons, S. (2003). Satisfaction and use of prenatal care: Their relationship among African American women in large Managed care organization. *Birth*, 30(1), 23-30.
- Hellerstedt, W. L., Pirie, P. L, Lando, H. A., Curry, S. J., McBride, C. M., Grothaus, L. C, et al. (1998). Differences in preconceptional and prenatal behaviors in women with intended and unintended pregnancies. *American Journal of Public Health*, 88(4), 663-666.
- Henshaw, S. K. (1998). Unintended pregnancy in the United States. *Family Planning Perspectives*, 30(1), 24-30.
- Hoffman, S. D., & Duncan, G. (1994). The role of incomes, wages, and AFDC benefits on marital disruption. *The Journal of Human Resources*, 30(10), 19-41.
- Hogan, D. P., & Kitagawa, E. M. (1985). The impact of social status, family structure, and neighborhood on

the fertility of Black adolescents. *American Journal of Sociology*, 90(4), 825-855.

Housing Authority of Savannah. (2003). Just the facts.

Retrieved August 16, 2004, from

<http://www.savannahpha.com/facts.htm>

Hulsey, T. M. (2001). Association between early prenatal care and mother's intention of and desire for the pregnancy. *JOGNN*, 30(3), 275-282.

Johnson, A. A., El-Khorazaty, M. N., Hatcher, B. J., Wingrove B. K., Milligan, R., et al. (2003). Determinants of late prenatal care initiation by African American women in Washington, DC. *Maternal and Child Health Journal*, 7 (2), 103-114.

Joyce, T., & Grossman, M. (1990). Pregnancy wantedness and the early initiation of prenatal care. *Demography*, 27(1), 1-18.

Joyce, T. J., Kaestner, R., & Korenman, S. (2002). On the validity of retrospective assessment of pregnancy intention. *Demography*, 39, 199-213.

Joyce, T., Kaestner, R., & Korenman, S. (2000). The stability of pregnancy intentions and pregnancy related behaviors. *Maternal and Child Health Journal*, 4(3), 171-178.

- Kashima, Y., & Kashima, E. S. (2001). Individual differences in the predictions of behavioral intentions. *The Journal of Social Psychology*, 128(6), 711-720.
- Kaufmann, R. B., Morris, L, & Spitz, A. M. (1997). Comparison of two question sequences for assessing pregnancy intentions. *American Journal of Epidemiology*, 145, 810-816.
- Kertzner, D. (1991). Household history and sociological theory. *Annual Review of Sociology*, 17, 155-179.
- Klerman, L. V. (2000). The intendedness of pregnancy: A concept in transition. *Maternal and Child Health Journal*, 4(3), 155-162.
- Klerman, L. V., Ramey, S. L, Goldberg, R. L, Marbury, S., Hou, J., & Cliver, S. P. ( 2001). A randomized trial of augmented prenatal care for multiple-risk, Medicaid eligible African American women. *American Journal of Public Health*, 91(1), 105-111.
- Klima, C. S. (1998). Unintended pregnancies: Consequences and solutions for a worldwide problem. *Journal of Nurse-Midwifery*, 43(6), 483-491.
- Kogan, M. D., Kotelchuck, M., Alexander, G. R., & Johnson, W. E. (1994). Racial disparities in reported prenatal

- care advice from health care providers. *American Journal of Public Health, 84(1)*, 82-88.
- Kost, K., Landry, D. J., & Darroch, J. E. (1998). The effects of pregnancy planning status on birth outcomes and infant care. *Family Planning Perspectives, 30(5)*, 223-230.
- Kost, K., Landry, D. J., & Darroch, J. E. (1998). Predicting maternal behavior during pregnancy: Does intention status matter? *Family Planning Perspectives, 30(2)*, 79-88.
- Kroelinger, C. D., & Oths, K. S. (2000). Partner support and pregnancy wantedness. *Birth, 27(2)*, 112-119.
- Lee, L. R., & Stewart, F. H. (1995). Failing to prevent unintended pregnancy is costly. *American Journal of Public Health, 85(4)*, 479-480, 1995.
- Lu, M. C., & Halfon, N. (2003). Racial and disparities in birth outcomes: A life-course perspective. *Maternal and Child Health Journal, 7(1)*, 13-30.
- Luker, K. C. (1999). A reminder that human behavior frequently refuses to conform to models created by researchers. *Family Planning Perspectives, 31(5)*, 248-249.



- Marshall, C, & Rossman, G. B. (1995). Designing qualitative research (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Marsiglio, W. (1993). Adolescent males' orientation toward paternity and contraception. *Family Planning Perspectives, 25*(1), 22-31.
- May, K. A. (1980). A typology of detachment/involvement styles adopted during pregnancies by first time expectant fathers. *Western Journal of Nursing and Research, 2*(2), 444-461.
- Mayer, J. P. (1997). Unintended childbearing, maternal beliefs and delay of prenatal care. *Birth, 24*(4), 247-252.
- McAllister, L. E. (1997). A study of African American women receiving prenatal care in a housing product. *Dissertation Abstracts International, 175* (01), 647A. (UMI 9729414).
- McAllister, L. E., & Boyle, J. S. (1998). Without money, means, or men: African American women receiving prenatal care in housing project. *Family and Community Health, 21*(3), 67-79.
- Melvin, C. L, Rogers, M., Gilbert, B. C, Lipscomb, L, Lorenz, R., & Ronck, S. (2000). Pregnancy intention: How PRAMS data can inform program and policy. *Maternal and Child Health Journal, 4*(3), 197-201.

- Meikle, S. F., Orleans, M., Leff, M., Shain, R., & Gibbs, R. (1995). Women's reasons for not seeking prenatal care: Racial and ethnic factors. *Birth, 22*(2), 81-86.
- Mikhail, B. (2000). Prenatal care utilization among low income African-American women. *Journal of Community Health Nursing, 17*(4), 235-246.
- Millard, G. L., Beerman, K. A., Massey, L., Shulz, T., & Heiss, C. (1999). Pregnancy and birth outcomes of high-risk women participating in a multidisciplinary intervention program. *Topics in Clinical Nutrition, 14*(4), 64-75.
- Miller, W. B. & Pasta, D. J. (1995). Behavioral intentions: which ones predict fertility behavior in married couples? *Journal of Applied Social Psychology, 25*(6), 530-555.
- Moos, M. K., Petersen, R., Meadows, K., Melvin, C. L., & Spitz, A. M. (1997). Pregnant women's perspective on intendedness of pregnancy. *Womens Health Issue, 7*, 385-392.
- Morbidity & Mortality Weekly Report. (1999). Insurance coverage of unintended pregnancies resulting in live-born infants- Florida, Georgia, Oklahoma, and South

Carolina, 1996. *Morbidity & Mortality Weekly Report*, 48(5), 100-105.

Morbidity & Mortality Weekly Report. (2002). Infant mortality among low birth weight among Black and White infants- United States, 1980-2000. *Morbidity and Mortality Weekly Report*, 51(21), 589-592.

Morgan, S. P., McDaniel, A., Miller, A. T., & Preston, S. H. (1993). Racial differences in household structure at the turn of the century. *American Journal of Sociology*, 98, 798-828.

Mosher, W. D., & Bachrach, C. A. (1996). Understanding U.S. fertility: Continuity and change in the national survey of family growth. *Family Planning Perspectives*, 28(1), 4-13.

Moynihan, D. P. (1965). *The Negro family: The case for national action*. Washington, DC: U.S. Government Printing Office.

Musick, K. (2002). Planned and unplanned childbearing among unmarried women. *Journal of Marriage & the Family*, 64(4), 915-929.

Nuckolls, K. B., Cassel, J., & Kaplan, B. H. (1972). Psychosocial assets, life crisis and the prognosis of pregnancy. *American Journal of Epidemiology*, 95(5), 431-441.

- Newes-Adeyi, G., & Maxwell, J. P. (2000). Preventive care seeking among inner-city African American pregnant women. *American Journal of Health Behavior, 24*(4), 254-267.
- O'Campo, P., Faden, R. R., Gielen, A. C, Kass, N., & Anderson, J. (1993). Contraceptive and sexual practices among single women with an unplanned pregnancy: Partner influences. *Family Planning Perspectives, 25*(5), 215-219.
- Pagnini, D. L., & Reichman, N. E. (2000). Psychosocial factors and the timing of prenatal care among women in New Jersey's Health Start program. *Family Planning Perspectives, 32*(2), 56-64.
- Park, H.S. (2000). Relationships among attitudes and subjective norms: Testing the theory of reasoned actions across cultures. *Communication Studies, 51*(2), 162-175.
- Parnell, A. M., Swicegood, G., & Stevens, G. (1994). Nonmarital pregnancies in the United States. *Social Forces, 73*, 263-287.
- Peterson, L. S., & Mosher, W. D. (1999). Options for measuring unintended pregnancy in cycle 6 of the national survey of family growth. *Family Planning Perspectives, 31*(5), 252-253.

- Poole, V. L., Flowers, J. S., Goldenberg, R. L., Oliver, S. P., & McNeal, S. (2000). Changes in intendedness during pregnancy in a high-risk population. *Maternal and Child Health Journal, 4*(3), 179-182.
- Power, C., & Matthews, S. (1997). Origins of health inequalities in a national population sample. *The Lancet, 350*, 1584-1589.
- Pulley, L. Klerman, L. V., Tang, H., & Baker, B. A. (2002). The extent of pregnancy mistiming and its association with maternal characteristics and behaviors and pregnancy outcomes. *Perspectives on Sexual and Reproductive Health, 34*(4), 206-211.
- Roberts, E. M. (1997). Neighborhood social environments and the distribution of low-birth weight in Chicago. *American Journal of Public Health, 87*(4), 597-603.
- Rolison, G. L. (1992). Black, single female headed family formation in large U.S. cities, *Sociological Quarterly, 33*, 473-481.
- Rothe, J. P. (1993). Qualitative research: A practical guide. Toronto: RCI.
- Rubin, R. (1976). Maternal tasks in pregnancy. *Journal of Advance Nursing, 1*, 367-376.
- Ruggles, S. (1994). The origins of African- American family structure. *American Sociological Review, 59*, 136-151.

- Ryder, N. B. (1973). A critique of the National Fertility Survey. *Demography*, 10, 495-505.
- Sable, M. R. (1999). Pregnancy intentions may not be a useful measure for research on maternal and child health outcomes. *Family Planning Perspectives*, 31(5), 249-250.
- Sable, M. R., & Libbus, M. K. (2000). Pregnancy intention and pregnancy happiness: Are they different? *Maternal and Child Health Journal*, 4(3), 191-196.
- Sable, H. R., Spencer, J. C., Stockbauer, J. W., Schramm, W.E., Howell, V., & Herman, A. A. (1997). Pregnancy wantedness and adverse pregnancy outcomes: Differences by race and Medicaid status. *Family Planning Perspectives*, 29(2), 76-81.
- Sable, M. R., Wilkinson, D. S. (2000). Impact of perceived stress, major life events, and pregnancy attitudes on low birth weight. *Family Planning Perspectives*, 32(6), 288-294.
- Santelli, J., Rochat, R., Hatfield-Timajchy, K., Gilbert, B. C, Curtis, K., & Cabral, R. (2003). The measurement and meaning of unintended pregnancy. *Perspectives on Sexual and Reproductive Health*, 35(2), 94-101.

- Sagrestano, L. M., Rodriguez, A. C, Carroll, D., Bieniarz, A., Greenberg, A., Castro, L., et al. (2002). Comparison of standardized measures of psychosocial variables with single-item measures used in an urban obstetric clinic. *JOGNN*, 31, 147-155.
- Shupe, A. K., Smith, A. E, Stout, C. L., & McLaughlin, H. 2000. The importance of local data in unintended pregnancy prevention programming. *Maternal and Child Health Journal*, 4(3), 209-214.
- Skutch, J. (2004, October 2). Dispensing health care and hope. *Savannah Morning News*, p. 1A.
- Stanford, J. B., Hobbs, R., Jameson, P., DeWitt, J. M., Fischer, R. C. (2000). Defining dimensions of pregnancy intendedness. *Maternal and Child Health Journal*, 4(3), 183-189.
- Stevens-Simon, C. Kelly, L, & Singer, D. (1996). Absence of negative attitudes toward childbearing among pregnant teenagers. *Archives of Pediatric and Adolescent Medicine*, 150(10), 1037-1043.
- Stout, A. E. (1997). Prenatal care for low-income women and the Health Belief Model: A New Beginning. *Journal of Community Health Nursing*, 14(3), 169-180.
- Sulak, P. (1993). Unwanted pregnancies: Understanding contraceptive use and benefits in adolescents and older

women. *American Journal of Obstetrics and Gynecology*, 168, 2042-2047.

Trussell, J., Stewart, F., Guest, F., & Matcher, J. (1992).

Emergency contraceptive pills: A simple proposal to reduce unplanned pregnancies. *Family Planning Perspectives*, 24, 269-273.

Trussell, J., Vaughn, B., Stanford, J. (1999). Are all

contraceptive failures unintended pregnancies? Evidence from the 1995 National Survey of Family Growth, *Family Planning Perspectives*, 31(5), 246-247 & 260.

U.S. Census Bureau. (2000). Census 2000 data for the state

of Georgia. Retrieved August 16, 2004, from

<http://www.census.gov/census2000/states/ga.html>

U.S. Department of Health and Human Services. (2000).

Healthy people 2010: Understanding and improving health (2<sup>nd</sup> ed.). Washington, DC: U.S. Government Printing Office.

Williams, L. (1991). Determinants of unintended childbearing

among ever-married women in the United States: 1973-1988. *Family Planning Perspectives*, 23(5), 212-221.

Williams, L. & Abma, J., & Piccinio, L. J. (1999). The

correspondence between intention to avoid childbearing and subsequent fertility: A prospective analysis.

*Family Planning Perspectives*, 31(5), 220-227.



- Wu, L. L. (1996). Effects of family instability, income, and income instability on the risk of premarital birth. *American Sociological Review, 61*, 386-406.
- Wu, L. L. & Martinson, B. C. (1993). Family structure and the risk of premarital birth. *American Sociological Review, 58*, 210-232.
- Zabin, L. S. (1999). Ambivalent feeling about parenthood may lead to inconsistent contraceptive use and pregnancy. *Family Planning Perspectives, 31*(5), 250-251.
- Zabin, L.S., Astone, N.M., & Emerson, M.R. (1993). Do adolescents want babies? The relationship between attitudes and behavior. *Journal of Research on Adolescents, 3*(1), 67-86.
- Zabin, L. S., Huggins, G. R., Emerson, M. R., & Cullins, V. E. (2000). Partner effects on a woman's intention to conceive: Not with this partner. *Family Planning Perspectives, 32*(1), 39-45.
- Zayas, L. H., Cunningham, M., McKee, D. M., & Jankowski, K. R. B. (2002). Depression and negative life events among pregnant African- American and Hispanic women. *Women's Health Issues, 12*(1), 16-22.

Zuravin, S. J. (1987). Unplanned pregnancies, family planning problems, and child maltreatment. *Family Relations*, 36, 135-139.

Zuravin, S. J. (1991). Unplanned childbearing and family size: Their relationship to child neglect and abuse. *Family Planning Perspectives*, 23(4), 155-166.

**APPENDICES**

**APPENDIX A**

(Survey Instrument)

**DEFINING THE DIMENSIONS OF PREGNANCY INTENDEDNESS  
WOMEN'S INTERVIEW QUESTIONS**

Subject ID No. \_\_\_\_\_

Date: \_\_\_\_\_

Interviewer initials: \_\_\_\_\_

The women's interview is in 4 parts: A-D. Record Parts A, B, D on paper. For Part C take notes. Tape record parts C and D. The general term "partner" is used throughout this interview but where appropriate you may substitute the partner's name or another appropriate word such as "husband", "boyfriend", etc.

**PART A: INTRODUCTORY COMMENTS AND PRELIMINARY ELIGIBILITY**

Hello, my name is \_\_\_\_\_ and I'm from Georgia Southern University. I would like to talk to you about possibly participating in a study. If you decide to participate I would interview you about your pregnancy.

The purpose of this study is to research how women define intended versus unintended, planned versus unplanned, and wanted versus unwanted pregnancy. We hope to discover what these terms mean to different women and men and how these terms influence pregnancy decisions. The study is confidential. If you participate, you will not be identified in any way. Are you willing to participate?

Yes [go to A 2] No [go to A 1]

**A 1. [Clarify questions or concerns and see if she is interested now. If not thank her and end interview. Record in your log the subject number, the reason she prefers not to participate, and any other information that you may know about her (such as age and ethnicity).]**

A 2.Great! Thank you for your interest! In this study, we are trying to interview women from ethnic background and perspectives. The interview takes about 30 minutes to complete. I need to ask you a few questions about yourself to see whether you are eligible for the study. Do you have any questions so far? (Let's proceed then.)

**[If sampling grid used proceed with A 3; otherwise skip to A 8]**

A 3. I need to ask you a few questions about yourself to see whether you are eligible for the study. Do you have any questions so far? (Let's proceed then.)

A 4.What is your age? \_\_\_\_\_ <18                      =>18

A 5.What is your race or ethnic origin?                      White                      Any other race/ethnicity

A 6.What is your marital status? \_\_\_\_\_ Married                      Not married

**Review answers and place in sampling grid. If ineligible based on above questions, thank her for her willingness and terminate interview.**

A 8. **[Give her a copy of the informed consent, review it with her, and ask her to sign two copies. Clarify points in the consent form as needed. Give her one of the copies of the consent form to keep. She need sign only the first line to be interviewed for the study. You sign as witness. All other lines are optional.**

**As necessary, clarify that this information may be used in reporting research data, but no published identifiers or names will be associated with the data.**

#### **SETTING UP AND TESTING THE RECORDING EQUIPMENT**

**Ask permission to record the interview. Place the tape recorder on a hard surface about half way between you and the subject. Turn on the tape recorder and identify the interview by speaking your name, the date, and the subject number on the tape. Next test the recorder by asking the subject to speak (or read) a sentence clearly and loudly toward the tape recorder and playing it back to be certain both you and the subject can be heard clearly. Adjust as necessary until recording is adequate. If necessary, remind the subject throughout the interview to speak clearly and loudly toward the recorder. If she mumbles a response, ask her to repeat it for the tape.**

**If recording a phone interview, set up the equipment in advance and test your voice. After asking permission to record interview, turn on tape recorder and as subject to say a sentence. Check to be certain her voice is also being recorded. If not adjust equipment as necessary.]**

**Once you are done testing the recording equipment, you can turn off the recorder until part C.**

Next, I will ask you several questions which have been used in national surveys. These questions are about how women feel about being pregnant. They deal with your current pregnancy (or as if you are currently pregnant). The questions are worded in exactly the same way as they were in national surveys. Do you have any questions before we proceed? **[Clarify as necessary.]**

#### **PART B: QUESTIONS FROM THE NATIONAL SURVEY OF FAMILY GROWTH**

B 1. **[Show card.]** [Looking at the card,] what birth control methods were you using at the time you became pregnant?

**[If she says they weren't using anything at the time , ask "what methods did you most recently use before the time you became pregnant?"]**

**[If by phone or card unavailable, read entire list verbatim]**

No method used.....	1
Unsure/Don't know .....	2
Birth Control Pills .....	3
Condom .....	4
Partner's Vasectomy .....	5
Sterilizing operation/tubal ligation .....	6
Withdrawal, pulling out .....	7
Depo-provera, injectables .....	8
Norplant .....	9
Rhythm or safe period by calendar.....	10
Basal body temperature, cervical mucus, or natural family planning .....	11
Diaphragm .....	12
Female condom, vaginal pouch .....	13

Foam .....	14
Jelly or cream .....	15
Cervical cap .....	16
Suppository, insert .....	17
Today sponge .....	18
IUD, coil, loop .....	19
“Morning after” pills or emergency contraception .....	20
Other method (specify).....	21
Respondent’s partner sterile .....	22
Lunelle injectable (monthly shot).....	24
Contraceptive Patch .....	25

B 2.Before you became pregnant, had you stopped using all methods of birth control?

Yes No **[go to B 5]**

Never used birth control **[go to B 5]**

B 3.How much time was there between when you stopped using all methods of birth control and when you got pregnant?

\_\_\_\_\_ days weeks months years

B 4.Was the reason you had stopped using all methods of birth control because you yourself wanted to become pregnant?

Yes**[go to B 8]** No

B 5.The next few questions are important. They are about how you felt right before you became pregnant.

Right before you became pregnant, did you yourself want to have a baby at any time in the future?

Yes**[go to B 8]** No Don’t know **[go to B 7]**

B 6.So right before you became pregnant, you thought you did not want to have any children at any time in your life, is that correct?

Yes **[go to B 10]** No (I must have misunderstood. Let me ask this question again.) **[go back to B 5]**

B 7.It is sometimes difficult to recall these things, but right before this pregnancy began, would you say you probably wanted a baby at some time in the future or probably not?

Probably Yes Probably No **[go to B 10]** Didn’t Care

B 8.So would you say that you became pregnant too soon, at about the right time, or later than you wanted?

Too Soon  
 Right Time **[go to B 11]**  
 Later **[go to B 11]**  
 Didn’t care **[go to B 11]**

B 9. How much sooner than you wanted did you become pregnant? \_\_\_\_ Months \_\_\_\_ years

**[Go to B 12]**

**B10. [This is an unwanted pregnancy by NSFG criteria. Circle B10. Do not announce this to the participant. Go to B 14.]**

**B11. [This is an intended pregnancy by NSFG criteria. Circle B11. Do not announce this to the participant. Go to B 13.]**

**B12. [This is a mistimed pregnancy by NSFG criteria. Do not announce this to the participant. Circle B12. Go to B 14.]**

B13. Sometimes how people feel about having a baby in general can be different from how they feel about having a baby with a certain partner. Right before this pregnancy, did you want to have a baby with this partner?

Definitely Yes    Probably Yes    Probably No    Definitely No

**[Go to B15]**

B14. Sometimes how people feel about having a baby in general can be different from how they feel about having a baby with a certain partner. Right before this pregnancy, did you think you might ever want to have a baby with this partner?

Definitely Yes                      Probably Yes                      Probably No                      Definitely No

B15. **[Show card.]** Please choose from a scale from one to ten. On this scale, a one means that you were very unhappy to be pregnant and a ten means that you were very happy to be pregnant. Tell me which number [on the card] best describes how you felt when you found out you were pregnant.

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Very Unhappy to be pregnant  
pregnant

Very happy to be

B16 Right before you became pregnant did the father want you to have a baby at any time in the future?

Yes      No **[Go to B18]**      Not sure, don't know **[Go to B18]**

B17 So would you say you became pregnant sooner than he wanted, at about the right time, or later than he wanted?

Sooner                      Right time                      Later                      Didn't care

B18. **[Show card.]** Please choose from a scale from zero to ten. On this scale a zero means trying hard not to get pregnant, and a ten means trying hard to get pregnant. If you had to rate how much you were trying to get pregnant or avoid pregnancy right before you got pregnant this time, how would you rate yourself?

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10



Trying hard not to get pregnant

Trying hard to get pregnant

B19. **[Show card.]** Please choose from a scale from zero to ten. One this scale, zero means you wanted to avoid a pregnancy and a ten means you wanted to get pregnant. If you had to rate how much you wanted or didn't want a pregnancy right before you got pregnant this time, how would you rate yourself?

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Wanted to avoid pregnancy

Wanted to get pregnant

**PART C: OPEN-ENDED QUALITATIVE INTERVIEW  
NOT TO BE USED VERBATIM--ASK 'WHY' WHENEVER YOU CAN**

**[The following is a general outline of the questions to be covered, but order and exact wording will vary depending on the participant's responses. As appropriate, use follow-up questions to clarify issues raised by the participant's responses. Use this page as a checklist and to record impressions and notes for follow-up questions.]**

**!!!TURN ON THE TAPE RECORDER NOW!!!**

**CURRENT PREGNANCY**

How do you feel about this pregnancy?

Did you expect this pregnancy?

[Did you get pregnant at the time that you expected to?]

How did you tell your partner about the pregnancy?

What was your reaction when you first found out you were pregnant?

Did you and your partner discuss the possibility of you getting pregnant before it happened?

[When you first started having sex? What did you do? What did you talk about?]

[At the time you had sex that led to this pregnancy, were you thinking that you might get pregnant?]

[How long had you been trying to get pregnant? What did you do to try?]

What is your partner's attitude about this pregnancy?

In what ways do you feel that you are ready for this pregnancy?

In what ways do you feel that you are not ready for this pregnancy?

[Is there something you wish that you had done before this pregnancy to be more ready?]

What kind of support are you getting from others about the pregnancy?

**[Explore: financial, material, emotional, social, moral ]**

In what ways is your life changing with this pregnancy?

In your opinion, is this a (planned/unplanned) pregnancy? Why?

[What would have to be different in your life to make this an (unplanned/planned) pregnancy?

What does unplanned/planned mean to you?]

In your opinion, is this a (wanted/unwanted) pregnancy? Why?

[What would have to be different in your life to make this an (unwanted/wanted) pregnancy?  
What does wanted/unwanted mean to you?]

### **BEFORE CURRENT PREGNANCY**

Before this pregnancy, had you imagined having a (another) child someday?  
[Thinking back to before this pregnancy, how much did you want to have a (another) child?]

What would you say the ideal number of children would be for you [your family]?  
[How many children do you hope to have ultimately?]

Have you or your partner had any previous pregnancies?  
[Explore as necessary for a complete pregnancy history, and if there were any substantially different circumstances around those pregnancies]

Other than your partner, have you ever had sex with anyone else?  
[Did you discuss the possibility of pregnancy in those situations?]  
[Explore as necessary to establish history of attitudes towards sex, procreation, and birth control]

### **GENERAL ATTITUDES**

In your opinion, what are some reasons women get pregnant when they aren't planning to?

In your opinion, what are some reasons that men get women pregnant when the men aren't planning to?

If a woman has an unexpected pregnancy, do you think she should continue the pregnancy or not?

What is the role of the man in this decision?

[Explore what they think of abortion or adoption specifically]

[Can you imagine a situation where you would support a woman to have an abortion? Can you imagine a situation where you would support a woman to give a baby up for adoption?]

[In your opinion, what are the key factors that a woman and her partner should consider in deciding whether to keep a baby, give it up for adoption, have an abortion?]

Do you personally know anyone who has had an abortion?

[Explore closeness of relationship, and what she thinks of the choice]

Do you personally know anyone who has placed their child for adoption?

[Explore closeness of relationship, and what she thinks of the choice]

In your opinion, how should a couple decide whether to have sex?

What role do you think men play in preventing pregnancy?

What role do you think men play in planning pregnancy?

Are there any other comments you would like to make on these issues?

What was the age of your first pregnancy?

How did it affect your life?

Did you go back to school or did you not go back to school?

**PART D: DEMOGRAPHIC INFORMATION**

Now I would like to ask you some more general information about yourself.

D 1. **Verify and record age** [What is your age?] \_\_\_\_\_

D2. Are you Hispanic or Latino? [circle]

Yes                      No

D 3. What is your race? [Circle all that apply]

American Indian or Alaska Native  
Asian  
Black or African American  
Native Hawaiian or Other Pacific Islander  
White

D 4. In what country were you born? \_\_\_\_\_

D 5. In what country were your parents born? \_\_\_\_\_

D 6. How long have you lived in the United States?

1.            <= 1 year
2.            >1-5 years
3.            >5-9 years
4.            >9 years, not entire life
5.            entire life

D 7. How many adults are in your household? \_\_\_\_\_

Who are they? [What relation are they to you?]

Record relationships, not names

D 8. How many children are in your household? \_\_\_\_\_

Who are they? [What relation are they to you?]

Record relationships, not names

D9. How many times have you ever been pregnant, including the current pregnancy, and including miscarriages or abortions?

\_\_\_\_\_ Total # of pregnancies

\_\_\_\_\_ Total # of term deliveries

\_\_\_\_\_ Total # of miscarriages

\_\_\_\_\_ Total # of elective abortions

\_\_\_\_\_ Total # of other pregnancy outcomes (LIST \_\_\_\_\_)

D10. How far along in your pregnancy are you currently? \_\_\_\_\_ weeks \_\_\_\_\_ months

**[Record preferably in weeks]**  
**[if unsure, ask if she knows her due date, and record that here \_\_\_\_\_]**

D11. What is the source of payment for your [prenatal care or abortion]? Is it

1. Medicaid [includes Baby Your Baby]
2. Private Insurance
3. Self-Pay
4. Other \_\_\_\_\_

D 12. What is the highest grade in school you have completed?

1. Less than high school
2. High school
3. Some college or technical
4. College graduate
5. Postgraduate

D 13. What was your total household income last year? Was it

1. Less than \$10,000 or
2. At least \$10,000 but less than \$20,000 or
3. At least \$20,000 but less than \$30,000 or
4. At least \$30,000 but less than \$40,000 or
5. At least \$40,000 but less than \$50,000 or
6. At least \$50,000 or more
7. Don't Know

D 14. What is your occupation \_\_\_\_\_

D 15. **Verify and record religious activity.** [Are you an active member of any religion?]

Yes      No

D16. What is your religious affiliation (if any)?

1. Catholic
2. LDS
3. Episcopalian
4. Methodist
5. Jewish
6. Baptist
7. Other. Explain \_\_\_\_\_
8. NONE

D 17. **Confirm marital status** [What is your marital status?]

1. Married
2. Single, living with partner involved with pregnancy
3. Single, not living with any partner
4. Divorced or separated

5. Other \_\_\_\_\_

D 18. **[Only if married]** How long have you been married?

\_\_\_\_\_ days wks. mos. yrs.

D 19. How long have you known the father of the baby?

[Or how long did you know...]

\_\_\_\_\_ days wks. mos. yrs.

D 20. How long have you had a sexual relationship with the father of the baby?

[Or how long did you have...]

\_\_\_\_\_ days wks. mos. yrs.

D 21. How involved do you expect the father of the baby to be with this pregnancy? Will he be:

1. Not involved,
2. Somewhat involved,
3. Very involved, or are you
4. Unsure

D 22. How much financial support do you expect from the father for the baby?

[OR for the abortion or adoption] Is it

1. Full,
2. Some,
3. None, or are you
4. Unsure

Finally, I would like to ask you a few questions about your partner [*the father of the baby*]:

D 23. What is the age of your partner? \_\_\_\_\_

D 24. Is he Hispanic or Latino? [circle]

Yes      No

D 25. What is his race? [Circle all that apply]

American Indian or Alaska Native Asian Black or African American  
Native Hawaiian or Other Pacific Islander White

D 26. What is the highest grade in school he completed?

1. Less than high school
2. High school
3. Some college or technical
4. College graduate
5. Postgraduate

D 27. What is his occupation \_\_\_\_\_

This completes the interview. Thank you very much for your participation!

**APPENDIX B**

(Informed Consent)



Health and Human Services

---

**COLLEGE**

Giann-Ping School of Public Health

---

**DEPARTMENT**

### **INFORMED CONSENT**

Title of Project: Pregnancy Intendedness in a High Risk Group: Reassessing its Meaning

Principal Investigator: Mary Miller, 138 Silverton Road, Pooler GA 31322

mmille36@email.georgiasouthern.edu

Other Investigator(s): None

Advisor: Helen M. Graf, PhD Associate Professor at the Giann-Ping Hsu School of Public Health

1. Purpose of the Study: This study is designed to research how high-risk African American women define intended vs. unintended, planned vs. unplanned, and wanted vs. unwanted pregnancy. We hope to discover what these terms mean to high-risk African American women and how these terms influence pregnancy decisions.
2. Procedures to be followed: There is only one interview in this study. The interview will be tape-recorded and an assigned number will identify you. Your interview will probably last between 30 and 45 minutes. The interview will be about your about your experiences, perceptions, and decisions about your pregnancy. The interviewer and transcriber will be the only ones allowed to hear the recording. The tapes will be erased and incinerated after transcription.
3. Discomforts and Risks: The possibility exists that you might be uncomfortable answering some of the interview questions that deal psychologically with the manner in which your child was conceived, personal issues, such as desire for a pregnancy, planning a pregnancy, contraceptive use, and reaction of family and friends if you are pregnant. You are free to choose not to answer any questions when you so desire. If you were raped, molested, or a product of incest, you may feel uncomfortable with answering these questions.
4. Benefits:
  - a. The possible benefits to you participating in this study are that you will help us find ways to more accurately define pregnancy intendedness thus assisting in the future help of women at high risk.
5. Duration: Your interview will probably last between 30 and 45 minutes. This study will begin in February 2005 and end in July 2005.
6. Statement of Confidentiality: All efforts will be made to keep your participation in this study completely confidential. After transcription, the audiotape of the interview will be erased. Your first name (and phone number, if you choose to provide it) will be kept in a separate file from the



interview transcripts, and will be used only if it is necessary to contact you. Those who read and analyze the interviews will not have your name. All presentations or publications from this study will be presented without names or identifying information. The tapes that are being transcribed and all other data are kept under secure and locked conditions, and are accessible only to the study investigator and authorized research personnel.

7. **Right to ask Questions:** Participants have the right to ask questions and have those questions answered. If you have questions about this study, please contact Mary Miller at (912) 441-4700. For questions concerning your rights as a research participant, contact Georgia Southern University Office of Research Services and sponsored Programs at 912/681-7758, or 0843.
8. **Compensation:** Participants will receive no form of compensation for this study.
9. **Voluntary Participation:** You do not have to participate in this research. You can end your participation at any time by telling the primary investigator that you do not want to continue. Also, you do not have to answer any questions that you do not want to answer
10. **Penalty:** There is no penalty for deciding not to participate in this study.

You must be 18 years of age or older to consent to participate in this research study. If you consent to participate in this research study and to the terms above, please sign your name and indicate the date below.

You will be given a copy of this consent form to keep for your records.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

I, the undersigned, verify that the above informed consent procedure has been followed.

\_\_\_\_\_  
Investigator Signature

\_\_\_\_\_  
Date

**APPENDIX C**

(Institutional Review Board Approval Page)

Georgia Southern University  
Office of Research Services & Sponsored Programs  
**Institutional Review Board (IRB)**

Phone: 912-681-5465

Fax: 912-681-0719

Ovrsight@GeorgiaSouthern.edu

Administrative Annex  
P.O. Box 8005  
Statesboro, GA 30460

**To:** Mary Miller  
138 Silverton Road  
Pooler, GA 31322

**cc:** Helen Graf, Faculty Advisor  
P. O. Box 8076

**From:** Office of Research Services and Sponsored Programs  
Administrative Support Office for Research Oversight Committees  
(IACUC/IBC/IRB)

**Date:** February 3, 2005

**Subject:** Status of Application for Approval to Utilize Human Subjects in Research

After a review of your proposed research project numbered: **HO5064**, and titled "**Pregnancy Intendedness in a High Risk Group: Reassessing its Meaning**", it appears that (1) the research subjects are at minimal risk, (2) appropriate safeguards are planned, and (3) the research activities involve only procedures which are allowable.

*Therefore, as authorized in the Federal Policy for the Protection of Human Subjects, I am pleased to notify you that the Institutional Review Board has approved your proposed research.*

This IRB approval is in effect for one year from the date of this letter. If at the end of that time, there have been no changes to the research protocol, you may request an extension of the approval period for an additional year. In the interim, please provide the IRB with any information concerning any significant adverse event, **whether or not it is believed to be related to the study**, within five working days of the event. In addition, if a change or modification of the approved methodology becomes necessary, you must notify the IRB Coordinator prior to initiating any such changes or modifications. At that time, an amended application for IRB approval may be submitted. Upon completion of your data collection, you are required to complete a *Research Study Termination* form to notify the IRB Coordinator, so your file may be closed.

Sincerely,

Julie B. Cole  
Director of Research Services and Sponsored Programs

**APPENDIX D**

(Copyright Permission)

17 June 2005  
Mary Miller

Our Ref: HG/jj/Jun05/J556

138 Silverton Road  
Pooler GA 31322  
USA

Dear Mary Miller

***ORGANIZATIONAL BEHAVIOR AND HUMAN DECISION PROCESSES, Vol 50, 1991, pp 179-211, figure 1***

As per your letter dated 16 June 2005, we hereby grant you permission to reprint the aforementioned material at no charge in your thesis subject to the following conditions:

1. If any part of the material to be used (for example, figures) has appeared in our publication with credit or acknowledgement to another source, permission must also be sought from that source. If such permission is not obtained then that material may not be included in your publication/copies.
2. Suitable acknowledgment to the source must be made, either as a footnote or in a reference list at the end of your publication, as follows:  
  
“Reprinted from Publication title, Vol number, Author(s), Title of article, Pages No., Copyright (Year), with permission from Elsevier”.
3. Reproduction of this material is confined to the purpose for which permission is hereby given.
4. This permission is granted for non-exclusive world English rights only. For other languages please reapply separately for each one required. Permission excludes use in an electronic form. Should you have a specific electronic project in mind please reapply for permission.
5. This includes permission for UMI to supply single copies, on demand, of the complete thesis. Should your thesis be published commercially, please reapply for permission.

Yours sincerely

Helen Gainford

Rights Manager