The National Academy of Sciences has asserted that “…unintendedness itself poses an added, independent burden beyond whatever might be present because of other factors, including the social and economic attributes of the mother in particular.” That mothers of unintended births are slower to recognize their pregnancy and to obtain medical attention increases their health risks and those of their baby. This underscores the need for increased support for couples’ ability to plan whether and when to have a child, through increased information about and access to contraception and other family planning services, as well as toward providing general health information about pregnancy, early pregnancy testing and easy access to prenatal care. Such information and services provided outside prenatal care settings have a role to play in increasing the proportions of women who begin prenatal care early in their pregnancy.

Given the expected findings that intention status has independent effects on women’s recognition of pregnancy and on the timing of prenatal care initiation, and the significant bivariate relationships between intention status and the other variables measured in this study, it is surprising that only the relationship between mistimed births and smoking cessation remained significant once we controlled for women’s social and demographic characteristics.

Certainly, further work is needed on the measurement of intention status. Surveys that collect retrospective reports of intention status do not necessarily reflect the mother’s commitment to the pregnancy and child once pregnancy occurs. Furthermore, a woman’s feelings about the pregnancy can vary over time—both during the pregnancy and afterwards. We need measures that are more sensitive to such fluctuations and allow us to capture different aspects of attitudes toward pregnancy and childbirth.

Moreover, intention status may have less impact than expected because the study population, by definition, includes women who are relatively positive about their pregnancies. Although some women with unintended pregnancies are unable to obtain abortions in the United States, most who want to do so are able to terminate pregnancies they do not wish to carry to term. In earlier times (and even today in most developing countries), women with unwanted pregnancies had little alternative to childbirth other than clandestine and medically unsafe abortion. Today, in contrast, fewer than half of U.S. women with unplanned conceptions carry their pregnancies to term. Even though women in the United States today who opt to carry unplanned pregnancies to term start with some disadvantage from later recognition of pregnancy and later entry into prenatal care, there appears to be little residual effect of intention status on their behavior once they enter prenatal care.

Like other work, these analyses show effects of women’s social and demographic characteristics on the timing of their recognition of pregnancy and initiation of prenatal care, as well as on their behaviors during pregnancy. The social and demographic differences in mothers’ behavior are largely unaffected when we control for differences in planning status across these groups. Thus, subgroup differences in behavior are not due solely to differences in women’s feelings about their pregnancy. Instead, they probably reflect differences in environmental and cultural factors that affect access to knowledge and services.

Work to elucidate and ameliorate the effects of these factors should continue. These findings do, however, serve as reminders that it is inappropriate, as well as ineffective, to attribute problems of late initiation of prenatal care and lack of adherence to recommended behaviors during pregnancy solely to a woman’s attitude toward her baby. Rather, effects of social and demographic characteristics indicate personal and contextual factors that play a role in women’s behavior.

The amount of agreement between the findings of the two surveys is encouraging. However, it is not clear how much of the discrepancy in the findings may be due to differences in sample size, design of the survey or unmeasured characteristics of the women. The guidelines we used to select the samples for analysis were aimed at making the data comparable, but the populations of births represented in the NMIHS and the NSFG may be quite different. In addition, slight variations between the two surveys in the measurement of the outcome variables may partially account for differences in the findings.

The most consistent social and demographic results are for mother’s education: Women with more education are generally more likely to recognize pregnancy and begin prenatal care early and to follow recommendations regarding the number of visits and advice on smoking, drinking and taking vitamins. Since most babies are born healthy, the value of such behaviors for