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“The worst part about my pregnancy was stuff that didn’t have to do with my pregnancy”: Medicaid Beneficiaries’ Pregnancy Intentions & Experiences in South Carolina

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"THE WORST PART ABOUT MY PREGNANCY WAS STUFF THAT DIDN'T HAVE TO DO WITH MY PREGNANCY":

MEDICAID BENEFICIARIES' PREGNANCY INTENTIONS & EXPERIENCES IN SOUTH CAROLINA

By

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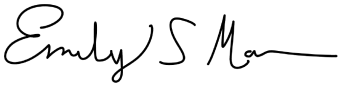

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THESIS SUMMARY

Low-income women and women of color experience adverse birth outcomes at disproportionately higher rates in the United States than most people who give birth. This thesis examines individual interviews conducted with 30 low-income women whose most recent birth was covered by Medicaid, the United States' largest means-tested public health insurance program. The aim of this thesis is to examine how the women in the study thought about pregnancy, and how they described their intentions to become or avoid becoming pregnant at various times in their life. While public health researchers often frame pregnancy as an event that is either intended or unintended, this thesis argues that pregnancy intentions and reactions to pregnancy among low-income women are much more complex, with various interpersonal, social, and economic factors shaping the way study participants thought about their chances of becoming pregnant, and the acceptability of their pregnancy. The attitudes and beliefs of pregnancy-capable people is deeply intertwined with their social contexts, including their experiences with gynecological and obstetric care, as well as their interpretations of the experiences of their friends and family members. As such, these findings can enhance researchers' and clinicians' understandings of the diverse factors that can contribute to positive and negative experiences during pregnancy and childbirth among low-income women and contribute to ongoing efforts to better support patient autonomy and person-centered gynecological and obstetric care and reduce pregnancy-related health inequities. Additionally, this thesis provides insight for policymakers and wider general audiences alike, in understanding the complex pregnancy experiences and desires of publicly insured women in the United States, and best supporting the autonomy and needs of their peers, constituents, and loved ones who may be capable of pregnancy. I hope that my thesis may be able to contribute to the burgeoning field of research on pregnancy desires, in shifting discussions away from the narrow view of unintended pregnancy as a problematic source of risk.

I. INTRODUCTION

Unintended Pregnancy

Unintended pregnancy has long been held as an essential parameter for demographers studying population fertility patterns, and public health practitioners seeking to prevented unwanted childbearing or otherwise study pregnancy outcomes. Unintended pregnancy is associated with early childbearing, socioeconomic disadvantage, delayed seeking of prenatal care, smoking during pregnancy, low birth weight, and not breastfeeding (Mohllajee et al., 2007). Early correlative studies were quickly taken up by public health practitioners, under the assumption that unintended pregnancy is the cause of these adverse outcomes, and as a result, reducing unintended pregnancy has since been the focus of countless national and regional public health efforts in the last few decades (Mann & Grzanka, 2018).

The prevailing definition held in both public health and demography includes (1) unwanted pregnancies, which were not desired, and (2) mistimed pregnancies, which specifically occurred earlier than desired, under the category of unintended pregnancies. Under this paradigm, researchers have viewed pregnancy intention as an essentialized, binary variable – whereby pregnancies may be strictly categorized as either fully intended or fully unintended. Notably, pregnancies which occur later than desired (e.g., due to infertility or difficulties conceiving) are also excluded from the definition of mistimed-type unintended pregnancies and are instead combined into the count of intended pregnancies. Oftentimes, intentions are only measured or examined for pregnancies ending in live births, and pregnancies ending in abortion are rather unequivocally assumed to have been unintended. The development of this definitional construct for measuring unintended pregnancy can be traced back to early population studies focused on

fertility, which was first incorporated into the 1973 National Survey of Family Growth (NSFG) and has since persisted in the study of pregnancy intentions (Santelli, 2003).

The basis for this mainstream definition is an underlying assumption that pregnancy is a conscious decision, which falls along a rigid dichotomy of intention. However, some researchers have criticized this paradigm as overly reductive, and have expressed growing concerns regarding the validity of pregnancy unintended-ness as a discrete measurement. Some researchers have instead called for a more holistic measurement of pregnancy desires, which account for the continuum of preferences and beliefs that constitute pregnancy wanted-ness and intended-ness (Arteaga et al., 2019; Borrero et al., 2015; Santelli, 2003). Under existing paradigms of pregnancy intention, however, ambivalence, unsureness, and indifferent preferences for pregnancy are unaccounted for, and instead are often grouped in with the catch-all categorization of "intended".

Additionally, nationwide surveys of pregnancy intentions contribute greatly to understanding fertility and reproductive behaviors, forecasting population trends, maternal and child health outcomes, and assessing access to contraception. As a result, the accurate measurement of pregnancy intentions critically contributes to the provision of high-quality care at both the population and clinical levels, as well as assessing and addressing community-based needs for family planning, and effective solutions for contraceptive access and counseling. In the United States, 45% of pregnancies were estimated to be unintended, as of data from 2011 (reported by Finer & Zolna in 2016), with 18% of all pregnancies reported as unwanted, and 27% reported as mistimed. Of the approximately one out of every two pregnancies in the US that are unintended (excluding miscarriages), 42% end in induced abortion, while 58% end in

birth (Finer & Zolna, 2016). Given the widespread prevalence of unintended pregnancy in the United States, it is of critical importance that researchers have not only accurate measurements, but also nuanced understandings of the realities of pregnancy intentions.

Disparities

It is also critical to recognize demographic disparities in unintended pregnancy, as stratified particularly by race/ethnicity, age, and socioeconomic status in the US. Unintended pregnancy rates are the highest among low-income women, women aged 18 to 24, cohabiting women, and women of color; simultaneously, rates of unintended pregnancy are often the lowest among higher-income women, white women, college graduates, and married women. Rates of unintended pregnancy among women with income lower than the federal poverty line are also over five times higher than women with incomes of at least 200% of federal poverty; rates of resulting unintended births were also seven times higher. Additionally, unintended pregnancy rates for non-Hispanic Black women in 2011 was over two times higher than that of non-Hispanic white women (at 7.9% and 3.3% respectively) (Finer & Zolna, 2016). While rates of unintended pregnancy overall have dropped in the decades leading up to 2011, rates have at timers increased and dropped more slowly along these disparities. These inequalities reflect upstream sociocultural, structural, economic, and political systems of oppression, and determinants of disadvantage, as well as the foundations of deeply rooted stigma surrounding unintended pregnancy in the US.

Stigma

Social norms and stigma are non-trivial factors that impact reproductive health behaviors and decision-making (Mann et al., 2015). It is worth nothing the existing (albeit limited) research on the presence and ways in which these discourses manifest surrounding unintended pregnancy, resolution options, and related parenting pressures. Smith et al. (2016) conducted qualitative interviews with young, low-income women in Alabama in similar fashion to the methodology of the original study from which the data of thesis originates. Participants described common social expectations for pregnancy to occur within the context of stable, monogamous relationships, where both partners were mature, educated, and financially stable. In contrast, however, the women in the study reported that unintended pregnancy outside of said ideal circumstances is common, and that community members expect young women to bear and raise a child when an unintended pregnancy occurs. Social perceptions evaluate women who do so more positively than women who opt for other methods of resolving unintended pregnancy (i.e. abortion or adoption). The participants generally felt that abortion and adoption were unacceptable alternatives to parenting, and discussed these options in terms of negative labels, social judgement, and non-disclosure. The social environment in which these women lived was often at odds with their empowerment and autonomy to be able to evaluate and opt for the best reproductive decisions for themselves. More generally, it can be noted from this study that social perceptions and the judgement of others has a tangible impact on decision-making for women experiencing unintended pregnancy and is a significant determinant of unintended pregnancy resolution. Additionally, it is of note that the women themselves experiencing unintended pregnancy were subject to internalized notions of stigma, and concerns of social desirability and reaction with regard to their responses in research interviews.

Stigma is also pervasive within healthcare systems at both the interpersonal and structural levels, and is detrimental to diagnosis, treatment, and the overall provision of high-quality care. Decreasing the proportion of pregnancies that are unplanned is a major healthcare goal in the United States, and the focus of many family planning campaigns (Mann & Grzanka, 2018). Stevens (2015) reports from qualitative research interviews that healthcare providers strongly hold pregnancy planning as a result of individual choice and behaviors, reminiscent of the theoretical framing of the Theory of Planned behavior, in framing pregnancy as a result of conscious, self-determined intentions. This rigid view of pregnancy as controllable contributes to the major theme from Stevens' work, in that healthcare providers overwhelmingly hold normative expectations about what it means to be ready to have a baby. Providers' ideal circumstances for childbearing excluded poor, single, and young women, and instead framed pregnancy planning as part of a broader process of milestones achieved in a successful middle-class life, which should be preceded by the attainment other successes such as a long-term relationship, a good job, and financial stability. Even in some cases where patients expressed intentions and positive desire to become pregnant, providers may still have characterized their pregnancies as less/not acceptable, because they occurred in a context outside of normative "readiness". Providers engaging in this cognitive process were prioritizing their own perceptions of intention and readiness, likely from a highly medicalized perspective of risk aversion as well as socioeconomic stigma, and as a result, may have eclipsed patients' own evaluations of readiness and pregnancy acceptability. While planning for pregnancy has demonstrated improved health outcomes, it was suggested critically by Stevens that providers may actually be perpetuating stigma and stratification in high-care quality delivery by prioritizing their own privileged norms about pregnancy planning (see also Mann, 2013, 2022).

Furthermore, despite public health discourses that claim delaying pregnancy is associated with social and economic benefits, research has shown that young people's future outcomes are most impacted by structural inequity, regardless of childbearing. Qualitative research conducted by Gomez et al. (2021) with young men and women highlighted the ways in which social advantage is strongly associated with feelings of reproductive autonomy, and the ability to optimally provide for potential children. Structural inequities in SES limited reproductive self-determination for adolescents approaching adulthood, whereby the most privileged participants were able to align their pregnancy desires with actual childbearing and contraceptive behaviors, while the most marginalized participants felt significant doubt about ever attaining the ideal circumstances for pregnancy preparedness, and therefore did not engage in significant pregnancy prevention. Thus, it can be observed that public health narratives that emphasizes behavioral pregnancy prevention for multiply marginalized people without addressing the barrier of structural and economic inequity in their lives ultimately exacerbates reproductive oppression. Public health campaigns often promote pregnancy prevention to no avail among low-income people, as the false guise that contraceptive use ensures future economic success fails to compare to the economic oppression people may otherwise already feel in their lives. Nonetheless, public health campaigns frequently tout the high risks of pregnancy, and particularly unintended pregnancy for young people of low SES. The resulting risk distortion among the public may not only be unwarranted, but likely also contributes to worsened stigma towards pregnancies that occur outside of the set of purported ideal economic, social, and planned circumstances.

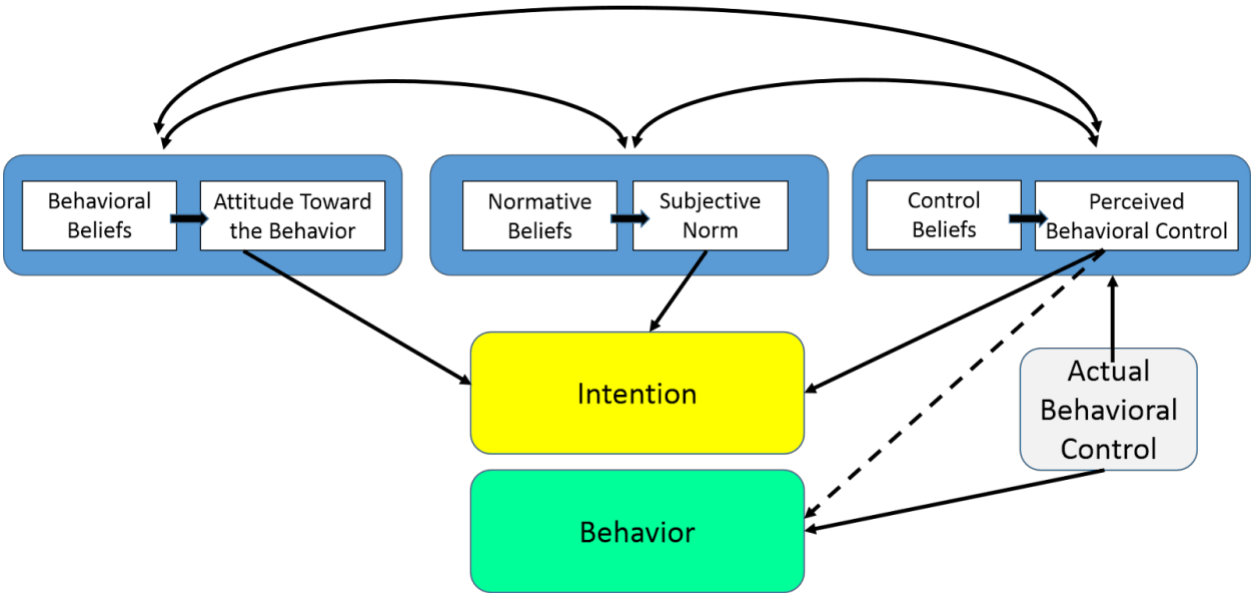
When women with less education give birth, they are more likely to be classified as unintended than other births. There is a common assumption within public health that women with lower education levels have a corresponding lack of contraceptive knowledge, health

literacy, or self-efficacy among. However, comprehensive research has shown that educational advantages early in life is related to future structuring of pregnancy desires and the salience of the benefits of precise fertility timing. Wise et al. (2016) showed that educational disadvantage was correlated with greater likelihood of unintended pregnancy, when other covariates were controlled for, this correlation was not as apparent. Instead, educational advantage in reality serves as more of a marker of assumptions and expectations about a woman's health literacy and is in fact a larger structural dynamic that impacts contraceptive behaviors. It is far from a simple, correlative trail of causation that women with lower SES are more likely to have unintended pregnancies and therefore more likely to be at economic disadvantage or experience adverse health outcomes. Instead, structural inequality that modulates SES is the basal determinant of quality of life, knowledge, and health, and it is these structural factors that condition wider perceptions and measures of pregnancy intention and acceptability (Gomez et al., 2021)

Contraceptive Intentions & Causes of Unintended Pregnancy

Contraceptive behaviors constitute a set of a proximate causes of unintended pregnancy which can be divided into four main categories: (1) non-use, (2) inconsistent use, (3) incorrect use, and (4) contraceptive failure (Finer & Zolna, 2016). While the proximate behavioral causes of unintended pregnancy may be observed as relating to contraceptive knowledge, behavior, stigma, access, and related factors of reproductive autonomy, these factors are also built upon the context and foundation of structural upstream factors that must be recognized.

Figure 1. The Theory of Planned Behavior (LaMorte, 2019)



The Theory of Planned Behavior (TPB) stems from the Theory of Reasoned Action and the Health Belief Model and is a pervasive framework for behavioral analysis in public health program planning and intervention design in health promotion. The Theory of Planned behavior posits that intention to carry out behavior is what stimulates action, and that a behavior is a planned result based on how a person perceives its potential benefits, social acceptability, and their own self-efficacy (LaMorte, 2019). Methodological and conceptual criticisms of TPB are centered around how it fails to account for: the ways in which intentions change over time, the influences of risk, fear, and mood, as well as quite critically, how access to resources, opportunities, and wider environmental and economic structures influence behavior (LaMorte, 2019). In applying the Theory of Planned Behavior to unintended pregnancy, there is a foundational assumption that unintended pregnancy stems from specific, conscious intentions and subsequent behaviors. An application of TPB could ostensibly suggest that unintended

pregnancy be traced primarily to purposeful choices to use or not use contraception. This not only excludes a major source of unintended pregnancy – contraceptive failure – but also fails to encompass the full range of complex attitudes, beliefs, and knowledge that factor into contraceptive behaviors. Such a theory also fails to cover the potential for contraceptive non-use due to coercion (i.e. coercive partner dynamics), rather than truly voluntary choice.

Qualitative researchers, however, have shown that women do not always formulate specific pregnancy intentions and subsequent behaviors. Borrero et al. (2015) found that most women generally fall into four categories of pregnancy intentions: (1) wanting to avoid pregnancy, (2) desiring pregnancy, (3) ambivalent about pregnancy desires, and (4) lacking intention. Their study found that many women expressed feeling limited or no reproductive control and autonomy in their lives and relationships, and therefore did not formulate clear pregnancy intentions. Many women in the study Borrero and colleagues conducted expressed that pregnancy was something that "just happens", and that intentional pregnancy planning was often seen as an unattainable ideal, expressing various and often limited levels of knowledge about the potential health benefits of a planned pregnancy. Additionally, the authors noted that there was not a clear congruency between people's desires not to become pregnant, and their contraceptive use/behavior (Borrero et al., 2015).

From the same work of Borrero et al. (2015), participants' perceptions about pregnancy intendedness, happiness about pregnancy, and acceptability of pregnancy were all distinct constructs. It was particularly of note that because pre-conception intentions and planning did not necessarily occur, judgements about the acceptability of a pregnancy were typically determined after one had already become pregnant. Other factors contributing to incongruent contraceptive

behaviors and pregnancy intentions included women's perceptions of their own potential infertility, and experiences of contraceptive sabotage or coercion into non-use by male partners. The interpersonal and cognitive factors that lead to higher risk of unintended pregnancy were significant, and potentially modifiable, as pathways to higher risk, unintended pregnancies. These findings also assist healthcare providers who work with low-income women, in not only better understanding pathways leading to their reasoning and behaviors related to fertility. Exploring the complexities of pregnancy intentions among Medicaid beneficiaries ostensibly offers a pathway to uncovering the roots of inferior care, provider miscommunication and conflict with patients, patient non-compliance with clinical recommendations, and ultimately, reducing disparate pregnancy and birth outcomes for multiply marginalized low-income women.

Pregnancy Desires

A growing area of research is focused on shifting discussions from pregnancy intentions to multifaceted measures of pregnancy desires. Pregnancy desires encompass how people feel and felt about becoming pregnant at the time of occurrence. Pregnancy desires are able to accommodate more specifically for pregnancies that may have been wanted sooner, and uncertainty or unsureness if a pregnancy was desired prior to its occurrence, as well as more traditionally "unintended" pregnancies that may have been wanted later or not wanted at all. Some of the emerging work in this field comes from psychology research, in assessing pregnancy desires as affective, cognitive, cultural, and contextual in nature. For example, Rocca et al. (2019) created the Desire to Avoid Pregnancy (DAP) scale, which measures a prospective range of attitudes and desires to avoid pregnancy, across multiple questions and parameters, in

contrast to the typical single question of whether one is intending to become pregnant at the moment, or the retrospective equivalent of asking if a past pregnancy was intended or not.

Qualitative research using semi-structured interviews has bolstered understandings of holistic pregnancy desires. Arteaga et al. (2018) studied how young people conceptualize planned, unplanned and "in-between" pregnancies, suggesting that pregnancy desires may be best captured by a continuum between planned and unplanned, rather than the traditionally rigid binary structure of intent. In their qualitative research interviews, they found that many participants described being in the in-between stage of "not not trying", during which one would find an unplanned pregnancy acceptable, but one was also not taking explicit, concerted steps to become pregnant. They also reported that pregnancy desires and behaviors were strongly informed by people's past experiences, particularly of unplanned pregnancies or normative behaviors among their peers and social circles. Many women in the "not not trying" group also expressed feeling a lack of control over pregnancy, and more generally, autonomy over their life circumstances and potential pregnancy context. This is yet additional strong evidence for recognition of pregnancy intentions and constructs outside of the rigid healthcare definition of intent, with final suggestions by the researchers that healthcare providers increase flexibility when it comes to assessing and approaching contraceptive counseling and inquiring for more details about pregnancy intentions.

Pregnancy intentions among adolescents are driven by complex, contextual social perspectives. Participants interviewed in a previous study by Offiong et al. (2021) expressed five salient perspectives which informed a range of pregnancy intentions among them: (1) sex is a gendered responsibility, (2) teen pregnancy is cyclical and common, (3) teen pregnancy is not a

completely negative experience, (4) having a child fulfills emotional and relational voids, and (5) pregnancy should happen early, just not too early. Notably, the normalization and even embracing of unintended pregnancy occurring as a teen was seen as a possible protective factor as well as a potential form of stigma management behavior (Geronimus, 2003; Mann et al., 2015). This thesis attempts to contribute to expanding field of research that aims to better capture the full nuances of people's lived experiences with pregnancy intentions and desires, and investigate factors that contribute to pregnancy desires in the life context of publicly insured women in South Carolina, as well as the southern United States more generally.

Medicaid & Marginalization in the US

Medicaid is the largest public health insurance program in the United States, providing millions of low-income people health insurance. Medicaid covers the costs of pregnancy-related care for most uninsured women, as part of a nationwide effort to improve maternal and child health outcomes. In 2020, 42% of all births in the US were covered by Medicaid, and 64.8% of births for Black women (Osterman et al., 2022). However, despite expanded access and financial support for obstetric care, low-income pregnant women still face significant barriers to high quality obstetric care.

Social class or socio-economic status (SES) is often defined by personal markers of wealth, income, education, and family background. However, SES is markedly shaped by political institutions, such as Medicaid, as well as socially pervasive systems of oppression in the US. As such, any analysis of the experiences of low-income birthing people must take into consideration the intersectional nature of gender, race, class, and age, in how the lived experience of SES is constructed and determined. The deeply racialized distribution and experience of social class in

the US is perpetuated by institutional practices, and particular interest has grown in recent years regarding how this contributes to persistent racial health disparities the field of obstetric care.

Allen et al. (2014) outline stigma being described by publicly insured women as a fear of being treated poorly in the healthcare setting, resulting from their public insurance status. Interviews elucidated that these fears often resulted from people's interactions with healthcare providers that felt demeaning, rather than an internalized sense of shame attached to receiving public insurance. Experiencing stigma in this regard was associated with unmet health needs, poorer quality of care, and worsened health outcomes.

Michener (2017) argues that Medicaid beneficiaries are made to feel powerless in the experience of receiving healthcare funded by public insurance. Her qualitative interview data found that Medicaid recipients express being stigmatized within the healthcare system, and frustrations emerging from regional differences in Medicaid expansions and implementation. As a result, they are more likely to disengage from political participation, and shift towards attitudes of fatalism. Additionally, the bureaucracy of enrolling and receiving Medicaid often makes recipients feel that they are unimportant and ineffective, and that they may receive lower quality care, and that such a disparity would be justifiable, given that their health insurance is publicly funded.

Medicaid is undoubtedly an important lifeline for low-income people in the US, improving health outcomes, and providing insurance for pregnant and birthing peoples who otherwise may lack insurance coverage. The way it is administered however, and the attitudes held by healthcare providers, often leads to inferior care, and impacts the way recipients think about their place in society, and their levels of political participation. In this regard, the way Medicaid

recipients experience obstetric care not only directly impacts maternal and child health outcomes, and the (dis)trust multiply marginalized people feel towards healthcare systems, but also further exacerbates disparities in political participation, and the representation of low-income peoples voices in democratic political processes. The concentrations of disadvantage, whether they be economic or health-related, is modulated by intersectional systems of oppression, disproportionately harming economically and racially marginalized Americans.

It has been shown that publicly insured women experience class bias due to their insurance status, and that BIPOC women experience obstetric racism, which takes the form of "critical lapses in diagnosis; being neglectful, dismissive, or disrespectful; causing pain; and engaging in medical abuse through coercion to perform procedures or performing procedures without consent" (Davis, 2019). Furthermore, childbirth in the US is particularly modulated by the process of medicalization, which prioritizes a technocratic, interventionist approach. This often results in negative experiences for birthing peoples, and the infringement of their autonomy, concerns, and desires. Economically and racially marginalized birthing peoples thus experience a disproportionate risk of obstetric violence, birth trauma, and adverse birth complications.

Additional Clarifications

Some researchers use the term "unplanned pregnancy" to refer to a distinct classification from unintended pregnancy – it is used in these cases to refer to a pregnancy that occurs while using contraception, or while not desiring to become pregnant but not using contraception. This notion of "unplanned"-ness is rather ambiguous and incomplete however, and as such, I will use unplanned somewhat interchangeably with unintended pregnancy in this thesis and make clearer distinctions in the range of pregnancies that may occur unexpectedly or in spite of intentions

and/or contraceptive behaviors. Additionally, I wanted to recognize that women are not the only people capable of pregnancy or giving birth. While transgender men and nonbinary people can and do experience pregnancy, I wanted to clarify that all of the participants in this study identified as women, and much of the literature and historical survey data at the national level is limited to population counts of women as presented by the Census Bureau. Thus, while this thesis may at times specifically refer to publicly insured "women" or "mothers", I wanted to express my explicit recognition of the fact that pregnancy, motherhood, parenting, and childbirth all exist independently of gender, and that women are very much not the only people who experience pregnancy. My hope is that the findings of this thesis may be helpful in aiding the autonomy and increasing the sharing of the experiences of all people whose lives are shaped by the intersectional systems of oppression on the basis of race, ethnicity, gender, age, socioeconomic status, ability status, and otherwise.

II. METHODS

The data used for this thesis comes from a study conducted by my thesis director, Emily Mann. Dr. Mann and her research team conducted 30 qualitative interviews between November 2016 and March 2018. I was granted access to the study data in the format of text-based transcripts for the purposes of writing this thesis. The interviews were conducted with publicly insured women, aged 19 to 34, who had given birth in South Carolina within two years of the interview. Participants in the study were recruited from various healthcare clinics, social service agencies, and community-based organizations across the state. The interviews were originally collected for a study exploring participants' experiences with a state-level Medicaid policy that facilitated access to immediate postpartum long-acting reversible contraception (IPLARC)

(Mann et al., 2019). The interviews also solicited participants' perceptions and of quality obstetric care, prenatal care, immediate postpartum care, contraceptive counseling, birth experiences in the hospital, and open-ended responses regarding their overall pregnancy. labor, and delivery experiences.

I gained access to the interview data from the original study in 2021, and first became familiar with it while working as a research assistant under the guidance of Dr. Mann. I was not personally involved during the original collection of the research data, and thus I was not present during any of the interviews or the designing of the original study. There may be text-based data that I over-interpret or am unable to detect the tone of, thereby limiting my data analysis. It is also of importance to fully note my positionality with regard to the data and analysis of this thesis. I am an Asian-American, 22-year-old, cisgender man, pursuing an interdisciplinary undergraduate degree focused on the intersections of public health and social sciences. My previous research work and publications have focused largely on patient-provider relationships, contraceptive care delivery, social determinants of health, and public health applications of qualitative research. I am incapable of pregnancy, and I have had limited personal experiences related to the pregnancy among my immediate family or friends.

The interviews were conducted by my thesis director, who served as principal investigator, a White woman sociologist in her early 40s, and three undergraduate research assistants in their early 20s. Two research assistants were Black women, and the other was a White woman. The interviewers sought to achieve racial concordance during data collection, but a few interviews were conducted with Black participants by White interviewers. All of the interviews were conducted in person, at a location of the participants' choice, and lasted an average of 41 minutes

each. All interviews were audio-recorded and professionally transcribed. Participants selected pseudonyms to preserve their confidentiality and anonymity which are used throughout all data and findings. Each participant received compensation for their time in the form of 30 dollars in cash. The study protocol was screened and approved by the principal investigator's university Institutional Review Board.

For this thesis, I conducted qualitative data analysis, utilizing a grounded theory approach, whereby ideas emerge from the data itself inductively, rather than data being collected to validated hypothesized theories, deductively (Charmaz, 2006; Corbin & Strauss, 1990). I utilized Atlas.ti qualitative data analysis software, and engaged in an interpretive systematic process of coding, and memo-writing. I worked directly from the transcripts of the interview data, and developed codes based on observations I was making with regard to salient themes and experiences of participants' pregnancy intentions. I developed codes through a cyclic process of sampling, saturation, and sorting codes into major themes (Charmaz, 2006). The guiding research questions I used for this thesis were as followed:

1. How do participants articulate their pregnancy intentions?
2. How do participants describe their experiences with unintended pregnancy?
3. How do participants think about the acceptability of pregnancy in various times in their lives?
4. How do participants' views about pregnancy intentions and acceptability compare to public health and medical discourses?

I then consolidated codes into major categories, and while referring to existing codebooks from previous analyses of this dataset, elucidated major recurring themes among the codes, and categorize coded quotes under corresponding categories. Data analysis was focused the ways in which participants described how they thought about their intentions and desires to avoid and/or become pregnant. The findings were continually organized into larger, more coherent thematic categories, and built into the findings (i.e., an integrated results and discussion) section. The narratives of participants were also interpreted following critical and interpretive medical anthropology approaches.

III. FINDINGS

Participant Characteristics

Among the 30 participants in the study, 20 were Black/African American, eight were White, and two were multiracial. Participants' ages ranged between 19 and 34. Eleven participants had one child, eleven participants had two children, and the remainder had three children. Most participants (n=18) were in a committed relationship with a male partner. Nineteen participants had attended some college (n=16) or completed a bachelor's degree (n=3), 9 had a high school diploma, and two had not completed high school. All participants had given birth within two years of the interview. While all participants were publicly insured through Medicaid at the time of their birth, only two-thirds had health insurance at the time of the interview. Half of the participants experienced induced labor. 13 participants had a vaginal birth and seven participants gave birth via cesarean delivery. About one third of the participants experienced at least one pregnancy complication, defined as a health problem with the mother,

the fetus, or both (National Institute of Child Health and Human Development, 2021). Complications included preterm birth, placenta previa, and preeclampsia.

Theme 1: Ambivalent Pregnancy Desires and Behaviors

Participants' preferences for fertility regulation and preventing pregnancy, despite norms in public health that it is either mandatory, or must be an explicitly decided behavior, exists on a continuum of beliefs. Gomez et al. (2019) reported findings in a previous that in "ambivalent" pregnancy intentions may vary widely and may be better characterized with more specific categorizations, especially for young people. Using ambivalence as a blanket term for any intention that does not fit into the strict paradigm of intended or unintended pregnancy often, again, essentializes the complexities of people's actual pregnancy desires. The in-depth qualitative interviews collected by Gomez et al. (2019) found that existing measurements for ambivalent pregnancy intentions overwhelmingly resulted in misclassification. In particular, misclassification was in the form of conflation of current pregnancy desires with past and present feelings, perceived acceptability of an undesired pregnancy, adjusting survey answers to account for partner's desires, as well as failing to account for perceived overall lack of fertility control, and subjugation of pregnancy desires for the sake of self-protection. Current measurements for pregnancy ambivalence often fail to grasp the full range of desires and experiences young people attach to pregnancy intentions, and clinical practice. Thus, ambivalence and "in-between" preferences have been broken into a few sub-categories in the findings of this thesis under this theme, in order to better understand the wide and often overlapping range of attitudes that exist with regard to pregnancy desire and aversion.

<u>Contraceptive Non-Use Despite Wanting to Avoid Pregnancy</u>

Marie, a White 22-year-old mother of one, in the process of getting divorced from the father of her children, responds to a question about LARC by stating that she is not interested. She then states that she has never been on any form of birth control. In this quote, she explains turning down the offer of immediate postpartum placement of an IUD because she wants another child eventually. The implication is that she does not want to opt into sterilization, and might view the longevity of IUDs as having a permanency like that of sterilization. Marie's concerns about difficulties with returning fertility after IUD removal are also reflected in her response to being asked if she would consider an IUD if it were covered by insurance: "Probably not. It took a while to even get pregnant with my daughter. It was months. We actually tried for her. I ended up finding out I was pregnant with her three months after I got married."

> [An IUD is] just something I'm not really wanting, I guess. I do eventually want another child. I've never had a problem since then. I've been with other people of course, other than my [ex] husband, but I've just never had an issue with any scares or anything like that. I feel like if I would have had a scare here or there with another person or something, then yeah, because I didn't want that to happen with that person if I'm not serious with them. I've never really had an issue, so I don't think that I need it, I guess. I wouldn't say need it, but I don't feel like it's an issue, getting pregnant, as of right now.

Marie states that she has not become pregnant with anyone other than her ex-husband, despite having unprotected sex with multiple partners since then. As a result, she feels like unintended pregnancy is not of concern to her, because of beliefs she has developed about her fertility, i.e. her inability to get pregnant by accident. She even mentions that if she had had a pregnancy scare with any one of her recent partners that she was not in a serious relationship

with, such a pregnancy would not only have been unintended, but also perhaps undesired. But because she has never had this be an issue before, she states that she does not feel like it is a concern to her at the moment, and thus she does not use any form of contraception. This experientially guided attitude of "it has not happened to me yet" when it comes to unintended pregnancy is well documented among women in the US as a common form of non-specific pregnancy intention and is grounded in misguided/magical thoughts about one's fertility. Marie believes that because she has not had any unintended pregnancies in the past, she will continue to be immune to unintended pregnancies in the future, despite not taking any contraceptive steps to prevent them. Marie has most likely experienced a form of sampling bias, in that she has not become pregnant thus far, however, she conflates this to believing that her body's potential infertility is a protective factor from unintended pregnancy.

Nonetheless, when thinking about the future, she plans to opt for sterilization after having the one more child she desires. There is no definite timeline or plan for this future pregnancy, but she knows that she would like it to be somewhat soon, so that her children are close in age. To summarize her pregnancy intentions, she plans to have one more pregnancy, without a specific timeline on that plan. Thus, if she were to have an unintended pregnancy soon, she may not consider it mistimed, and likely would not consider it unplanned. She also mentions the desire to have all of her children before she is "too old", so that she can still live a young, independent life after her children turn 18 and ostensibly become independent from her. She states that her first pregnancy was very much thought out and planned for, particularly in terms of timing. Despite the fact she may not have specific pregnancy intentions in conventional ways, she makes it clear that a lot of thought is being put into planning and preferences for the number (specifically one more), timing (soon), and context (stable relationship) of her pregnancies.

Pregnancies Later Than Desired and/or Expected

Several participants described their reaction to an unexpected pregnancy as initially incredulous, often questioning how they became pregnant. This was especially true among participants who were actively utilizing a form of birth control, or otherwise had had multiple unsuccessful attempts at becoming pregnant and had started to believe in suspicions about their own infertility.

Tammy describes her pregnancy as expected in this way, in that is was literally difficult to accept as truthful. After a year of trying to become pregnant multiple times, she was happily shocked to discover that she was pregnant, and in order to reaffirm her doubts, repeats the pregnancy tests 10 times. This behavior may be interpreted as a protective measure to ensure that her celebration is not premature, and avoiding the grief and disappointment of false hope, that perhaps she had already experienced more than once.

> I was expecting [my most recent pregnancy]. I was obsessed with trying to get pregnant. When I did got pregnant, I took about 10 of the tests. I was like, this can't be right. I've been doing this for a year…This can't be right. This can't be right. After the 10 I was like, I'm not spending no more than this. I'm pregnant. [I felt] happy. Shocked because I thought I couldn't get pregnant. [It had] been a year.

As put by another participant, Marie, “you’re wanting it to happen, but when it actually does it's still a shock because it's a life changing moment.” Savannah also expresses a similar experience of disbelief upon realizing she was pregnant. Of note is how she makes a distinction

between the fact that her pregnancy/child was not a mistake (i.e. connotations of regret), but was indeed unexpected, because she had stopped after a period of trying to get pregnant:

> [The baby] was kind of meant to be here, because we were trying after I had a miscarriage. But then it's like when we were trying it just never worked, so were just like, uh, bump it and stopped. Then like a month later I was like, "Oh, wow, I'm pregnant,". He was kind of not a mistake, but he was a surprise, let's put it like that. Because we tried, but then we stopped. Then we're like, "It'll happen when it happens." Then it happened.

Conflicting Pregnancy Desires -- Timing vs. Wantedness

Preferences for pregnancy may be loosely defined with regard to timing and context. Pregnancy desires however encompass more than just an evaluation of intention in the form of wanted-ness and/or timing acceptability; pregnancies may satisfy both, neither, or one and not the other. As such, participants clearly described how their desires were a more subtle feeling of openness to the possibility of a pregnancy. Subsequent behavioral change take the form of ceasing or less consistent use of contraception, rather than a deliberate process and timeline to become pregnant.

Amani, a White 23-year-old mother of one, stated that her pregnancy “wasn't planned, but it wasn't so much of a surprise either. My husband and I, we didn't want to get pregnant right away. We thought some time this year we'll probably get pregnant. We weren't totally surprised, but we weren't planning it either, so yeah.” This idea of a pregnancy that is loosely planned in terms of life context/timing, and one that is not particularly surprising despite not being explicitly planned characterizes ambivalent fate-driven pregnancy intentions. Amani expands

upon this, with parallels to the majority of the participants in this study, describing her intentions to become pregnant again in the future, but without specific plans for the timing yet. She states, “My husband and I, we would like to have maybe one more child in the future. We're just not sure yet or the timing.”

Tiffany echoes these ambivalent pregnancy intentions in her interview. She describes a pregnancy that was unexpected, and recounts having to figure out why she was feeling unwell. However, in response to being asked if this pregnancy was a surprise, she states “not really.” She simply went to the hospital to investigate why she felt ill, and describes how she found out that she was pregnant:

> Not really. I been feeling sick. I been feeling sick and I didn't know what was going on until I been sleeping a lot, been nauseated, dizzy, all that so I went to the hospital. Somebody told me to go to the hospital. I was at my house, so I was like "something ain't right." I was not even a week yet and they said, they couldn't even see the bag yet. They tell me I was pregnant. I went to Baptist and they told me what it was. I was pregnant.

And yet, despite the fact that she seems to not have expected or intended to become pregnant at this exact time, she was not particularly surprised that she was pregnant, either. Her ambivalent pregnancy intentions ultimately gave way to positive feelings and the desire to spread the good news that she was pregnant. Her pregnancy intentions are yet another example of how in reality, pregnancy intentions are complicated, layered, and do not fit neatly into the binary public health paradigm of intended and unintended pregnancy.

Theme 2: “I didn’t know what I was going to do”: Uncertainty & Parenting Pressure

Feeling Unprepared for Parenthood

In some cases, participants' initial shock about an unexpected pregnancy was followed by overwhelming anxiety. These pregnancies are perhaps some of the ones that may be more accurately described as unintended, unprepared for, and in some cases, unwanted. The fears participants described often revolved around not knowing how to take care of a child, particularly given some participants' own young age, and fears of not being able to provide for and protect a child. The feelings described by participants were distinct from the simplicity of an "unwanted" label, in that many concerns revolved around providing for and preparing for a potential baby (i.e., parenting quality and knowledge). The overwhelming nature of anxiety upon discovering an unintended pregnancy was also described by some participants as stemming from the fact that any and all options would be filled with grief and pain — whether it be abortion, adoption, miscarriage, or being responsible for a child.

For example, Alissa describes her first pregnancy as being "a very big surprise." When she found out she was pregnant she states that she was "excited but I was really scared because I was only nineteen whenever I got pregnant. I was scared. I didn't know what I was going to do. My period wasn't late or anything, but I had a feeling. I took a pregnancy test. I ended up taking six pregnancy tests. They were all positive."

Nonetheless, multiple participants in a position similar to Alissa went on to express that they were excited, but that the experience was overall characterized by a feeling of dread. It is of note to recognize, however, that Alissa, and other mothers in her situation, may underreport negative emotions they felt about their pregnancy, given that they carried them to term, and have since given birth to a child. Exploration of social desirability bias, stigma management work,

and resulting potential error is further discussed in the Conclusion and Limitations section(s) of this thesis.

Not Wanting to "Make Mistakes" as a Parent

Amani talks about the joys of, and pressure to, provide an enriching, supportive upbringing. This highlights a common theme among participants, as they describe the deeply fulfilling sense of responsibility for a child's life as a mother, as well as feeling like their own parenting is informed by trying to rectify the shortcomings of their own parenting they received as as child.

> It's just the blessing of raising your on child, how you feel he should be raised and with hopefully, the life experiences that you want him to have. I mean, it's scary at the same time. It's daunting because you don't want to royally mess up their lives, but at the same time, you do have your own experience from growing up. My husband had his own experiences and from his parents and we have learned from that, so we feel like we can avoid some of the mistakes that our parents have made, but still make our own, so yeah.

Amani recognizes that all parents inevitably make mistakes, including her own parents, and herself. The pressure to be the best parent possible is made clear in Amani's description of the challenges of being a parent, as she and her husband must face the difficult compromise between time spent procuring financial security, and time spent actively present in their child's upbringing. Without comprehensive parental leave in the US, and more generally, a lack of comprehensive social welfare programs to accommodate for childcare, Amani describes the emotionally fraught stress of "work-life balance" familiar to many American parents.

I've applying for just different jobs, my husband and I both and we know that we have to financially provide for our family. I guess the hardest thing is deciding how much time to devote to work and providing for the future versus just take the time right now and don't miss out on his life. That's what we're trying to decide with jobs. We don't want to send him to day care. We want to raise him ourselves, but then our work schedules have to work out and that's tricky, so just work-life balance, I guess.

Theme 3: "A Blessing in Disguise": Retrospective Stigma Management

"A Blessing in Disguise"

After the initial shock of discovering that they had unintentionally become pregnant, many participants described their pregnancy as a "blessing in disguise." Regardless of the fact that the participants' pregnancies were often unexpected, and many of the participants felt unprepared to be mothers at the time, they overwhelmingly described how the overall experience of having a child ended up being beneficial to them. Nonetheless, the notion that the benefits were "in disguise" alludes to the fact that their unintended pregnancies were expected to be a source of negative impacts on their life, at least upon first discovery.

Interviewer: Right now, are you currently pregnant or are you trying to get pregnant?

Liz: Hell no. No. Wait, can I say "hell no"? But hell no. The one I have is a blessing in disguise, so I'm good with her until life allows me to become a mother again. I'm not really looking to having any more kids. But if it happens, I'm not opposed to it. I wouldn't say [I never want to have kids again] because you never know what could happen. But as far as me planning to have anymore, Carson is a blessing in disguise in so many ways, and

> everything about her is just so easy. If I happen to get pregnant and find someone to marry and have kids with, then by all means, I'm not opposed to it. But as far as right now, my answer's no.

Despite an absolute ruling out of intending to become pregnant at the moment, Liz issues a caveat about her pregnancy intentions in that they are limited to her current socioeconomic, marital, and life context, but that circumstances may change in the future. In particular, she highlights that if she were to become married in the future, she would then want to have more children.

There are commonalities with Liz's reactions to an unexpected pregnancy with the experience of another participant, Mary, who was taking oral contraceptive pills (OCPs) at the time fairly consistency said similarly that an unexpected pregnancy helped her reaffirm her priorities and served as a beneficial "reality check" to organize her life.:

> Yes. I was not planning on having any children until we got to a better space. Then pop there's another baby. Then I was in school so I was like, "Okay, I want to finish school completely before I do that again." It didn't stop me. Well I started back after she was two. I started in January this year…I guess my last baby was a reality check. This is number three, what you gonna do?

Despite her shock that her use of OCPs and emergency contraception did not prevent pregnancy, she accepted the pregnancy citing that "it happened for a reason." Despite having previously had an abortion, she did not view abortion as an option for this pregnancy and alluded to faith and fate-based narratives about pregnancy, as well as retrospectively feeling like the

baby was overall beneficial to her life. One might predict however that people who have carried a pregnancy to term and gave birth to a child would downplay or perhaps conceal any consideration they gave to an abortion during that pregnancy, given the tangibility of their child and their love for that child. Nonetheless, when asked if she considered any other options other than birth for this child, she stated:

> No, I decided after that, the first fluke that I wasn't ever going to do that again. I was like, "It happened, and it happened for a reason." Basically, she was a lifesaver and a reality check. I would not trade her for the world. I'm glad I did.

Mary also describes that upon finding out she was pregnant most recently, that her initial shock was quickly replaced by an urgent sense of determination, clarity, and drive for attaining self-sufficiency:

> I was really shocked. I was like, "Okay, how am I still having my cycle and now I'm still pregnant?"…I was like, "There's no way, something's not right." Then I was like, "Okay, now it's time to get things in order because you're not just going to have two children, now you have three." It actually made me go into hustle mode, like let's get this done. Let's get everything you need to get done. Focus on yourself, getting yourself better so you don't have to depend on anybody. That's how I was at that point.

In a concluding remark, Savannah puts out a proverbial reminder that babies are expensive, as a reminder to utilize contraception. While they may also be blessings in her view, she caveats that perhaps a bigger blessing for oneself, is ensuring access to contraception.

> I don't know. Birth control is very important, especially if you don't have a full-time job because babies are very expensive, but they're blessings. If you aren't on any kind of birth control, I would recommend just researching it to get on something besides just condoms because they don't always work.

This notion of an "expensive blessing" by Savannah echoes findings presented by Aiken et al. (2015), that characterized unintended pregnancy as "A blessing I can't afford". Aiken et al. attempt to resolve the paradoxical measurement and interpretation of unintended pregnancy being reported as a happy event, despite the presence of incongruent intentions and feelings. Women were noted to frequently profess happiness within the set of qualitative interviews in the study. Women were selected for interview on the basis of wanting no more children and consistently professing either happiness (n = 17) or unhappiness (n = 10) at the prospect of pregnancy. The qualitative findings demonstrated that many participants express happiness at the idea of pregnancy while simultaneously earnestly trying to prevent conception. Satisfactory affect was associated with the idea that unintended pregnancy is almost always characterized by deep, heartfelt feelings which prioritize the child over practical considerations, and minimizing the stress that the child could cause. For women celebrating, unintended pregnancy was too rationalized by fate and faith-based narratives in this study. However, there was a major exception to the sincerity of mothers' professions of happiness in this study, and perhaps in our own study, in that happiness was sometimes conveyed as a result of social pressure, despite truly negative feelings. Simultaneously, the authors also it of note to further investigate consider the potential ways in which reacting to unintended pregnancy with happiness may serve as a protective factor for maternal and child health outcomes, compared to those met with unhappiness.

Regardless of the fact that the participants' pregnancies were often unexpected, and many of the participants felt unprepared to be mothers at the time, they overwhelmingly described how the overall experience of having a child ended up being beneficial to them, rather than a setback. However, this must be taken with a grain of salt in that it could and very likely is a form of internalized stigma management, and perhaps is masking negative feelings that feel like they cannot be freely expressed during the interview.

A Source of Self Efficacy & Motivation for Perceived Self-Improvement

Despite stigmatized notions among many public health academics, unintended pregnancy as a young woman may serve in a protective role, allowing the pregnant person to re-center their priorities, and center the baby rather than themselves. It has the potential to be a selfless experience, whereby struggles may be overcome, out of a sense of responsibility and duty to protect a better future for the child and to be able to serve as role models. Rather than serving as an additional burden for multiply marginalized women, many participants described how unintended pregnancy allowed for the redistribution of priorities and focus, and a clear, unwavering extrinsic source of motivation for self-improvement. For example, Kalynn recalled the follow experience,

> I still went out and drank. I never had a substance abuse problem after that but I still went out and I drank and smoked, and did everything under the sun until I got pregnant. As soon as I got pregnant with my oldest that was it. That was done because it wasn't about me anymore and I wasn't going to be the mom that I grew up with. That was a cut for me. I think I got pregnant when I was 20, my first. Yeah. That was it, I was done. How am I going to tell them you're going to choose wrongly if this is what your mom was doing the

> whole time you were growing up? So I just quit. Treatment got me to realize how to handle having a self abuse problem and where you can turn to when you feel certain ways and not to mix that with alcohol, and not to mix that with anything else because they're depressants and they make it 10 times worse. It was not until I got pregnant with my first that any of it hit me as to what I was doing.

Mary, too, mentions how her pregnancy spurred newfound motivation within herself to "get things in order". This drive to become self-sufficient turned out to be a protective factor, given that she and the baby's father separated, and she lost him as a source of support.

> Okay, now it's time to get things in order because you're now going to have two children, now you have three. It actually made me go into hustle mode, like let's get this done. Let's get everything you need to get done. Focus on yourself, getting yourself better so you don't have to depend on anybody. That's how I was at that point. I'm glad I did that because of course me and her dad's not together but yeah.

Theme 4: Pregnancy Resolution & Concerns in Family Context

It is important to recognize the role of social and family norms in shaping perceptions of pregnancy acceptability, as well as evaluations of various methods for resolving unintended pregnancy (i.e. birth, adoption, or abortion).

<u>Family Disapproval of Abortions</u>

Marie, like many of the participants, states that she follows the beliefs held by her family regarding abortion – that it is not an option. She indicates a fairly strong sense of family support

present in her life, mentioning that in response to her brother's girlfriend becoming pregnant unintentionally at a young age, her grandmother reassured her fears with the fact that the family was there to support them. Marie furthermore refers to the fact that unintended pregnancies are caused by making "that choice" (i.e. having unintended/premarital sex), and that one must carry the pregnancy to term, as an unavoidable, and perhaps even self-caused, consequence of making said choice.

> My [whole] family don't believe in abortions. If you're pregnant, you're having it. When my brother's girlfriend was pregnant, my grandmother said, "Yes, you all are young but you have family here to support you." That's how our family is. We don't believe in abortions, so if [you get pregnant] you made that choice, you're going to take care of it.

Marie states her and her family's opinions on abortion, stating that these "rules" outlined that disallow abortion, have exceptions for certain extenuating contexts (explicitly mentioning rape). Of interest is how Marie justifies this belief that abortion is not acceptable, by stating that the consequence of conceiving a child by "doing it" (unintended pregnancy as a consequence of making "the choice to conceive, i.e., having unprotected intercourse") is that you must carry the pregnancy to term and care for it, as to not infringe upon the baby's involuntary role in conception and personal right to life and freedom from suffering. She outlines this reasoning, as her own assumed reasons for why her family is against obtaining abortions for unintended pregnancies, given that her family has never explicitly talked about why they hold this belief. She also goes into detail that her stance, which she also refers to as her family's stance, on abortion as unacceptable, applies regardless of whether or not one is in or stays in a stable and/or co-parenting relationship with the child's biological parent. This is notable, as she stated that she

would not consider abortion in the case of an unintended pregnancy, and would prefer her next pregnancy, which she anticipates will be her final one, to occur in the context of a stable relationship. She does not mention adhering to abstinence or utilizing contraception as a method for avoiding pregnancy.

> "My [whole] family don't believe in abortions. If you're pregnant, you're having it. When my brother's girlfriend was pregnant, my grandmother said, "Yes, you all are young but you have family here to support you." That's how our family is. We don't believe in abortions, **so if it happens then you made that choice, you're going to take care of it.**" – Marie. She also does not utilize any contraception to prevent unintended pregnancy, perhaps reflecting more radically polarized views about fertility, and perhaps the religious "sanctity" of conception

Family Pressures to Have an Abortion

Liz describes how she had originally planned to have an abortion, but felt that she would be unable to cope with the emotional ramifications of having an abortion while simultaneously working through (unspecified) traumatic childhood events. Initially, she then describes how she had originally planned to have an abortion, but felt that she would be unable to cope with the emotional ramifications of having an abortion while simultaneously working through (unspecified) traumatic childhood events. She eventually describes having the baby as helping her work through her issues, and as a source of agency, to provide a better childhood for her child than she experienced herself:

> I was already stressed about other things, and I was working through the emotional issues of my childhood, so my body's like stressed and I didn't really pay attention to the symptoms because I was just stressed about everything else. When I found out [I was pregnant], I was just overwhelmed because I didn't know how to take it. At first, I was for an abortion, but then I was just I couldn't deal with all that and what I was dealing with at once, so I just said I'd keep her and it helped me work through my issues because I didn't want to bring her into what I grew up in. [People around me] wanted me to get an abortion. A lot of people wanted me to have an abortion, but I couldn't do it. I had an appointment and all that scheduled a few days later, and I was just like, "I can't do it". She's here.

Liz makes further reference to the nature of unhealed intergenerational trauma, stating that her mother "still had issues that she needed to work through from her childhood." She reasons that this is why her mother pressured her so strongly to have an abortion, and was fiercely unsupportive of her choice to carry the pregnancy to term, given that she was a young mother, and "didn't want [Liz] to struggle because she was a single mom [too]".

Having reconnected with her mother and feeling gratitude for the love shown to her daughter by her mother, Liz reflects that "A lot of it was her trying to look out for my best interests. A lot of it was her, taking her issues and putting them on me. It was a lot. It was a lot. It's hard." Liz captures the profound emotional toll an unintended pregnancy can have on a young adult, and the damage it can inflict upon relationships within a family. At the time, perhaps Liz's mother was dismayed to see Liz perpetuating the cycle of unintended pregnancy at a young age, echoing a fear heard from many mothers in the study, that their children would one day experience the same trauma and struggles in life as their mothers.

Savannah echoes these themes in her interview, stating that despite being financially independent and done with school, her first big concern about being pregnant was the disapproval of her father. Although she then recognizes that her fear was probably distorted compared to the reality of his reaction, she nonetheless reminds us that unintended pregnancy occurs within the context of family relationships, and that ultimately the most acceptability, emotional impact, and coping methods for unintended pregnancy must be considered within the social context. Her primary concern was not caring for her child (this was actually an area of confident self-efficacy), but instead, the social reactions to her unintended pregnancy — as shaped by stigma. Recognizing the morally relativistic nature of how people react to an unintended pregnancy is an important foundation of person-centered care and counseling by providers in this field. Savannah elaborates,

> When I found out the first time that I was pregnant, I mean, I was out of school and everything. I pay all my own bills, but still in my soul and spirit I was like, oh my god, my daddy is going to kill me. After I got over the whole daddy thing, I was excited because I've always liked kids or whatever. I'm a very independent person, so I wasn't worried about being able to take care of him.

IV: CONCLUSION

Pregnancy intentions are much more diverse than a simple binary classification between intended and unintended. Pregnancy desire includes both affective and cognitive aspects, and desire and mistiming factor strongly into pregnancy acceptability and resolutions of unintended pregnancies (Sanitelli, 2009). While the timing and wanted-ness of a pregnancy and/or baby are

key factors in determining pregnancy intendedness, they do not encompass the entirety of one's intentions and desires.

Qualitative analyses in this thesis gave profound insight into the complex and often conflicting ways participants thought about their intentions and desires to become pregnant at various times in their life. Some of the participants indicated ambivalent or otherwise neutral pregnancy intentions, whereby contraceptive behaviors may not have always aligned with intentions, and intentions themselves were often not concrete at all. The other major theme that arose among participants was the experience of anxiety brought on by fear of being unable or unqualified to provide care for a baby – a key factor of pregnancy acceptability and reaction which is evaluated after a pregnancy occurs.

Nonetheless, given the nature of the data, in that participant's pregnancy intentions were solicited retrospectively with regard to previous pregnancies, it is of key importance to recognize the positive framing and stigma management likely being done by the participants. Given the pervasive stigma in the US that pregnant people face when the pregnancy occurs outside the ideals of a rich, white, married woman becoming pregnant, many of the women vehemently touted the joyous nature of their unintended pregnancies, even when it was in direct contrast with recounted experiences of provider mismanagement, or other negative experiences or affect. It is important to recognize that there is the potential for unintended pregnancies to serve in a protective capacity for some women, bolstering motivation and stimulating critical self-reflection. Overall however, participants' statements must be considered in context, and given that all of the women recounted pregnancies that they had carried to term and had resulted in their currently living children, it would be difficult to imagine any participant overly

emphasizing the negative experiences of their unintended pregnancy. Among the negative experiences recounted however, it is notable that all women except for one in the study did not disclose ever receiving or even considering an abortion for more than a brief moment. This is somewhat expected given the heavily stigmatized nature of abortion as a resolution to unintended pregnancy in the conservative atmosphere of the U.S. South, and the already hostile environment towards abortion and even contraception as early as the mid 2010s at the time of this interview.

While unintended pregnancies do carry certain elevated risks of adverse health outcomes for some populations, the undue stigma associated with unintended pregnancies is deeply detrimental to people's birth experiences and autonomy over their pregnancy. As recounted, the greatest modulator for young people's wealth is not their childbearing behavior, but the structural contexts of advantage and oppression in which they are born into. Socioeconomic privilege once again trumps all when it comes to disparities, even when it comes to the distribution of the most basic of maternal and child health outcomes.

Of particular note is Theme 4, which focuses on the ways in which family context shape attitudes and decisions related to unintended pregnancy resolution. While the interviews were conducted a few years ago, the data in this section remain highly relevant, if not even more so relevant to this day. Given the hostile policy changes towards abortion in much of the United States recently, this data becomes even more valuable, as it was conducted with the people most vulnerable to limited abortion access. At present in South Carolina (in August 2022), there is statewide ban on abortions after 6 weeks' gestation and the state legislature is currently considering enacting a total abortion ban. Thus, publicly insured women in South Carolina now

have very few accessible options for the management and resolution of an unintended pregnancy except to carry the pregnancy to term. As such, Medicaid is an integral program, particularly in South Carolina, providing critical health insurance coverage to the pregnant women and their prospective children at their most vulnerable.

What is most clear is that definitionally, pregnancy desires are best clarified and solicited from each individual person, in their own terms. While classification categories may be helpful, the true nature of grounded theory qualitative research is that constructs are informed by the data. Unintended pregnancy in its ubiquitous dichotomous definition revolves around the rigid criteria of the pregnancy happening too soon, and/or happening when unwanted. The findings of this study show in depth how pregnancy desires encompass cultural, social norms, economic inequalities. True person center care arises from the ultimate respect of each and every patients' self-directed care.

Family and social contexts also informed opinions about pregnancy acceptability, and decision making surrounding contraception and reproductive healthcare. Parenting often served as an opportunity for birthing people to engage in self-improvement and bolster motivations to become self-sufficient and reflect on life-course accumulation of trauma and future goals. Given the stress and fears new parents feel with regard to making mistakes or otherwise failing to support and protect the lives of their young children, it is critical that they feel supported in this process. Pregnant people must be supported in building agency, self-efficacy, and feeling like they can turn to healthcare providers with concerns, questions, and as a source of reassurance and knowledge. This process supports the best with outcomes for marginalized birthing peoples, and bolsters medical trust, and faith in institutions which serve the needs of low-income women.

Particularly when it comes to birthing people whose obstetric care is covered by Medicaid (who are disproportionately economically and racially marginalized), healthcare providers should reflect upon their implicit biases, and reflect on the negative associations they may attach to unintended pregnancies, and the health literacy, autonomy, and centrality of their patients (Mann, Chen, & Johnson, 2022). It is important to prioritize tenets of person-centered care in all elements of healthcare delivery to low-income people, but particularly when it comes to matters of fertility and pregnancy, person-centered care is integral to preserving the rights of patients when it comes to reproductive and birthing experiences.

In the shift from pregnancy intentions to a fuller view of pregnancy desires, it is important to recognize that intentions are heavily shaped by experiential knowledge and insight derived from social sharing – far more so than formal education (or the lack of formal sex education from school). In addition, it could be beneficial for healthcare workers to seek out approaches to trauma-informed care when possible, which enhance the quality of care pregnancy people receive. None of these factors, or these disparities, exist in a vacuum from structural determinants and systems of intersectional oppression.

While the results may interest healthcare providers, and a general audience capable of pregnancy quite clearly, there is also an important note of reflection for citizen-readers. As we move forward into 2022 with ever higher tensions surrounding abortion and access to reproductive autonomy, it is critical that we hear the stories of people who have experienced serious hardships accessing these services. One may also hope that these stories are able to garner compassion, whether it be from a casual reader or legislator. Contraceptive counseling, access to abortion, and pushback against stigmatization of unintended pregnancy are all key

contributors to revitalizing the climate of reproductive justice in South Carolina. Nonetheless, this data set providers rich insight and countless more analyses to be conducted to explore the pregnancy and birth experiences of this set of publicly insured women in SC.

I encourage readers to think about the way they judge pregnant people, and/or feel compelled to police pregnant women's' behaviors in public. The essentialization of women's bodies as reproductive vessels is detrimental to our progress in the world, and without critical reflection and a concerted effort to recognize your own implicit biases, you will continue to have them in all fields you interact with. Given the new landscape of a post *Roe v. Wade* U.S., it becomes more important than ever for us all to have more compassion and understanding of where people's beliefs, intentions, desires, and behaviors come from, even if they don't always make perfect sense with each other. Stigma surrounding who should be pregnant at what time in their lives is not a necessary function of our public health system – instead it is a greater stigma built into our society with regard women's sexuality and gender ideology, and growing gender equity and expanded gender roles.

Policymakers and public health practitioners in the United States frequently describe unintended pregnancy as a social problem in need of prevention (Mann & Grzanka, 2018). However, the risks of inaccurate and misguided measures of unintended pregnancy have additional implications in the structure and amount of support social welfare programs receive, as well as exacerbating stigma and social judgments of contextual pregnancy acceptability. The aggressive vilification of unintended pregnancy can be left behind, and its place, we can focus on affective, affective, cognitive, cultural and contextual dimensions, whereby aid and care is centered on the person in need of care, and the needs and desires they express, rather than the

needs assumed. Conceptual and methodological critiques of unintended pregnancy as a "gold-standard" measure continue to grow in popularity, and the hope is that thesis may contribute to that discussion.

Limitations & Extensions

Limitations of this thesis include the fact that the data are derived from a study conducted a few years ago that focused primarily on issues related to contraception. While policy changes with regard to Medicaid and abortion have changed since the interviews, the data remains a rich source of insight into how people who are affected most by these policy changes, and who are most vulnerable to adverse health outcomes as a result, recount both positive and negative experiences of pregnancy and childbirth. Nonetheless, approaching this dataset several years after it was collected, particularly in the form of text transcripts, may have placed some of the analysis at risk of misinterpretation or otherwise confusion with details or tonal implications of the interviews. Additionally, given that the original study was primarily focused on the implementation of a Medicaid policy in SC that fostered access to IPLARC, the pieces of data extracted that were relevant to pregnancy intentions and desires for this thesis only represented a minority of the overall datasets and responses within the interviews. Additionally, the sample of participants was primarily recruited through community organizations serving low-income mothers with young children, and as a result, all of the participants had children at the time of the interview. Thus, this thesis and dataset may fail to cover the experiences of women who experienced unintended pregnancy and may have opted for abortion or adoption. Additionally, there are some concerns to be had about the social desirability bias of the participant's responses, as the knowledge and power differential with the researchers interviewing them may have

pressured them into recounting positive impressions with the healthcare system. While this could be traced to the simplicity of the power imbalance, it could also be linked to stigma management, in that participants did not want to seem ungrateful for welfare supports they had received, or otherwise, managing the stigma of unintended pregnancy in and of itself. Thus, participants may have also downplayed negative emotions of feelings of regret related to their unintended pregnancies, given that they had mostly carried those pregnancies to term, and had given birth to a child as a result.

Possible extensions to the research here could involve conducting new interviews with publicly insured women to explore their how their pregnancy desires are being (re)shaped by recent abortion restrictions in the South Carolina and around many other states in the U.S. Additionally, it may be worth re-evaluating contraceptive access attitudes, and perhaps overall anxieties and fears of pregnancy-capable people, when it comes to options for resolution with it comes to unintended pregnancy. Other areas of continued research could look at how attitudes towards LARC are shifting, and particularly what factors contribute to LARC hesitancy or fears, in order to bolster its uptake among women vulnerable to unintended pregnancy. Additionally, this thesis is yet another testament to the power and value of qualitative research, in how it uncovers the full scope of desires, feelings, and beliefs that underly and lead to eventual health behaviors. Additional areas of interest to continue the work in this field could be to look at prevalence rates and intervention methods for intimate partner reproductive coercion, as well as correlations with parenting experiences, adverse childhood experiences (ACEs), and other sources of trauma which inform intentions and desires for pregnancy and parenting. Finally, another area of potential investigation could be to link religious understandings of fatalism and

faith-based values with unintended pregnancy discourses, and evaluations of acceptability for methods of unintended pregnancy resolution.

In sum, in order to improve pregnancy and birth outcomes, and better deliver person-centered reproductive health care to multiply-marginalized women, it is essential to examine their lived experiences with in-depth, semi-structured, individual interviews (e.g., Arteaga et al., 2019; Borrero et al., 2015; Logan et al., 2021; Mann et al., 2019; Morris et al., 2021). It is essential in attempting to improve care delivery and patient satisfaction and autonomy to investigate the ways in which women who receive Medicaid outline, evaluate, and reflect on their pregnancy intentions and prenatal care and birthing experiences. In understanding how pregnancy capable and birthing people define (dis)satisfaction in the gynecological and obstetric care they have received, providers can best support the tenets of reproductive justice (Ross & Solinger, 2017), which aims to empower pregnancy capable people to make informed, supported decisions about if, when, and under what circumstances they become pregnant.

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