

Understanding pregnancy in a population of inner-city women in New Orleans—results of qualitative research

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Abstract

Unintended pregnancy has conventionally been defined as a pregnancy that is mistimed or unwanted, and this classification has been widely used in survey research. This study explores the utility of these constructs for women who visited a family planning clinic and a prenatal clinic in inner-city New Orleans, LA, and, by extension, for women of similar background and experience. We used semi-structured, open-ended research to explore sexual debut and history, contraceptive knowledge and use, pregnancy history, partner relations, and service use among 77 women (73 of whom were African-American).

This study addresses the apparent paradox of high-risk sexual and contraceptive behavior in the presence of expressed preferences to postpone childbearing. It provides some insight into the cultural and social context in which these events and decisions take place and explores the multiple dimensions that shape women's sexual behaviors and their desires for pregnancy. The dimensions explored include perceptions of and experiences with sex/sexuality, values concerning childbearing/motherhood, relationships with partners, experiences with contraception, and attitudes toward abortion.

The apparent ambivalence seen in reports of women asked whether a pregnancy was intended, such as statements that they did not want to get pregnant but were either not using contraception or using it irregularly, calls into question the idea that intendedness can be routinely and easily inferred from survey research. Correspondingly, it is not possible to simply assume that either intentionality or future intentions directly affect decisions to use contraception. The problem is that the many factors—structural and individual—affect women's preferences and ability to postpone a pregnancy or to use contraception.

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Introduction

Unintended pregnancy, although an apparently common-sense notion, has spawned considerable debate about its meaning and measurement. In demography, the term is used to describe the sum of pregnancies that were either mistimed (a pregnancy was wanted but not

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at this time) or unwanted (a pregnancy was not desired at any time). In discussions about unintended pregnancy, simplistic notions about the relationship between intention and behavior have been questioned by demographers, anthropologists, and health care providers (cf. Luker, 1975; Trussell, Vaughan, & Stanford, 1999; Santelli et al., 2003; Moos, Petersen, Meadows, Melvin, & Spitz, 1997; Ward, 1990; Barrett & Wellings, 2002). The relationship between intentions and other behaviors has also been questioned, such as between intending to use a condom and self-report of condom use. In HIV/AIDS programs intention has been used to account for the effects of behavior change interventions that did not achieve changes in behavior, e.g., a change in intention to use condoms was achieved, but there was no difference in actual rates of condom use. To account for this, behavior change specialists have sought to build theory that sets intent within a broader framework of structural constraints such as availability and cost, community standards, gender power and roles and other issues. Theories of behavior have not been involved in discussions of pregnancy intendedness; instead the notion of intention is seen as a practical measurement tool in family planning. For example, rates of unintended pregnancies have been used to demonstrate an unmet need for family planning. But as the following discussion makes clear, changing demographics and community norms about sex, marriage and contraception, as well as improvements in social research demand that the intendedness of pregnancy be re-examined from a more comprehensive multi-dimensional and structural perspective.

One difficulty with exploring the notion of intendedness in pregnancy is that it overlaps contested domains of sex and sexuality, gender power and women's rights, adolescence, individual and jural autonomy, and ethnicity. As noted above, a diverse group of academics and health care providers have questioned its utility and its meaningfulness to women (cf. Luker, 1975; Trussell et al., 1999; Santelli et al., 2003; Moos et al., 1997; Ward, 1990; Barrett & Wellings, 2002). Given these critiques, this is a propitious time to re-examine the concept of intendedness. Comprehensive exploration demands multi-method design, combining qualitative and quantitative methods. Qualitative approaches also permit re-examination of critical assumptions embedded in constructs such as intendedness of pregnancy. Such was the goal of this study, and the paper reports on the ethnographic component of research conducted in New Orleans, LA, among pregnant and non-pregnant inner-city women. The domains of sex, motherhood and childbearing, marriage and partner relations, contraception, and abortion were explored in this investigation. These domains were identified in the literature and emerged in the interviews

as relevant to understanding the intendedness of pregnancy.

New Orleans

Studying unintended pregnancy in New Orleans might provide key insights for other poor urban environments given its socio-demographic composition and fertility patterns. About 28% of individuals in New Orleans live in poverty (Census, 2000), compared to about 17% in all of Louisiana (Proctor & Dalaker, 2003). In Louisiana, poverty is strongly associated with reported levels of unintended pregnancy. Overall, slightly more than half of live births to all women in Louisiana are reported as unintended (Louisiana Department of Health and Hospitals, 2000). However, among births to women who used Medicaid to pay for health care before and during pregnancy, for example, almost 70% were reported as unintended, compared to 31% among births to women who reported other sources of payment (Louisiana Department of Health and Hospitals, 2000). Nationally, reported unintended pregnancy increases with poverty level. For example, of the births to women with household incomes of less than 100% of the federal poverty level, almost 45% were reported as unintended, compared to 21% of the births to women with household incomes greater than or equal to 200% of the federal poverty level (Henshaw, 1998).

Teen births also contribute to elevated unintended pregnancy rates in New Orleans. Over 17% of births in New Orleans were to women age 15–19 years old in 2001 (Louisiana Department of Health and Hospitals, 2003). This percentage is much higher than the national average; about 13% of births in the US are to teens (AGI, 1999). Further, over 77% of live births that occur to women under 20 in Louisiana are reported as unintended (Louisiana Department of Health and Hospitals, 2000). This estimate is also high in comparison to the national average. According to the latest estimates at the national level, about 66% of live births to women 15–19 years of age are unintended (Henshaw, 1998). These data suggest that poor and young women in New Orleans are at higher risk of unintended pregnancy, in comparison to the general US population. This research attempts to provide a more in-depth look at adolescent and unintended pregnancy in a high-risk population; and explores the meanings of pregnancy planning and intendedness within this context. We believe that a qualitative study like this, in a context such as New Orleans, can contribute to the national discussion on unintended pregnancy, particularly since, as noted above, the overwhelming majority of adolescent pregnancies are reported as unintended (Henshaw, 1998); and adolescent pregnancies contribute to high rates of unintended childbearing in the US.

Background

Campbell and Mosher (2000) trace the history of the measurement of unwanted fertility back to fertility surveys conducted in 1941. But the growth in interest in this topic parallels the development of new contraceptive methods in the 1960s and the expansion of family planning programs. Anthropological interest in intendedness has developed alongside this demographic interest beginning with the work of Luker (1975) and continuing with the work of Joffe (1986), Mukhopahay and Higgins (1988), Glenn, Chang, and Forcey (1994), Ginsburg and Rapp (1995), Ginsburg (1998), Petchesky and Judd (1998), Russell, Sobo, and Thompson (2000), and Barrett and Wellings (2002). These authors have questioned the applicability of the concept outside of narrow middle class enclaves and have asked whether pregnancies can be “planned” and whether the woman herself—both physically and conceptually—is the locus of control for decision-making about contraception.

According to the conventional definition, an unintended pregnancy is a pregnancy that is considered either mistimed or unwanted. An unwanted pregnancy occurs when a woman either wants no more children or did not want that particular child. A mistimed pregnancy occurs when a woman wants a child at some time in the future, just not at the time of conception. In surveys, questions about pregnancy intentions always refer to the time at which a woman found out she is pregnant, but estimates of unintended pregnancy are usually gathered from retrospective reports, generally after the birth of an infant.

Although the conventional definition of unintended pregnancy seems reasonable, in a series of recent reports in *Family Planning Perspectives*, Trussell et al. (1999) comment on its inadequacy. First, Trussell discusses contraceptive failure and intendedness in pregnancy. One would assume that pregnancies that occurred when contraception was being used would be unintended, and yet, when intendedness is measured with questions about reproductive desires at the time of pregnancy, many of these contraceptive failures are classified as wanted pregnancies. According to 1995 data from the National Survey of Family Growth (NSFG), of pregnancies classified as contraceptive failures under the standard definition, only 68% were unintended, implying that the remaining 32% were intended. Trussell et al. carefully conclude with a concern for the way in which intendedness is measured, but many of the commentaries in this volume of *Family Planning Perspectives* address the meaningfulness of “unintendedness” as well.

Luker (1999), commenting on the contradictions presented by Trussell, emphasizes the critical shifts in the social and cultural meaning of motherhood and the decision-making process that couples use to decide this life-changing event. She questions the comparability of

estimates of unintended pregnancy over the decades it has been measured, given the shift in the population of women surveyed from those with completed fertility to those initiating childbearing. To an earlier generation of men and women, an unintended pregnancy was often an additional pregnancy after they reached desired family size. Now, intendedness often refers to first pregnancies. To the extent the measure captures unexpected pregnancies at the beginning of women’s reproductive career as opposed to “excess” births at the end, Luker argues, what is really being captured is willingness to enter a new social role, motherhood. She claims that what Trussell et al. describe as “contraceptive accidents” are the manifestation of normal human ambivalence about sex and childbearing and that becoming ‘accidentally’ pregnant permits people to duck the onerous responsibility of having to decide whether to consciously enter parenthood.

Zabin (1999) points out that exploring one decision-making process—intendedness—without addressing many concurrent concerns—such as ambivalence toward contraception and the changing dynamic of a relationship—is inappropriate. Bachrach and Newcomer (1999) support this multi-dimensional theme by proposing dimensions of intendedness that are linked to a broader set of circumstances. These authors argue that intendedness of a birth is linked to one’s community, partner, and values about childbearing; in contrast, planning a birth is tied to one’s preparation, life goals, and education.

Stanford, Hobbs, Jameson, DeWitt, and Fischer (2000), who also discusses dimensions of pregnancy intendedness, identifies a series of five dimensions: preconception desire for pregnancy, steps taken to prepare for pregnancy, fertility behavior and expectations, post-conception desire for pregnancy, and adaptation to pregnancy and baby. These dimensions of intendedness are perhaps more properly temporal sequences, but each sequence is clearly associated with discrete cognitive, social, and other domains.

It is not unreasonable that a single measure, a small number of measures, or even a series of algorithms for measuring pregnancy intendedness should fail to reflect complex circumstances and desires. Understanding these complex circumstances and desires was the primary motivation behind our effort to explore pregnancy intentions from the woman’s point of view. Several domains we identified as immediately relevant will be presented and their contributions to understanding the question of pregnancy intention discussed; these domains include contraception, motherhood, and relationship dynamics. In the course of our interviews, we noted two additional domains that were related to pregnancy intentionality. These additional domains were views toward adolescent sex and abortion. We explore these domains as they relate to pregnancy planning and

pregnancy prevention in a sample of inner-city, low-income women from public clinics.

The study

The Determinants of Unintended Pregnancy Risk in New Orleans study is a qualitative and quantitative study funded by the Centers for Disease Control and Prevention (CDC). The overall goals of this study are to (1) determine what pregnancy planning means in the study community, (2) examine the perceived consequences of unintended pregnancy in this community, (3) assess factors that differentiate women with intended pregnancies from women with unintended pregnancies, (4) determine factors that differentiate effective from less effective contraceptive users, and (5) develop better measures for the multiple dimensions of pregnancy intention that may be useful in research and surveillance. Two sites were used: a prenatal clinic and a family planning clinic. In the prenatal clinic, we interviewed currently pregnant women attending their first prenatal screening appointment. In the family planning clinic, we interviewed new and continuing users of family planning. This paper reports the result of the qualitative phase of the study, specifically to inform goals 1 and 2.

Designing the field guide

The research team—principal investigator, co-investigators, CDC project officer, graduate student, and fieldworkers—collectively developed the field (interview) guide that was used for the qualitative phase of the study. The fieldworkers had substantial experience working with the target population on family planning issues. Collectively, the team identified domains of interest derived both from the published literature and from personal experience with the target population. The team then identified a range of topics within the domains, and it specified information to be collected about each topic. The guide was repeatedly tested in the field for salience, ability to engender discussion, and duration. The final guide was a semi-structured interview guide that contained 115 open- or closed-ended items. Open-ended items predominated and included free-lists, and responses to extended hypothetical scenarios. Among the close-ended items were dates and timing of pregnancies, and tables documenting contraceptive use. The guide was developed to elicit women's perceptions of community standards as well as their expectations and experiences. After sufficient information on community standards was elicited and no new information was being obtained, the sections assessing these standards were eliminated for subsequent interviews. The data provide rich detail about community

expectations, community support, and individual decision-making.

The guide consisted of 11 sections, two of them on basic demographic information and four for eliciting information on community standards. The sections on community standards covered general attitudes toward childbearing and contraceptive use, perspectives on pregnancy planning and contraceptive practices of the women's friends and acquaintances, and attitudes toward sexual practices and motivations of boys and girls (these were the sections dropped for later interviews). The seventh section used a scenario approach to elicit respondent attitudes about abortion, marriage, sex, and adolescent childbearing. In the scenarios, Tanya, a 16-year-old high school girl, must make decisions about an unintended pregnancy with her 21-year-old boyfriend, James. Sections 8–11 dealt with more personal information about the respondents' own experiences and relationships. First, we gathered demographic information about current boyfriends, fiancées, and husbands along with information about the partners' personalities and interactions with the interviewees. Specifically, we explored communication and power dynamics between the women and their partners. Second, we assessed women's contraceptive method history and asked a series of questions about pregnancy and childbearing experiences and the impact of these pregnancies on relationships and plans for the future. The emphasis here was on first and last (or most recent) pregnancies. Third, women were asked about their personal sexual histories, including the age at which they had sex for the first time, and their concerns about sexually transmitted diseases (STDs). Finally, women were asked about their experience with clinical reproductive health services.

No names or patient numbers were collected, but because adolescents were included in the sampled population, the interviews were not treated as exempt. The complete field guide and the consent procedures were approved by the institutional review boards (IRB) of the Tulane University Health Sciences Center, CDC, and the collaborating clinics. The interviews were conducted between February and August of 2001.

Fieldworkers

Three female fieldworkers with masters of public health degrees and experience conducting qualitative research in this community were selected for the study. Their training included sessions reviewing the topic and individual knowledge and biases about it as well as participation in designing the guides. Although taping and transcribing field notes are rapidly becoming standard for many qualitative inquiries, we decided not to do this. Taping and transcribing interviews would permit detailed content and linguistic analyses and provide a check of the performance of our interviewers.

However, the clinics where the interviews were conducted were noisy, which would have required the informant to hold an intrusive and conspicuous tape recorder or microphone to the respondents' face. Overall, we felt that tape recorders would be viewed with suspicion. Further, recording and transcription adds substantial time and costs to the process. Given the instrument, confidence in the interviewers, the relatively large number of interviews, and the expectation that much of the interview would be either short answer or redundant, we opted to not record the interviews. We taped a small number of interviews (approximately 5%) for quality control, but for all interviews the fieldworkers transcribed responses in notebooks as the interview was being conducted. Later that day, they retyped and expanded those notes into electronic field notes using the research guide as a template. These field notes were reviewed by project staff and returned to interviewers for revision when appropriate. Final versions were collated into the project database. Normally, two interviews were completed each day. The three fieldworkers transcribed verbatim as well as paraphrased responses, a method that guarantees both content relevance and the alertness of the interviewer.

Each week, fieldworkers met with the rest of the research team and were asked to provide summaries, including composite results, unusual cases, and to ask any questions that they had about the interviews. These meetings also provided a forum for discussion of problems and challenges encountered during the interviews. At these meetings, interviewers would indicate if they thought that a particular informant was open and forthcoming, or not. For the most part, the interviewers felt that their interviews and interaction with the women went well. They noticed that the women talked candidly about sex, and appeared quite eager to talk about topics that they admitted they might not discuss freely with friends or family. These findings were fairly consistent across informants and inspired confidence in their veracity. After all the data had been collected, the interviewers participated in summarizing, analyzing, writing reports, and preparing this paper.

Recruiting clients

At the prenatal clinic, fieldworkers recruited patients at their first prenatal screening appointment to avoid interviewing the same women twice. Most of the screening patients were in the early stages of pregnancy, although some were six or more months pregnant. In the family planning clinic, fieldworkers kept a list of women who had been interviewed, to avoid duplication. In both clinics, women three or four places back in line were recruited because they had the best chance of completing the interview that took between 45 min and 1½ h without

interruption. Women were not selected by age, race, marital status, and childbearing status, but fieldworkers occasionally looked for women in certain age ranges to compensate for under-representation in the total sample. No inclusion or exclusion criteria were used to screen prenatal or family patients into the sample. The interviews took place in a private, non-examination room of the clinics.

Data management and analysis

A project database was created to archive interviews. The field notes were reviewed for completeness before being added to the project database. The weekly meetings provided a forum to discuss themes relating to the research domains from the original research guide and determine new, emerging themes. Quantitative responses from the few close-ended questions were coded and analyzed with SPSS and simple frequencies were run. The interviews were indexed and searched with a full text retrieval and search engine dtSearch 5.25 (© dtSearch Corp.). User thesauri were developed and potential relationships among terms explored. The final dimensions analyzed in this paper were chosen based on conclusions that emerged from research meetings where we discussed results of analyses of terms and themes in the data. Both the terms explored and the conclusions drawn were based on independent agreement among the entire research team including: co-investigators, field workers, and the project coordinator. The findings that emerged were outlined and illustrated with quotes from interviews. These quotes were selected because they characterized the main positions shared by women in the sample, especially when they seemed to capture a particularly revealing issue.

The sample population

Seventy-seven interviews were completed, 37 in the prenatal clinic and 40 in the family planning clinic. Age of respondents ranged from 14 to 38 years. Half the women were 19 or younger, with the average 21. Seventy-three women were African-American, three Hispanic, and one white. Fifty-three were Baptist, seven Catholic, five 'other', and 12 reported no religion or did not respond. We measured degree of religiosity by asking the women whether they felt themselves to be 'not', 'somewhat', 'very', or 'extremely' religious. A little over half said 'somewhat religious', 15 not religious, and 12 'very' religious. Only one answered as 'extremely' religious.

About a quarter of the sample were attending high school, and 17 women were attending or had completed college. Twenty-nine were not attending college but had completed high school. Ten women had dropped out of high school.

Among women aged 20 and over, 14 were unemployed and 23 were employed. Exactly half of the 22 18–19-year olds were employed, as were five of the 11 16–17-year olds but none of the three 14–15-year olds. Most of the employed women worked in the retail, restaurant, and tourism sectors or in administrative support positions.

Nine of the women reported they were not currently in a relationship. Forty-nine reported having boyfriends, nine were engaged, and nine married. Some of the women with boyfriends were planning to marry in the near future but did not consider themselves ‘engaged’.

Age at first sex ranged from 12 to 22 years, with a median of 16.0. Among those who ever had a birth, age at first birth ranged from 13 to 28 years, with the median 21 (mean 18.5) years. Of the 64 women who reported at least one pregnancy, 37 reported using a contraceptive method at the time of conception. Of the 97 first or last pregnancies with detailed information, 45 took place when the woman reportedly used a contraceptive method. The frequency of contraceptive use at the time of pregnancy corresponds closely to the frequency of reported use in the year before the pregnancy in the quantitative data generated in the survey component of the study (see Speizer, Santelli, Afaible-Munsus, & Kendall, 2004, for details of the quantitative data).

Findings

The classification of pregnancies as intended, mistimed, or unwanted was a difficult task. Our examination reveals the relevance of the multiple domains we identified, as illustrated in the account of this 26-year-old single mother (family planning client):

When I got pregnant when I was 17 I had an abortion. I wanted to graduate high school and go off to college. I found out I was pregnant 2 weeks before graduation. That was messed up. I wanted to get an abortion, I was too young to have a child, I could have gone to college even with a baby but it would have been too hard. The second time I got pregnant I was 24 and I felt like I was old enough to have that baby. I was in school and I didn’t think it would change things too much. I was in a bad relationship with that baby’s father so I knew I would have to have it by myself but I wanted her. Even though I didn’t plan on getting pregnant I wanted her once I did. It was different than the first time. I wasn’t using birth control and so I knew it was possible I would get pregnant, that’s why I was taking pregnancy tests every 2 months.... With me, I didn’t plan on getting pregnant and I did, but it was because I wasn’t using birth control so I knew it was

possible and it happened, so I didn’t really plan it but I didn’t really prevent it either.

The interview demonstrates how important contextual issues are for decision-making about fertility. Timing, the difference between her expectation of ideal age for pregnancy and her actual age seem critical reasons for her initial abortion. With respect to her second pregnancy, a bad relationship with her boyfriend and being in college seemed sensible reasons for this woman to avoid pregnancy, but she did not use birth control. Although she did not plan to become pregnant, once she did, that became the reason to want the pregnancy, reversing our expectations of the sequence of planning. A conventional approach to determining whether this woman was experiencing unintended pregnancies would classify the second pregnancy as unintended. Yet, the account provides evidence to support the opposite conclusion as well. The woman in question, as did many others in the study, seemed to take risks with pregnancy that she manifestly—if somewhat ambivalently—claims to be avoiding, a phenomenon that perplexes many researchers in this field. Clearly, a complex web of motivations underlies her decision. The present study addresses only part of this paradox by providing insight into the cultural and social context in which key events and decisions take place. The following sections will explore the multiple domains that shape women’s sexual risk-taking behavior and desires for pregnancy.

Sex

Initiation of sexual intercourse, generally during adolescence, places a young woman at immediate risk of pregnancy, but motivation to have sex is often unrelated to a desire to have children. Our respondents are clear about what constitutes sex. Sex is penile–vaginal sex and it occurs soon after girls start dating. Dating means spending time alone with a partner. Sex often begins within a year after a girl starts dating, and fully a third of the sample population reported getting pregnant in the first year after they first had sex. Because dating starts at around age 14, this pattern contributes enormously to teen pregnancy. The women often treated sex as unavoidable and seemed unconcerned about the possible pregnancy and STD risks they were taking when engaging in sex. Although some women reported having discussed sex with their boyfriends before it happened, having sex was generally described as something expected and rather uneventful. The following passage illustrates this perspective:

(18-year-old, family planning client, 1 child)

I had first sex at 13, had sex for a year before I got pregnant. Didn’t use birth control. Didn’t worry

about pregnancy or STDs. I did it just to do it, I don't even know why. Like, my cousin and him [first sex partner] was best friends, and my cousin was telling me that he [the friend] wanted to just to do it, so I just did it.

Our adolescents had a difficult time explaining why they had sex at an early age and often blamed it on the boys. One respondent remarked:

(17-year-old, family planning client, no children)

It feels good, they like it, they're freaky, if you are young and the boy keeps bucking his head against you then you might do it for him, it's like drugs, once you start you keep doing it, you have a weak mind, you should be thinking of other things. I don't know really why girls do, I don't get it, I don't even really like kissing.

Many responded with "I don't know" when asked why girls have sex. Others gave "disinterested" reasons:

(29-year-old, prenatal client, no children)

(Reasons to have sex) Just to do something, to feel important, just because other girls did it already.

Informants were also asked to give reasons why boys have sex. According to some, sex for boys is a "need" or "urge". According to many, boys are obsessed with how reports of their sexual activity boost their reputation. They reported that boys have sex to impress their friends or "be macho", and to feel like a man. Yet, sexual curiosity, feeling accepted among peers, and occasionally being in love were sentiments reported to be shared by both girls and boys. Further, the ways in which sex asserts adulthood was a common theme, as illustrated in the following accounts:

(23-year-old, family planning client, 2 children)

Some boys think having sex makes them a man, some boys think having babies make them a man. They just trying to be big like that.

(22-year-old, prenatal client, on 3rd pregnancy)

Make them (girls) feel grown, they want babies, most when they start having sex that young it's because their fathers weren't in the picture, or didn't give them enough attention, so they need attention from another man.

Sex, for these young women, was reported to fill an emotional void. Sex can secure the attentions and affections of boys, and ultimately can bring a child, universally described as one of the only reciprocated loves in a woman's life. All in all, the picture these young women paint of sex and sexuality is an emotionally logical and coherent one. It legitimizes intercourse, rather than alternative forms of sex, and justifies it for its potential outcome as a life-giving event rather than as a

self-indulgent act. The link between a sexuality that publicly denies pleasure and promotes pregnancy and the idea that any pregnancy is intentional is real, but not straightforward, and this ambiguity characterizes intentions:

(25-year-old, prenatal client, no children)

It just happens—it's one of those things that happen. It's gonna happen.

You want one of your own—after you take care of other kids soon you want one too.

You can trick a guy and have one—girls do this cause they think the guys will stick around for them, some guys do and some don't. Girls think it's worth the try.

Thus, early first sex and sexual play exposes young women to the risk of an unintended pregnancy, especially because contraception is often not used.

Childbearing and motherhood

Respondents were asked at several points in the interview about their perceptions of childbearing and motherhood. A theme that emerged was that the women's ideal childbearing goals seemed incongruent with their lived reality, in which early fertility was a key feature. In fact, women in our study reported two different responses when confronted with an early pregnancy: an ideal one in which teen pregnancy was frowned upon, and an alternate one in which teen pregnancy was accepted and eventually supported by families and friends; one that sometimes brought greater intimacy and communication with family.

The ideal reproductive life course

When asked about the "best" or "ideal" time to have a baby, many responded that it was preferable to wait until after school was finished and a steady job was found and the woman felt prepared to raise a child or was more or less "established":

(18-year-old, family planning client, no children)

(Ideal time to have a child) I think 24 or 25. I want to finish school. I want to have more to offer to my child when I have one. I'm here today worrying about my pregnancy test, so it's funny to tell you this. But I do want to wait until I get established before I have children. I think you should stop when you are 30. After that you are old to be having kids. I don't want to be 35 having a little baby, when your child is a teenager you'll be too old to enjoy it. I think I want my baby before 30. If I don't have one by then maybe I'll change my mind.

Another common theme that emerged from the discussion was that a woman is not ready to have a

baby if she lacks responsibility or cannot take care of herself. An interesting observation here is that this negative was not age related. Older women and younger women were considered equally able or unable to fulfill these criteria.

(18-year-old, family planning client, no children)

If you're not ready for the responsibility, can't take care of yourself, no job, if you got no goals as far as school, people that like to go out a lot can't take care of a baby and do that at the same time.

(23-year-old, family planning client, 2 children)

You should be financially stable, emotionally stable, able to take care of the kids, finish high school. It isn't really about age.

Reasons not to have a baby included schooling and valuing yourself:

(17-year-old, family planning client)

So you can finish school, education is important and you should concentrate on school; so you put yourself first, the boy should not be, he should be last and you should be concentrating on yourself; if you are too young; if you are in school you need to worry about the new LEAP (Louisiana Standardized Test) tests so that you can graduate, you can't do that if you are caring for a baby; your boyfriend is not serious about having kids.

Although many women consistently reported ideal expectations about pregnancy, they often found themselves living a different life. This situation was a source of anxiety for many young women, like this 20-year-old mother (family planning client) of a 4-month-old son, who reflected on how she was unable to live up to her father's expectations:

My dad, he's a minister and it took him some time (to accept the pregnancy). He found out when he saw my navel popping out, I was 7 months pregnant. I was scared to tell him. He was disappointed. My older sister got pregnant at 16. I was his baby. He didn't think I would get pregnant without being married. Even though I was in school and older, it still was hard for him. I was a good girl to him, his little girl. Then they treated me differently. I made the choice to be an adult. I was not the baby any more. They wanted me to move out and get a job and take care of myself like an adult. It was stressful.

These initial feelings of surprise and confusion were later tempered with the unconditional support of family and friends, as discussed in the next section. As these women lived out their own reproductive careers, they described their own norms and values as an alternative to the ideal.

An alternative reproductive life course

Many young women described an alternative life course to one portrayed as the ideal of career and marriage before childbearing. The goal of this alternative life course is to complete fertility at a very early age. According to one young woman, completing fertility by the age of 22 seemed to be pretty common among her peers:

(17-years-old, family planning client, no children)

They want to have their family soon, not worried about much after graduating high school. Some act like they want to go to college but they don't really want to, if they had a baby they'd be fine. Most of my friends do want to finish school first. They think they should have all their babies by the time they are 22. Get it all done with. The school I go to has about 1100 kids and lots of the girls are pregnant. In the graduating class maybe there is 200 boys and 100 girls and maybe 30 of those girls are pregnant. Some in my class are already working on their second child. Now they talk about finishing school but it is so hard for them to really do it, how would they have the time?

In fact, many younger respondents spoke about the benefits that having a baby at a young age could bring. They revealed that a baby was an opportunity to have someone to love, to receive love back, and to receive attention either from a boyfriend, other friends, or parents. Many of the younger respondents stated that pregnancy was a way to restore a young woman's self-confidence. This young prenatal patient reflects some of these issues in the following quote:

(15-year-old prenatal client pregnant with second child, first pregnancy at 13-years-old)

They really give me a lot with these babies I got a lot of new attention when before they really didn't. They are making sure I'm ok, buying lots of things, I didn't buy anything the whole time.

Older women were more likely to mention starting a family and settling down as reasons for having a baby (ideal expectations). Still, they also articulated feelings similar to their younger counterparts. A 29-year-old pregnant woman listed the following reasons for having a baby:

Makes you feel important, to get attention, to get at your parents.

Furthermore, although women acknowledged potential obstacles in the future, there was a general sense of acceptance of an unplanned pregnancy by them and their community and little apprehension about the long-term impact. Surprisingly, many women reported that their first pregnancy had little or no effect on their

dreams or goals. Of those who admitted their goals would have to be put on hold, many did not seem too disappointed about the unexpected turn of events. In fact, some women perceived an early pregnancy as something that brought meaning into their lives, indicating that it made them more motivated and more diligent about achieving their goals:

(20-year-old family planning client talking about her four-month old first child)

My life is more meaningful now. I'm not trying to get the guy anymore, wasting my time. Now I'm trying to get through my classes. I'm more focused. I've got to support my baby.

Therefore, while there appears to be an ideal time to have children, women are rather accepting of an alternative life course that permits variation in the timing of events. Whether this acceptance is because of alternative or changing ideals or reflects acceptance of the reality of mistimed or unwanted pregnancies can be further enlightened by examining factors that affect women's motivation and control over pregnancy timing including relationships, contraception, and abortion.

Marriage and partner relationships

First pregnancy had a special meaning in women's romantic lives. Many young respondents believed their first pregnancy affected their relationship with their boyfriend in a positive way. They felt that the pregnancy made them grow closer. When asked how their first pregnancies affected their relationships, two young women responded:

(21-year-old prenatal client pregnant for first time)

It brought us closer together. It's like we got a bond now.

(17-year-old prenatal client pregnant for first time)

Well, he (is) closer now. He just be doing different things. Every time he comes over, he touches my stomach. He rubs my stomach and asks me if I feel alright.

These positive sentiments were not always long-lived. As the demands of motherhood became more real and more taxing, so did the demands on the relationship, often eventually ending it. In fact, most women were no longer with the father of their first baby. Many women in the sample reported a general sense of scepticism about men, relationships, and marriage.

Unstable relationships characterized many of these women's lives, and many had to face a reality that foreshadowed life as a single mother. Generally, the women were determined to raise their children without the support of the men in their lives, as articulated by

this 26-year-old single mother of a 2-year-old girl (family planning client, who had an abortion at 17):

I didn't think he would care so little for the baby. I thought it would be ok with him but even if he left I wanted to have that baby. My girl could care less about him now. Most girls are daddy's girls and love their father, but my girl could care less about him.

Furthermore, many women, despite their age, did not foresee marriage at all. Just as the goal of "being established" before getting pregnant was somewhat "idealistic", so was the goal of being married. In some cases, marriage was even viewed as undesirable because it changed relationships in a negative way. Ironically, it was perceived as burdensome and signaled an even greater commitment than parenthood, as this young woman explains:

(15-year-old prenatal client currently pregnant with second pregnancy from a different father than the first child at home)

Yea, it's serious. We're having this baby together. I ain't marrying him. I'm not ready for that, wait until I get older. I'm not worried about being married. My momma isn't married, she's staying with my brother's daddy. Getting married isn't important really, as long as you are together. If you have a baby then that's one thing. You don't need the papers. Being married is different, it changes your life. (more than having a baby with someone?) yea, it's different, it's another person, adult in your life. Boyfriends get all unruly and then they can go, not when you're married.

Many of the women we interviewed recognized that the father would not necessarily be in the picture for the long term, even if the pregnancy was being used to "keep" the man. Women knew and accepted that pregnancy is associated with the risk of being a single parent.

Contraception

All respondents had experience using birth control. A common scenario in this community is illustrated with the following quotation:

(20-year-old, family planning client, 1 child)

I was using condoms only when I first started having sex and then decided to get pills my freshman year of college. I took them for a year and a half. They were giving me headaches and making me have worse cramps but that's not why I stopped taking them, I just didn't like taking them. I was using condoms after that and now after my baby I'm on Depo. It has made me bleed a lot, but that's been my

only side effect. I can't tell if it's making me gain weight because I just had my baby.

Misconceptions about use and effects of methods seemed to drive method switching. Periods when women switch methods may be periods of increased vulnerability to pregnancy. Many women switched because the effectiveness of methods was suspect. They were uncertain about the plausibility of planning a pregnancy:

(38-year-old, family planning client, mother of 3 children)

You know, I was using pills when I got pregnant with my last 2 children and I still got pregnant, so I don't know. Sometimes I wonder if God's got plans for me that I don't know about. With my last pregnancy I wanted to get my tubes tied and something happened with my delivery and they couldn't do it then. Must be something with me, I keep having these kids at this time in my life. I was not planning to but it happened anyway. I think we can do what we can do but sometimes things just happen to us that we aren't planning.

The women's uncertainty about contraception was related to (1) misinformation about hormonal methods and experience with a wide range of side effects; (2) the view that condoms can be and are intentionally perforated by men; and (3) the fact that there was very little discussion about contraception between the women and their partners. We cannot rule out difficulties with the quality of care these women received or poor patient-provider communication. We elaborate briefly on the first three areas.

Hormonal methods: side effects, misperceptions, misinformation, limited access

The pill and the shot (Depo-Provera) were the methods most commonly used, yet women reported a range of side effects with these two methods. Irregular bleeding, weight gain, nausea, leg pain, varicose veins, and mood swings were reported by women on the pill. Prolonged or breakthrough bleeding, headaches, and weight gain/loss were reported by women on the shot. Additionally, fatigue, migraine headaches, calcium depletion in the body, and links to cancer were side effects said to be associated with the shot. According to several women, the side effects often became so unbearable they had no choice but to discontinue the method. These respondents both suffered side effects and got pregnant.

(26-year-old, family planning client, 1 child)

I went on pills after my abortion until I was 21. I went on Depo after that for a couple of years but then I started having side effects. I was bloating and

had enlarged breasts and then having break-through bleeding. I thought I was pregnant so I didn't get my next shot. I kept asking the nurses here why I was all of a sudden getting these side effects and all they could say were they were side effects and it was ok but that wasn't good enough so I stopped the shots.

Similar to side effects, which concerned many women, misperceptions and misinformation about contraception served as potential barriers to effective method use. Women who had used or were using the pill or the shot often reported missing pills, failing to return to the clinic for a new pill prescription, or failing to return to the clinic for their tri-monthly injection, both because of their imperfect knowledge and financial inaccessibility as expressed by this young woman:

(23 year old, family planning client, 2 children)

I got on the pill at 15, before I was sexually active. It was a birthday present from my Aunt and Grandmother. I was seeing a boy and they brought me for pills. Then I got big on the pills so I stopped them. I was using condoms on and off and got pregnant at 18. After my son was born I got on Depo, it was good, no side effects, I liked it. I lost my Medicaid and couldn't afford to get the shot at my doctors, it was \$60 a visit and \$20 a shot. So I got off it. They told me there that I wouldn't get pregnant for a year after stopping, 6 months later I got pregnant.

Women had many misperceptions about contraception, including the injection's duration of effectiveness, as mentioned above. Other concerns included the risk of infertility and cancer from hormonal contraception and misinformation on how to take pills correctly. They expressed the belief that they needed to rest their body from birth control, particularly hormonal methods. Although we could not trace the origin of these beliefs, a few women mentioned learning about them from their family planning providers. Side effects of hormonal methods and misperceptions about method use led women to go on and off these methods, resulting in periods of risk, unless condoms were used in the interim. The next section discusses condom use and perceptions among the women interviewed.

Condoms

Almost all women reported having used condoms, often called protection. When used, they were often employed temporarily or as a default method during the transition between two hormonal methods. Respondents generally had little faith in the effectiveness of condoms. Many reported having condoms pop or fail, although some admitted it was the condom slipping off and not a tear or rip that was responsible for a pregnancy. Seven women even contended that men poke holes in condoms

on purpose so they can get the woman pregnant. According to one family planning client:

(19-year-old, 1 child)

I used condoms when I was having sex at first. I would bring ‘em. I didn’t want him to use his ‘cause who knows what kind they were, if they were old or something. We used condoms but one popped and I got pregnant. (how did it pop?) It just did, after we were done it was popped. I check ‘em too. Make sure there ain’t no holes in ‘em. So I got pregnant. (did that only happen once, that the condom popped?) yea. After my son was had I went on Depo in the hospital and that’s what I use still.

Another common reason mentioned for not using condoms consistently was that the women did not always have them around. Also, requesting a partner to use a condom can undermine the trust in the relationship. When describing her first time having sex, one woman expressed her reluctance to insist on using a condom because she feared that it would jeopardize her relationship with her first boyfriend:

(20-year-old, family planning client, no children)

(When did you first have sex?) My senior year when I was 18. His name was Harry. We went to 2 different schools but we were in this program where we went to Delgado in the morning. He was the first person I was talking to in the 9th grade, my first boyfriend or relationship. We always talked about it (having sex) because he always brought the subject up. I was scared. He didn’t use a condom. I asked him but he talked about, “Oh I trust you and you should trust me.”

Men are presented in these interviews as playing a covert role in contraception, often through sabotage or manipulation. This situation is exacerbated by the general lack of discussion about contraception between women and their partners, as discussed below.

Discussing contraception with partners

Women usually took it upon themselves to initiate a contraceptive method, because they reported that men generally responded apathetically when the topic was introduced. Even though women were cognizant of the potential risks to which they were exposed, they were reluctant to confront their partners about condom use or other methods, often leading to an unanticipated pregnancy.

(20-year-old, prenatal client, 1 child)

After my first son I went on Depo and then on pills. It was my decision. We don’t talk about it much. He knows I wouldn’t sleep around and I think he doesn’t. I should know better because he goes

away. If he brings back something (STD) I would just die but I just don’t do anything about it.

(26-year-old, family planning client, 1 child)

We use condoms, not every time but most of the time. He don’t really worry about it at all, I’m the one who’s here getting the shot. I decide on it. He would use nothing if it was up to him. He doesn’t really like condoms. He doesn’t like to use them.

Women were using contraception based on their own initiative to avoid an unintended pregnancy. In more challenging situations, however, such as having sex with someone for the first time or when the partner disapproves of birth control, many women seem more willing to risk a pregnancy than to confront their partners.

Abortion

To generate an understanding of unintended adolescent pregnancy and abortion, the questionnaire included several hypothetical scenarios describing a 16-year-old high school student named Tanya and her 21-year-old boyfriend James. In response to a scenario in which Tanya gets pregnant accidentally, there seemed to be a strong sentiment that the right thing to do was to keep and raise the baby even if the boyfriend was not willing to assume the role of father or if it interfered with Tanya’s career plans. Respondents generally assumed that Tanya’s family would help out, that she could “get the boy on child support”, get a job herself, and get help from the government, and that things would work out one way or another.

In addition, some respondents seemed to suggest that Tanya’s decision to keep the baby signaled greater self-confidence, responsibility, and maturity, a possible indication of her passage into adulthood. In contrast, when respondents raised the issue of abortion spontaneously, they portrayed it as less admirable because it allowed young women to duck the inevitable responsibility of motherhood.

Of the 72 women who responded to the scenario questions, 47 were opposed to abortion for any reason. Women commonly referred to abortion as “killing a baby”. Many of them expressed feelings about abortion similar to those expressed by this 15-year-old prenatal client, pregnant for the first time:

Scenario: Tanya and James talked about it (the unintended pregnancy). James is really worried about making enough money to support Tanya and the baby. Tanya wants to have an abortion. What should she do?

R: She shouldn’t have the abortion, her mama didn’t kill her, why should she kill the child? He’ll make some money, and save it.

Twenty-five of the 77 women felt that abortion was an acceptable option. A 22-year-old pregnant mother of three (on her fourth pregnancy) expressed the following:

R: If she wants it (the abortion), she should have it no matter what he say. Because sooner or later he's gonna be gone.

Women's personal experience with abortion coincided with these attitudes. Abortion was used rarely in this sample. Six women had a total of seven abortions in this group. The perceived immorality of abortion, combined with the women's perceptions of and experience with contraception, restricted the women's choices as articulated by this young women:

(18 year old, prenatal client, 5 month old child)

All the ones that take the shot, none of them get pregnant. But most of the ones who take the pill got pregnant. I knew that condoms break. I should have expected it (pregnancy) to happen... I don't mind having children. I want children. I love babies. I was the only child. It's not like I tried to get pregnant. But I feel if it does happen, I would accept. I would never get an abortion.

Ambivalence toward contraception, rejection of abortion, and acceptance of pregnancy created a different spectrum of choices for these women, one which excluded pregnancy termination and treated pregnancy as the inevitable consequence of sexual intercourse, no matter the woman's intent.

Discussion

The relevance of pregnancy planning: implications for future research and measurement of pregnancy intentions

It is important to emphasize, as Luker (1999) does, that the discourse of "unintended pregnancy" today refers to different issues than when it was introduced in the past. As discussed earlier, a study on unintended pregnancy conducted in the 1960s might have interviewed mothers in their 30s or 40s with large families to explore unwanted pregnancies at the end of the childbearing period. But the bulk of unintended pregnancies today are early (mistimed) pregnancies (Brown & Eisenberg, 1995). Certainly different factors are involved in the intentionality of a pregnancy measured at these two separate times. Our findings generally characterize women's preferences at the beginning of their reproductive careers, as opposed to women's or couples' views of how long to extend childbearing.

To plan a pregnancy, a woman would have to feel in control of many of the factors we outline above. This

study suggests that in the lives of the women we studied, having control over these factors is not a realistic expectation. In these circumstances women's report of the intendedness of a pregnancy often seems more like a rationalization after discovering a pregnancy than the outcome of a deliberate and voiced choice. The notion that planning a pregnancy is irrelevant for certain women is not a new one. Moos et al. (1997), who conducted focus groups with 18 African-American and White women in North Carolina, suggest that the concept of planning a pregnancy might not be salient in lower-income groups. However, Barrett and Wellings (2002), who conducted in-depth interviews with a diverse group of women in London, England, provide a cross-cultural perspective among a more diverse audience. Of the 47 women interviewed, 18 were not from the UK, and the pool represented ethnic diversity. Their data suggest that the act of deliberately planning a pregnancy is foreign to many women, despite their socioeconomic status and/or ethnic origin. In this study (Barrett & Wellings, 2002), a "planned" pregnancy had to meet four criteria: intending to become pregnant, stopping contraception, partner agreement, and reaching the right time in terms of lifestyle/life stage. They conclude that women tend not to use terms like "planned" and "intended" spontaneously; and there is variation in women's understanding of these terms (Barrett & Wellings, 2002). They also leave open for discussion the findings that the "adoption of planning behavior some of the time suggest that pregnancy planning is an available choice" and that "not planning may have particular advantages in certain context and needs further investigation" (Barrett & Wellings, 2002, p. 555).

Our study sheds light on the applicability of the concept of "planning" or "intending" a pregnancy. The study illustrates that the elements we explore in our domains—knowledge, access and support for use of contraception, the value of pregnancy timing, and supportive relationships with partners—that might make planning a pregnancy relevant are either absent, under transformation, or not perceived as under women's own control.

When discussing their first sex and first pregnancies, many of the women in our study described inadequate preparation for sex and contraception. Contraception as understood in this community has unpredictable consequences and is loaded with economic, physical, and psychological costs. Hormonal methods are perceived to take a physical toll on women's bodies, and continued use is easily disrupted by missed appointments and/or the inability to make payments. The effectiveness of the methods themselves is suspect, knowledge and use of them is inadequate, and reported condom failure is high. Women's partners are often able to manipulate the use or non-use of contraception.

These factors—side effects, negative knowledge and attitudes, and lack of partner support—that make contraception costly to women, and consequently difficult to adhere to, are not limited to the experiences of women in this study. These problems have also been reported by women in other settings (Sable & Libbus, 1998; Miller, 1986). Further, reports of condom breakage and/or slippage is consistent with findings of several clinic-based studies, although the magnitude varies according to the population studied (Crosby, Sanders, Yarber, & Graham, 2003; Macaluso et al., 1999; Spruyt et al., 1998). According to the most recent of these studies, which sampled both male and females in a university setting, reports of condom slippage/breakage reached 28% among those who had used a condom in the last 3 months (Crosby et al., 2003). Within this climate of family planning uncertainty, choosing to keep a pregnancy may be seen as a feasible act, while controlling conception may not. The family planning choice appears to be between abortion and pregnancy, not pregnancy and non-pregnancy, and abortion is not a viable option for many women in this sample.

Additional family and community factors influence pregnancy. For example, the negative consequences of early pregnancy seem less relevant to this population of women. Educational and career opportunities are often lacking; fathers of the babies are often not present; and marriage is viewed as a burden to women and sometimes an even greater commitment than motherhood itself. Zabin (1999, p. 2) makes a similar point when she refers to the “weakness of couples’ timing intentions” in the context of changing sexual dyads. She argues that women who expect to marry in the future may place more value on avoiding a pregnancy with a casual partner than women in similar relationships who do not foresee marriage at all. As suggested by several studies (Stevens-Simon, Beach, & Klerman, 2001; Zabin, Astone, & Emerson, 1993; Miller, 1986; Schoen, Astone, Kim, & Nathanson, 1999), effective planning or behaviors necessary to avoid conception occur only when there exist strong motivations and supportive environments to remain non-pregnant. Our study finds that the women in our sample express these motivations, but they also describe conditions that might make a pregnancy, or even an unplanned pregnancy, valued in this community.

Our study also suggests that the desire to assert adulthood, develop both natal and conjugal family stability, and attain greater intimacy with partners are possibly more powerful motivations than idealized scripts for career and marriage. These findings are consistent with the earlier literature on adolescent childbearing in poor African-American communities (Geronimus, 2003, 1991, 1996; Anderson, 1994; Burton, 1990). Much of this literature suggests that the idealized and conventional female life course that has prevailed in

higher-income groups—one that prescribes the sequence of educational achievement, career fulfillment, and then family formation—needs to be reconsidered. Anderson’s (1994) ethnographic work in inner-city Philadelphia suggests that as urban poverty persists, the conventionalized family constituted involving love, marriage, and career loses its meaning. In this context, early pregnancy is a consequence of young women’s search to fulfill normal developmental and emotional goals, such as the search for identity and love (Anderson, 1994). Burton’s (1990) work in a poor suburban Northeastern community also characterizes an accelerated family timetable, which she ascribes to perceptions of early mortality and the low probability of marriage, and gives rise to early childbearing patterns.

In line with our critique of the concept of pregnancy planning, Geronimus (1996, 2003) urges public health policy analysts and researchers to reconsider how they have come to understand and frame the public health issue of early childbearing in poor African-American contexts. She reminds us that fertility norms are culturally and socially defined, and demonstrates this notion with empirical evidence of differential age at first birth distributions in several US contexts (Geronimus, 2003). She argues that in the case of poor, urban, Black populations, an early fertility timing norm is a collective strategy in response to poverty and the rapid deterioration of poor Black women’s health (Geronimus, 2003, 2001). She claims that “poor women may attempt to fulfill their multiple roles and obligations in a sequence that fits the realities of a different social circumstance and health-risk profile than those familiar to many researchers and policy analysts” (Geronimus, 1991, p. 466). From this perspective, it is reasonable to conclude that the material, gender, and other socioeconomic realities of the women in our study give rise to a world in which planning a pregnancy, in the traditional sense, or from the majority’s perspective, loses its force. This reality shapes, and to some extent, makes uncertain, the elements—sexual experience, contraception, timing of motherhood, relationships with partners—of women’s lives that make pregnancy planning salient.

Given that this study reports on a small sample of 77 women recruited purposively from publicly funded reproductive health clinics in New Orleans, we cannot make a substantiated claim for the generalizability of the findings presented here. However, as discussed, many of the themes that emerged in this study are consistent with the unintended pregnancy literature and with the literature on adolescent childbearing in poor African-American communities. While these findings may not be strictly generalizable beyond our sample, to the extent that poverty and socioeconomic disadvantage shape and change personal motivations and the traditional institutions that make pregnancy planning salient, the themes presented here are relevant to other

populations (cf. Anderson, 1994). The portrait of young men and women faced with poverty, reduced schooling and/or job opportunities, in an environment of unstable and impermanent relationships and early sexuality is certainly not unique to these women, New Orleans, or even the US. To the extent that this paper contributes to understanding the interplay of reduced opportunities, sexuality and fertility, and community and individual response, it contributes to more universal concerns.

As we presented in this paper, women's decision-making about sexual risk-taking and childbearing is multi-faceted. Our respondents present a complex story to support their childbearing decisions: idealized expectations set against poverty and poor career opportunities; gaming with the chance of conception in the heat of the moment; conventional notions of sexuality and the inevitability of early intercourse; a community with high prevalence of teen pregnancy and acquiescence to it after the fact; the volatility of relationships and marriage; imperfect contraceptive practice and knowledge; and the rejection of abortion as an alternative to contraception. These concerns combine to explain the difference between general intentions—perhaps formed in retrospect—reported in surveys and the intentionality of pregnancy at the time of conception.

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