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Racial Differences in Pregnancy Intention, Reproductive Coercion, and Partner Violence among Family Planning Clients: A Qualitative Exploration

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Abstract

Background: Unintended pregnancy (UIP) is a persistent public health concern in the United States disproportionately experienced by racial/ethnic minorities and women of low socioeconomic status. UIP often occurs with experiences of reproductive coercion (RC) and intimate partner violence (IPV). The purpose of the study was to qualitatively describe and compare contexts for UIP risk between low-income Black and White women with histories of IPV/RC.

Study Design: Semistructured interviews were conducted with low-income Black and White women with histories of IPV or RC, ages 18 to 29 years, recruited from family planning clinics in Pittsburgh, Pennsylvania.

Results: Interviews with 10 non-Hispanic Black women and 34 non-Hispanic White women (N = 44) were included in the analysis. Differences between White and Black women emerged regarding IPV/RC experiences, gender roles in intimate relationships, and trauma histories, including childhood adversity. Fatal threats and IPV related to childbearing were most influential among White women. Among Black women, pregnancy was greatly influenced by RC related to

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impending incarceration, subfertility, and condom nonuse, and decisions about contraception were often dependent on the male. Sexual abuse, including childhood sexual assault, in the context of sexual/reproductive health was more prominent among White women. Childhood experiences of neglect impacted pregnancy intention and love-seeking behaviors among Black women.

Conclusions: Racial differences exist in experiences of IPV/RC with regard to UIP even among women with similar economic resources and health care access. These findings provide much-needed context to the persistent racial/ethnic disparities in UIP and illustrate influences beyond differential access to care and socioeconomic status.

Unintended pregnancy (UIP) rates have recently declined, but racial/ethnic differences persist (Finer & Zolna, 2016). In 2011, 64% of pregnancies among non-Hispanic Black women and 50% among Hispanic women were unintended—a greater proportion than the 45% national UIP incidence (Finer & Zolna, 2016). In addition to UIP-related health adversities that mothers and their children experience (maternal anxiety and depression, poor child development; Finer & Zolna, 2016; Gipson, Koenig, & Hindin, 2008; U.S. Department of Health and Human Services, 2013), UIP can be an indicator of unhealthy intimate relationships (Miller et al., 2010).

Racial/ethnic differences in UIP are intertwined with complex sociostructural risk factors that span all levels of the ecological model (Figure 1). In considering racial/ethnic differences in UIP risk among Black and White women, associated risk factors include young age at sexual debut among Black women, often compounded by nonuse of contraception (Grady et al., 2015; Kendall et al., 2005); contraceptive preferences that are less effective and male controlled (i.e., male condom; Jackson, Karasek, Dehlendorf, & Greene Foster, 2016); and misperceived subfertility (i.e., perception that one cannot get pregnant; Borrero et al., 2015). Further, among Black women, gaps in educational achievement (Musu-Gillette et al., 2016), low sex ratios resulting in competing partnerships (Adimora et al., 2013), and disproportionate male incarceration (Lynch, 2012) are additional factors associated with UIP risk. Nikolajski, Steinberg, Ibrahim, and Borrero (2015) explored racial/ethnic differences in reproductive coercion (RC) experiences, where partners actively try to impregnate their partner against their wishes, interfere with contraceptive use, and manipulate condoms. They found that Black women attributed men's pregnancy intentions and behaviors (specifically in the context of RC) to fear of impending incarceration and/or street-related death (Nikolajski et al., 2015). RC is a specific form of violence within an intimate relationship that is focused on reproductive outcomes. RC and intimate partner violence (IPV—e.g., physical, psychological, sexual, or economic abuse within an intimate relationship) can cooccur or exist as separate forms of violence. Further explication of how such partner behaviors (including RC and IPV) influence women's risk for UIP and how these experiences may vary by race/ethnicity are needed.

Racial/ethnic differences in UIP and correlates of these differences have been discussed extensively in the literature with an emphasis on sociostructural influences such as differential access to family planning services (Besculides & Laraque, 2004; Kim, Dagher, & Chen, 2016; Masho, Rozario, Walker, & Cha, 2016; Musick, 2002; Naimi, Lipscomb, Brewer, & Gilbert, 2003). Clinic-based and policy initiatives have focused on the provision

of contraception (Fox & Barfield, 2016). However, a more nuanced understanding of the drivers of racial/ethnic differences in pregnancy, contraception, and overall reproductive decision making is necessary (Garbers, Meserve, Kottke, Hatcher, & Chiasson, 2013), including attention to the impact male partners have on women's reproductive health and decision making.

Quantitative findings from our team suggest that male-enacted RC is more common among Black women compared with White women and is a UIP risk factor (Holliday et al., 2017). Although RC and IPV are independently associated with UIP, the odds of UIP are greatest when IPV and RC are experienced simultaneously (Miller et al., 2014). Forced condom nonuse, forced intercourse, and interference with contraceptive use have been associated with UIP in adolescents (Coles, Makino, & Stanwood, 2011; Miller et al., 2010; Roberts, Auinger, & Klein, 2005) and contribute to rapid repeat pregnancy (Raneri & Wiemann, 2007). In fact, the pregnancy intentions of Black couples in the National Survey of Family Growth were most likely to be discordant and male-partner preferred, resulting in greater odds of rapid repeat pregnancy (Cha, Chapman, Wan, Burton, & Masho, 2016). What remains unclear are the mechanisms and contexts for IPV and RC among Black women compared with White women and how these experiences in turn impact pregnancy risk.

This study, an extension of previous studies, explores and compares narratives of low-income Black and White women, ages 18 to 29, from family planning clinics in Western Pennsylvania, all with histories of IPV, regarding contraceptive use, reproductive decision making, and other relevant factors surrounding pregnancy and sexual health. By focusing on women already seeking reproductive health care, we shift this analysis of racial disparities away from differential access to care (an important structural factor) and toward an analysis of intrapersonal and interpersonal levels of the ecological model (McLeroy, Bibeau, Steckler, & Glanz, 1988). Conceptually, all levels of the ecological model impact UIP. However, for this analysis, we focus on the intrapersoanl and interpersonal influences (Figure 1). By examining and comparing contraceptive use and reproductive decision making between White and Black women with histories of IPV, the current analysis explores the research question, "What are mechanisms that may drive racial differences in UIP risk in the context of abuse throughout one's life-course and male partner influences?"

Methods

We analyzed semistructured interviews to understand the impact of unhealthy intimate relationships on the reproductive health of low-income women seeking family planning care. We compared pregnancy intentions, contraceptive use, and reproductive experiences of Black and White women in the context of partner abuse.

Recruitment

We recruited 50 low-income women, ages 18 to 29, to participate in semistructured interviews nested within a larger randomized controlled trial conducted in family planning clinics in Pittsburgh, Pennsylvania (Miller et al., 2016). The randomized controlled trial enrolled women ages 16 to 29 years old who were seeking services in participating family planning clinics. After the completion of the final survey, participants in the randomized

controlled trial who were ages 18 and older were asked if they were interested in learning about an additional study. After an eligibility screening, women who had vaginal sex with a man within the past year and ever experienced physical or sexual IPV or RC were invited to participate in an interview. The current analysis includes non-Hispanic Black (n = 10) and White (n = 34) women; the small number of multiracial (n = 3), Hispanic (n = 2), and American Indian/Alaskan Native (n = 1) women were excluded given the comparative analysis by race/ethnicity.

Interview Procedures

The interviews were conducted using a life history narrative approach, shown to yield richer data, especially when discussing difficult topics like IPV and RC (Hollway & Jefferson, 1997). Consistent with the life history narrative approach, participants were asked to share key life events (i.e., age, milestones, and family events) to anchor their stories. Interviewers then probed about intimate relationships and experiences of physical or sexual IPV and RC within the parameters of these events. Interviews covered a range of topics. This study focused on themes specific to pregnancy intention, sexual assault and RC, contraceptive use within intimate relationships, and pregnancy experiences across the life-course. We derived the study's focus from a systematic literature review showing evidence of racial/ethnic differences in UIP (Holliday, 2014).

All sessions were audio recorded and transcribed verbatim. Identifying information was redacted for confidentiality. Each participant received $50 remuneration for her time. The University of Pittsburgh Institutional Review Board approved this study.

Analysis

We used thematic analysis for these narrative life stories. A semistructured interview guide informed the open coding process, allowing for emergence of codes that would add granular details to predefined themes. To develop the codebook, two members of the investigative team independently coded five transcripts. The two investigators compared coding discrepancies, discussed them, and resolved them by consensus. They refined the codebook iteratively with emergence of new codes. For the current research question, we analyzed themes of contraceptive use, including partner influence through pregnancy pressure and birth control sabotage, and UIP in the context of physical or sexual partner abuse. Finally, we assessed patterns and differences in themes by race/ethnicity. For each theme, we selected illustrative codes most representative of the narratives. We used ATLAS.ti 7 for data management and coding (Scientific Software Development GmbH, Berlin, Germany, 2013).

Results

Study Sample

Forty-four women were included in this analysis; the majority of women were White (72%; Table 1). More than one-half of all women reported a UIP (57%), and RC was more prevalent among Black women than White women (60% vs. 24%; p = .05; Table 1).

The prevalence of UIP was not significantly different between Black and White women. For most women in the sample, a pregnancy diagnosis was described as a disappointment or misfortune, “It breaks my heart every time they told me yes,” a 22-year-old White woman shared; “It’s like the worst things happen to me. Cause I never wanted kids,” stated a 24-year-old Black woman. Nonetheless, White women were more likely than Black women to report desiring pregnancy or feeling happy about a UIP. For example, a 20-year-old White woman explained, “I found out on my 19th birthday that I was pregnant and I was so happy.”

Racial differences were noted with respect to 1) the context of IPV/RC experienced by women, 2) how women perceived gender-based roles in sexual relationships, and 3) their trauma histories beyond IPV/RC, including adverse childhood experiences. Themes are discussed in turn with illustrative quotes.

IPV and RC

The nature and extent of IPV in the context of the women’s sexual/reproductive health was similar between both groups of women, with physical and emotional abuse, controlling behaviors, and forced sex commonly described. However, three specific dimensions differed by race/ethnicity: IPV in the context of pregnancy, experiences of fatal threats, and RC. In relation to pregnancy, White women described IPV and RC as more commonly physical, more likely to include fatal threats, and used by male partners to leverage control when children were involved. IPV was less central to the sexual/reproductive health narratives of Black women. Instead, their narratives focused on various types of RC, including condom refusal, male-dominated contraceptive decision making, and intentional impregnation in ways that were not reported by White women.

White women discussed IPV in relation to coparenting and feeling trapped in an abusive relationship, whereas Black women most often discussed experiences of abuse relative to RC. One White woman shared, “I never wanted kids or to get married. The kids were kinda an accident and so was the marriage. Once I was knocked up he started beating the shit out of me and then I had to marry him or I was going to be alone and no one would want me because I had a kid” (age 27). One 24-year-old White woman explained, “I was gonna leave him, but I kind of felt trapped in a way [after becoming pregnant]. And now … I want to leave him, but at the same time I’m kind of scared to ‘cause he’s threatened to kill me if I ever leave him with his son.” Five White women discussed receiving threats of femicide upon ending the relationship; by contrast, Black participants did not report such experiences.

Reproductive and sexual coercion among White women was often illustrated by forced and pressured sex. “When he drinks he’s a little bit more mean at the things he says and stuff, or how he tells me he wants me to do something like, he’ll say, ‘Well, give me some head!’ or something like that. Or he’ll grab my hair and try to pull me down there … And he kinda just will force himself on me and stuff, he won’t stop, and … [sighs]” (age 25). Another woman recalled forced sex in the context of pregnancy, “He wanted me to get pregnant. He told me once that he had sex with me while I was sleeping, passed out drunk … ‘cause he wanted to have a baby” (age 25). White participants also described birth control sabotage and condom refusal. A 22-year-old described a series of RC behaviors she experienced, “He

pushed my pills down the toilet." When asked about the frequency of this behavior she replied, "Every time I came here and got them. Started getting the shot. He made me miss my appointment."

Black women's experiences of RC were more likely to include coercive control over women's reproduction to sustain the relationship. An 18-year-old woman described, "Well he had told me when he was locked up. He was like, 'I tried to get you pregnant so you wouldn't leave me.'" Additional RC nuances discussed among Black women include male partner deception through false claims of sterility and abhorrence for the health effects of contraception, and methods women use to evade RC experiences through covert contraceptive use. Professed infertility was perceived to be a RC tactic, "a lot of guys say that they can't have kids just to have unprotected sex or just so they can do whatever they want to do" (age 18). Furthermore, one woman reported that her partner was adamant that birth control was the devil and would harm her body. Other men would remove the condom during sex. One 18-year-old Black participant shared this, "If I ever told him to use a condom, he would tell me no he couldn't have kids, there's no point in it. Or, in the middle of it, he would take his condom off." One Black participant mentioned hiding her birth control pills, "[My birth control] was hidden. I had a secret compartment in a purse. I had to buy a special purse just to hide it because I knew even if he went through it, he wouldn't see this one section. I would take [birth control] in the bathroom with like, sink water, so just when he would think I was going to the bathroom" (age 24).

Gender Roles in Reproductive Decision Making

Sex scripts or norms around reproductive responsibility varied by race/ethnicity in the context of IPV and sexual experiences. Among Black women, RC and dependency on male partners to decide on pregnancy prevention and provide financial support influenced attitudes about pregnancy. White women discussed hopelessness and responsibility of the female partner to prevent pregnancy.

In the following narratives, two Black women described contrasting influences of their male partner's financial stability in their acceptance of becoming pregnant. First, in the presence of RC, a 27-year-old Black woman described, "He was the one who wanted a kid. He actually threw my birth control away … I knew there was a possibility of getting pregnant but I wasn't expecting to get pregnant because I wasn't ready at that age. But he was there to provide and everything so I didn't have to worry about my kid not being taken care of or anything like that." When another women, age 18, was asked about the use of contraception at first sex she replied, "None, I didn't do anything, that was just all him. I never had sex—first time was just, okay, alright, this is something new, I guess I'll try. But I guess we used the pullout method, or—one day he told me he did. I was like why would you—why do you want me—why do you want this [pregnancy]? I don't have a job; you're not even working, like" (Black, age 18).

One 27-year-old Black woman discussed her desire to become pregnant and how this affected her perceptions regarding male responsibility for condom use:

> He knew the consequences, he slipped up and didn't pull out twice and we went to the pharmacy and he got me the, whatever the pill … The third time I told him, no I'm not doing that because I want a kid, you already got a kid, … So he's responsible, he got a good job. Like he's responsible enough to take care of his responsibilities, but he just didn't want another kid. So if he ever does it again, I ain't getting the pill, I want a kid, I'm getting old.

She later described, "So I always let it be known, if you don't wanna use protection, if that's what we decide to do, just know if I end up getting pregnant, that's your responsibility." None of the White participants mentioned this approach to pregnancy.

Instead, White women described experiences of UIP in relation to hopelessness, lack of control to enact reproductive and sexual decision making, and the responsibility of the female partner to prevent pregnancy. One White woman said that severe abuse that resulted in hopelessness shaped her destiny. In response to learning that she was raped by her partner while sleeping, she described, "I just accepted that this is my destiny to be a wife, mother, whatever. I feel like I was kind of brainwashed. If it would have happened, I don't think I would have cared. I mean I—I didn't think much about having a future" (age 25). When asked how she feels when condoms are not used another woman added, "It doesn't really bother me but I know I probably should use it [condom] because he does have 2 kids. He has 2 kids already, and then, I don't know if like—what our relationship will be like later on down the line, but that would be kind of messed up on my part to just be irresponsible and have a kid" (White, age 24).

Adverse Childhood Experiences

Childhood adversities such as childhood sexual abuse (CSA) and neglect emerged in the women's narratives of pregnancy and reproductive health with varying influence by race/ethnicity. Additionally, having to care for other children while growing up encouraged Black women to delay pregnancy: "I always wanted kids, just not that soon. I had to grow up fast. I raised my two brothers" (age 29). In contrast, one White woman described her love for babysitting as a teenager and desire to become pregnant early in life. Black and White women in this sample differed in their self-described experiences of childhood abuse in relation to their narratives regarding their sexual/reproductive health. Seven White women reported being sexually abused by immediate family members, trusted family friends/associates, and individuals in their neighborhood; none of the Black women reported such sexual abuse. Some of the White women discussed the negative consequences after they notified their family of the sexual abuse. For example, when asked if she told her mom that she had been molested by her mother's boyfriend, a 20-year-old White woman responded, "Yeah, my mom actually told me that I was just jealous of her relationship [with the alleged abuser]." In another instance, a respondent mentioned, "Once when I was younger, my brother experimented with me and I told my dad. [He] ended up calling children and youth [services] and my mom flipped out and said it wasn't true and she hated me and she never wanted to see me again" (White, age 29).

Experiences of sexual assault were a reported contributor to insecurity particularly among White women ($n = 4$). Some participants said that they did not deserve a better partner or

that their current partner was the only man who would want them: “I felt like nobody was going to be with me” explained a woman who contracted herpes after being raped at a party (White, age 25). Another White woman shared in the context of adverse family experiences, including CSA, “It was the low insecurities, just made me feel like I didn’t deserve better. I’m like well this is what I get for what I did. Even though I didn’t do anything, I knew in my heart, but I was like well he says he loves me and this is all I’m going to get like no one else is going to love me. I hated myself.”

Two White respondents mentioned using sex to maintain a relationship. Specifically, when asked if she wanted to have sex at age 14, a participant described, “I was young, I was just trying to keep the guy that I liked. Because I thought at the time that I loved him” (age 29). One Black respondent attributed her love-seeking behavior to insecurity in the context of adverse childhood experiences: “Growing up, I didn’t experience love from anybody. I grew up in foster homes so it was like the first boyfriend I got I was so excited because he was showing me something different” (age 29).

Discussion

This study highlights key racial differences in experiences of IPV and RC as well as childhood abuse and different pathways to UIP. Findings from our comparative analyses elucidate factors that contribute to a relatively high prevalence of UIP among American women and persistent racial/ethnic differences therein. All participants experienced IPV and/or RC in their lifetime and the prevalence of UIP did not differ among White versus Black women in this sample. However, Black and White women’s experiences were different with respect to the contexts of their sexual and reproductive health, including varying experiences of IPV/RC, gender roles regarding sexual/reproductive decision making, and the role that adverse childhood experiences played in their sexual/reproductive health narratives. Male-dominated reproductive decision making, varied and prevalent experiences of RC, and social factors like medical mistrust and mass incarceration of men described by Black women in this study help to explain racial/ethnic differences in UIP risk.

RC was more common in Black women’s narratives (60% compared with 24% of White women). Both groups of women noted male control exhibited via RC and deception related to condom use and withdrawal. However, male partners of Black women were more likely to be deceptive about condom use, or simply refuse or remove condoms during intercourse, and to engage in behaviors specifically to impregnate a woman. Such behaviors may be indicative of deeply rooted social constructs like mass incarceration or neighborhood violence (Nikolajski et al., 2015). Fear of long prison sentences or street-related death may elicit a desire to establish a legacy through procreation (Nikolajski et al., 2015). Furthermore, historical mistrust of medical professionals (Arnett, Thorpe RJ Jr, Gaskin, Bowie, & LaVeist, 2016; Hammond, 2010) coupled with a lack of knowledge about contraception (Borrero, Farkas, Dehlendorf, & Rocca, 2013) may also influence RC perpetration among men through their concerns about harmful effects of female-controlled contraception. Perhaps because of a greater likelihood of experiencing RC, Black women described hiding birth control as a harm reduction strategy to evade pregnancy coercion.

These findings are helpful to place previous quantitative work in context. In a clinic-based study by our team, we found that RC contributed to UIP risk similarly among Black and White women, and that the odds of experiencing RC were significantly greater among Black women, suggesting that socially fueled drivers of RC were at play (Holliday et al., 2017). In the current study, experiences of RC and IPV were centered on power and control among White women, including threats of intimate partner homicide related to coparenting, and less centered on forced or coerced pregnancy. White women's reports of fatal threats are consistent with national data that demonstrate a significant gap in intimate partner homicide (Petrosky, 2017) between White (52%) and Black (35%) women (Smith, Fowler, & Niolon, 2014). Additional work is needed to understand factors that contribute to the increased prevalence of RC among women of color and should include the perspectives of men as perpetrators as well as seek to disentangle reasons for varied experiences of RC and IPV by race/ethnicity.

For instance, gendered social norms that favor violence against women are associated with increased IPV perpetration (Fleming et al., 2015; Santana, Raj, Decker, La Marche, & Silverman, 2006). In this study, Black and White women noticeably differed in how they described men's and women's roles in sexual health decision making. Black women described a greater reliance on male partners in contraceptive decision making relative to White women, which may facilitate or normalize RC behavior. Reliance and transfer of power may be hinged on low sex ratios among Blacks relative to other racial/ethnic groups that encourage competing sexual partnerships (Adimora et al., 2013). Also discussed was subfertility stated by Black men. Additional research should include the perspectives of men and women and begin to distinguish medically diagnosed infertility from deception and lack of reproductive health knowledge.

Women's discussion of childhood abuse also varied greatly, with seven White women reporting experiences of CSA. Consistent with the literature on the impact of CSA, in explaining the impact of early maltreatment and abuse, White women revealed learned helplessness and subsequent IPV (Renner & Slack, 2006; Widom, Dutton, Czaja, & DuMont, 2005). In contrast, despite probing for childhood experiences, Black women did not discuss sexual abuse, despite evidence that all racial/ethnic groups experience CSA (Amodeo, 2006; Kenny & McEachern, 2000). Disconnecting experiences of CSA from their narrative of sexual/reproductive health among Black women in the sample may be attributed to self-blame (Sciolla et al., 2012) or social burden to protect sexual assault perpetrators, often of the same race (Washington, 2001), from adjudication (Neville & Pugh, 1997; Tillman, Bryant-Davis, Smith, & Marks, 2010). Women from both racial groups reported insecurities that stemmed from childhood adversity. Such vulnerability can be used by perpetrators to enact control in relationships including RC behaviors (Jones et al., 2016).

Women from both racial groups mentioned caring for children during youth. However, Black women viewed having to care for young family members as a reason for wanting to delay pregnancy. Although both White and Black women alike expressed a desire for love resulting in an effective tolerance for mistreatment, the nature and root causes of this desire varied. Black women depicted their desire for love as stemming from childhood neglect, whereas White women emphasized the need to feel wanted and cared for in the context of

their experiences of sexual assault. The qualitative findings here suggest the need for greater distinction of pregnancy intentions, which are informed by multiple life experiences, beliefs, and influences by partner and community (Aiken, Borrero, Callegari, & Dehlendorf, 2016).

Limitations

These findings should be interpreted with consideration of limitations. The study focused specifically on understanding racial/ethnic differences in UIP in the context of IPV or RC; thus, interviews with women who had not experienced such abusive experiences were not conducted. Factors associated with UIP in this study may not be generalizable to low-income women in the Pittsburgh region outside of partner coercion and abuse. Furthermore, women were asked to recall specific incidents of abuse from previous and current relationships, providing contextual and historical information, and possible recall bias. Discomfort and/or feelings of shame or embarrassment related to the nature of the topics discussed may have resulted in underreported experiences with UIP, reproductive and sexual health, and IPV or differential discomfort in reporting based on race (Neville & Pugh, 1997; Tillman et al., 2010). The analysis includes a small sample of Black women ($n = 10$), which is slightly below the thematic saturation threshold established by Crabtree & Miller, 1999. Recent studies show that a majority of content-driven codes are established with the first six interviews (Guest, Bunce, & Johnson, 2006). A strength of this study is that all women were of low income and sought reproductive care from local family planning clinics. Therefore, with somewhat consistent socioeconomic factors as well as known histories of IPV, this study allowed for the qualitative synthesis of elements in which UIP may occur and provides insights into racial/ethnic differences contributing to UIP.

Conclusions

In-depth interviews with Black and White women highlight their varied experiences with IPV, RC, and UIP, and the formidable impact of male intimate partners on their reproductive health and decision making. Findings emphasize that while common factors may be associated with UIP (i.e., history of abuse, RC) across races, the mechanisms of influence may differ.

Implications for Practice and/or Policy

Clinicians offering contraceptive counseling should consider exploring women's pregnancy intentions and the role of male partners, IPV, and RC in their reproductive decision making. Clinic-based interventions have shown promise in addressing IPV and RC (Decker et al., 2017; Miller et al., 2016). Findings from this study can be used to develop intervention approaches tailored to women's diverse experiences.

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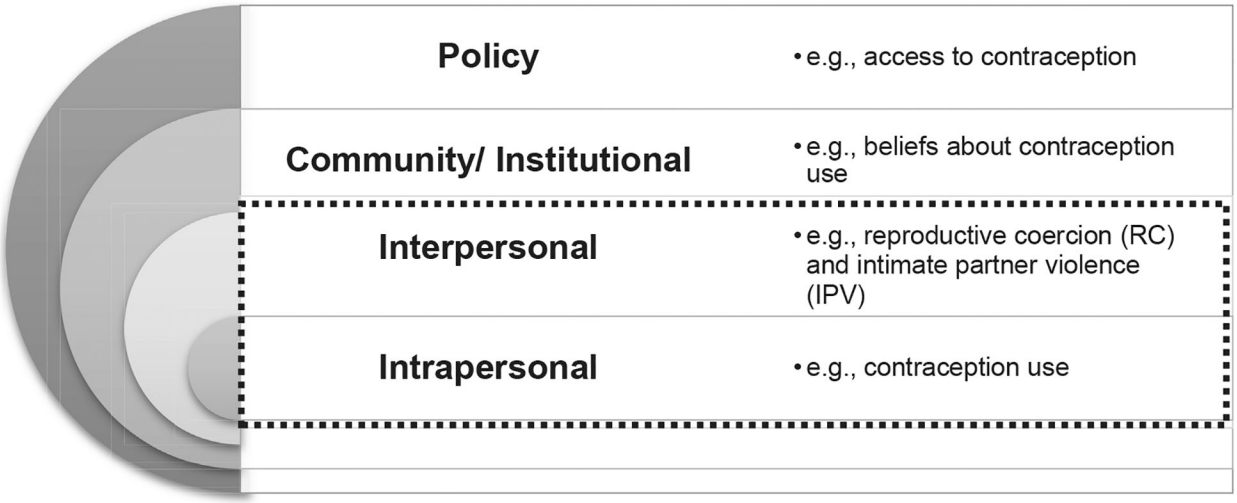

Figure 1.
Ecological risk factors of unintended pregnancy risk using a model adapted from McLeroy et al. (1988).

Table 1

Participant Demographics by Race

	Total	Non-Hispanic Black	Non-Hispanic White	*p* Value
Total	100% (44)	21% (10)	72% (34)	
Age (y)				.72
18–24	50% (22)	60% (6)	47% (16)	
25–30	50% (22)	40% (4)	53% (18)	
Education				.33
<High school diploma	18% (8)	10% (1)	21% (7)	
High school diploma/GED	25% (11)	20% (2)	26% (9)	
Some college	39% (17)	30% (3)	41% (14)	
College degree	18% (8)	40% (4)	12% (4)	
Parity				.98
0	41% (18)	50% (5)	38% (13)	
1	20% (9)	20% (2)	21% (7)	
2	18% (8)	10% (1)	21% (7)	
3	9% (4)	10% (1)	9% (3)	
≥4	11% (5)	10% (1)	12% (4)	
Unintended pregnancy				.62
Yes	57% (25)	50% (5)	59% (20)	
No	43% (19)	50% (5)	41% (14)	
Intimate partner violence				.23
Yes	98% (43)	90% (9)	100% (34)	
No	2% (1)	10% (1)	0% (0)	
Reproductive coercion				.05
Yes	32% (14)	60% (6)	24% (8)	
No	68% (30)	40% (4)	76% (26)	

Note: Column percentages