Social Norms and Stigma Regarding Unintended Pregnancy and Pregnancy Decisions: A Qualitative Study of Young Women in Alabama

CONTEXT: *Social norms and stigma may play important roles in reproductive health behavior and decision making among young women in the U.S. South, who disproportionately experience unintended pregnancies. No research has described the presence and manifestations of social norms and stigmas associated with unintended pregnancy and related decision making from the perspective of this population.*

METHODS: *Six focus groups and 12 cognitive interviews were conducted between December 2013 and July 2014 with 46 low-income women aged 19–24 living in Birmingham, Alabama; respondents were recruited from two public health department centers and a community college. Semistructured interview guides were used to facilitate discussion about social perceptions of unintended pregnancy and related pregnancy decisions. Sessions were audio-recorded, and transcripts were analyzed using a theme-based approach.*

RESULTS: *Participants described community expectations that pregnancy occur in the context of monogamous relationships, in which both partners are mature, educated and financially stable. However, respondents reported that unintended pregnancy outside of these circumstances was common, and that the community expected young women faced with unintended pregnancies to bear and raise their children. Women who chose to do so were viewed more positively than were women who chose abortion or adoption. The community generally considered these alternatives to parenting unacceptable, and participants discussed them in terms of negative labels, social judgment and nondisclosure.*

CONCLUSIONS: *Findings suggest a need to reduce stigma and create a social environment in which young women are empowered to make the best reproductive decisions for themselves.*

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By Whitney Smith, Janet M. Turan, Kari White, Kristi L. Stringer, Anna Helova, Tina Simpson and Kate Cockrill

Whitney Smith and Anna Helova are doctoral candidates, Janet M. Turan is professor and Kari White is assistant professor, Department of Health Care Organization and Policy, School of Public Health; Kristi L. Stringer is a doctoral candidate, Department of Medical Sociology, College of Arts and Sciences/ Center for Outcomes and Effectiveness Research and Education; and Tina Simpson is associate professor, Department of Pediatrics, School of Medicine—all at the University of Alabama at Birmingham. Kate Cockrill is executive director, Sea Change Program, Tides Foundation, Oakland, CA.

Women aged 18–24 have the highest rate of unintended pregnancy among all age-groups in the United States.[1] In this subgroup, 58% of unintended pregnancies result in childbirth and 42% in abortion (after exclusion of miscarriages).[1] Data on unintended pregnancies that lead to birth and subsequent adoption are scarce; however, 1% of all newborns are relinquished for adoption.[2] Women's decisions at the time of an unintended pregnancy are constrained by multiple factors, including intimate partner relationships and socioeconomic resources.[3–5] Social norms and stigma regarding unintended pregnancy and pregnancy options may also play an important role in how young women experience and respond to unintended pregnancy, yet we know little about these psychosocial factors within this population.

Social norms represent what behavior is accepted and expected in a community.[6] Stigma, defined as social disgrace or disapproval, functions as an informal control mechanism for individuals who do not adhere to socially defined norms.[7] Research has examined social norms and stigmas primarily in relation to isolated reproductive health behaviors or decisions, such as contraceptive use,[8,9] pregnancy,[10,11] childbearing[4,12] and abortion.[13,14] This literature suggests that these norms and stigmas have implications for pregnancy prevention and decision making. However, few studies have simultaneously explored social norms and stigmas regarding unintended pregnancy and all potential pregnancy decisions, despite the understanding that women who have an unintended pregnancy may encounter them.[15] Furthermore, women make decisions regarding pregnancy in part by contrasting pregnancy options in light of these norms and related stigmas.[3,16]

Two studies, conducted more than 10 years ago, have simultaneously considered social norms and stigma related to unintended pregnancy and pregnancy decisions. Edin and Kefalas found that regardless of reported pregnancy intention, low-income black, white and Hispanic mothers in Philadelphia viewed childbearing as an inevitability and a necessity from which they derived identity and purpose, and viewed abortion and adoption as being in moral opposition to parenting.[4] In Ellison's study of middle-class white women in California who had had an unintended pregnancy, respondents' attempts to avoid social stigmas had influenced their pregnancy experiences and decisions (inclusive of abortion, adoption and parenting).[17] While these are seminal studies, women's experiences may have changed over the recent decade.[18] In addition, both studies examined reproductive norms and stigmas among

adults broadly, and only Edin and Kefalas presented results by race and ethnicity, despite prior findings that rates of unintended pregnancy and reproductive norms and stigmas vary by age and racial or ethnic group.[1,10,19] Only the Edin and Kefalas study included exclusively low-income women, given that this population bears a greater burden of unintended pregnancy and its consequences, and that reproductive norms vary by socioeconomic status. Moreover, both studies explored norms and stigmas among women who have been pregnant, and thus do not include the perspectives of women who are at risk for, but have not experienced, an unintended pregnancy.

Finally, little research has examined reproductive norms and stigmas in the southern United States, where rates of unintended pregnancy are highest.[20] Two studies, conducted in Louisiana and Georgia, suggested that culturally and socially defined fertility norms regarding the ideal circumstances for pregnancy shape intendedness.[5,21] Kendall et al. explored women's perceptions of childbearing and abortion, and found that women had negative views of the latter.[5] This finding aligns with reports of more hostile abortion attitudes in the South than in other regions.[19,22] In view of these norms and attitudes, reproductive stigma may be higher in the South than elsewhere. Some studies have hypothesized that it may be especially salient in this region because of dominant tendencies of traditionalism and Christian religiosity.[19,23]

The aims of the current study were to explore perceptions of norms and stigmas related to unintended pregnancy, parenthood, adoption and abortion, and to examine racial and ethnic differences in these perceptions, among young, low-income women in Birmingham, Alabama. Birmingham is a socially conservative city with marked levels of poverty, racial residential segregation and health disparities.[24] Thirty percent of Birmingham residents live in poverty, as do similar proportions of residents of more densely populated southern cities, such as Atlanta (25%) and New Orleans (28%).[25] The proportions of black, Hispanic and other minority groups who are living in poverty in the city are more than 2.5 times as large as that of whites.[26] Consistent with national trends, minority women and women of low socioeconomic status in Alabama experience considerably higher than average rates of unintended pregnancy.[27] Despite this local context, the state's government did not expand Medicaid under the Affordable Care Act[28] and has enacted restrictive abortion policies;[29] consequently, access to reproductive health care has been constrained, especially for women with limited resources. In fact, the only abortion clinic in Birmingham was temporarily closed for several months during the current study, which meant that women in Alabama had to travel great distances to visit an abortion provider.[30] Studying reproductive norms and stigmas in Birmingham may provide insight into the situation in other urban and rural environments.

METHODS

Study Design

An all-female study team, consisting of the principal investigator and six trained master's and doctoral students, recruited participants and collected data between December 2013 and July 2014. We approached potential participants at two Birmingham public health department centers* and a local community college during business hours and posted flyers in the common areas; all of these venues served mainly low-income populations. The study staff and flyers invited women to participate in a focus group or cognitive interview to discuss attitudes about family planning, pregnancy and health decision making.

We screened women recruited in person during initial contact and screened those who responded to flyers by phone. Women were eligible if they attended one of the study venues, were aged 19–24 (in Alabama, 19 was the age of consent for research at the time of the study), spoke English and were not pregnant. We invited eligible women to select from prearranged focus group or interview times and locations (i.e., private meeting rooms at or near the recruitment locations). We recruited approximately 100 women; however, roughly half did not participate because of schedule conflicts or lack of transportation, or because they could not be contacted.

We initially employed focus group methodology, given its suitability for the exploration of sensitive issues when group members are relatively homogeneous and confidentiality is assured.[31,32] Focus group findings were also intended to inform the development of new quantitative measures of reproductive stigma as part of an additional study aim.[33] We conducted six focus groups, which included 34 participants overall, lasted an average of 82 minutes and were stratified by race (three white and three black). Each group had a race-concordant moderator and note taker. In some cases, young children were present, as we did not provide child care.

Moderators used a semistructured guide to pose questions designed to elicit views on norms and stigma related to unintended pregnancy and pregnancy options. Discussion probes were employed to help participants elaborate on and verify their responses. Questions included "In your view, when is a good time for a young woman to get pregnant?" "What do people in the community think about a young woman who has gotten pregnant when she wasn't planning it?" and "What do most young women in your community end up doing [if they have an unintended pregnancy]?" Toward the end of the discussions, to offer standardized stories for participants to discuss, the guide also included three vignettes, describing scenarios in which a young woman chooses either abortion, adoption or parenting in response to an unintended pregnancy. For example, one of the vignettes read as follows:

"I am 21 years old. I recently found out that I am pregnant. I can't become a mother right now because I don't have enough money to raise a child. I've decided that the best thing for me to do is to give the baby up for adoption."

*Within the two centers, participants were recruited at Women, Infants and Children Nutrition Program, family planning and STD clinics.

The vignette was followed by a series of questions, including "How do you think people close to her would react to this situation?" and "How do people in your community generally view a young woman who has given a child up for adoption?" The vignettes on abortion and parenting followed the same format.

We next used cognitive interviews both to test the theoretical ideas that emerged from the focus group findings in a new sample as a method of data triangulation[34] and to pretest quantitative measures we developed from the group findings. For this study, we sought to determine whether the individual perceptions of social norms and stigma expressed within the interviews corroborated our interpretation of the shared perceptions of norms and stigma that arose from the focus groups.

Following preliminary data analysis from five groups, we recruited 12 interview participants, who were purposively sampled to include equal numbers of black and white women, a few interviewees of other racial or ethnic background, and similar proportions of women from the health department and community college locations; this mix of individuals was selected to ensure that a variety of experiences were represented. We did not match interviewers and interviewees by race. Using a semistructured interview guide designed to elicit perceptions of the same topics discussed in the focus groups, the interviewer asked participants to read and respond to prompts such as "What do you understand by accidental pregnancy?" "Are there other common opinions about women your age who become pregnant accidentally that were not included as part of this question?" and "What is the first thing that comes to mind when you think of abortion?" Interviews lasted 52 minutes, on average.

To assess face validity of the focus group and interview guides,[35] prior to finalization and use, we had them reviewed by experts at nonprofit national reproductive health organizations that were not directly associated with the study; the focus group guide also was pretested to assess content validity.[36] All focus groups and interviews were audio-recorded and transcribed verbatim. Study staff obtained informed consent from individuals before each session, and all participants received $30. The institutional review boards of the first author's university and of the county health department approved the study protocol.

Analysis

We developed codes using a priori themes based on previous research,[6,37] and employed a thematic data analysis approach.[38,39] The codes included perceptions of other people's behavior (descriptive norms) and behaviors expected by others (normative expectations), as well as expressions of favor or disfavor (attitudes) and assigned responsibility (blame) regarding a stigmatized behavior or decision.[33] To refine the codebook and ensure consistency, the first and last authors individually coded initial focus group transcripts and then discussed their interpretation of codes to arrive at a shared understanding. Once we achieved thematic saturation, a revised codebook was developed and finalized. The first author analyzed all remaining transcripts using NVivo 10.[40] The coders iteratively presented preliminary findings to the research team and other colleagues as a means of peer debriefing for quality control.[35]

TABLE 1. Percentage distribution of women aged 19–24 participating in a study of attitudes toward pregnancy and pregnancy-related decision making, by selected characteristics, according to method of data collection, Birmingham, Alabama, 2013–2014

Characteristic	Total (N=46)	Focus group (N=34)	Interview (N=12)
Race/ethnicity			
Black	52.2	52.9	41.7
White	41.3	47.1	41.7
Other	6.5	0.0	16.7
Education			
<high school	6.5	5.9	8.3
High school/GED	28.3	29.4	25.0
Some college	45.7	52.9	25.0
College	10.9	8.8	16.7
Graduate school	8.7	2.9	25.0
Relationship status			
Not in a relationship	63.0	64.7	58.3
In a nonmarital relationship	28.3	23.5	41.7
Married	8.7	11.8	0.0
No. of pregnancies			
0	54.4	44.1	83.3
1	28.3	32.4	16.7
≥2	17.4	23.5	0.0
No. of children			
0	56.5	50.0	75.0
1	28.3	29.4	25.0
≥2	15.2	20.6	0.0
Religious affiliation			
Christian	82.6	88.2	66.7
Other	2.2	0.0	8.3
None	15.2	11.8	25.0
Total	100.0	100.0	100.0

Note: Percentages may not add to 100.0 because of rounding.

RESULTS

The combined sample of 46 focus group and interview participants had a mean age of 21.* Some 52% self-identified as black, 41% as white and 7% as being of other race or ethnicity (Table 1). Overall, 46% of participants reported a prior pregnancy. Although both types of participants were recruited from the same locations, compared with individuals in focus groups, interviewees had more education, were more likely to be in a nonmarital relationship and were less likely to have ever been pregnant or given birth. Despite these differences, we found that interviewees shared many of the perceptions of reproductive norms and stigma reported by focus group participants.

Unintended Pregnancy

Participants across racial and ethnic backgrounds spoke of common expectations for educational attainment, financial stability and personal maturity prior to getting pregnant

*The mean ages of focus group and interview participants were 21.1 and 20.8, respectively; the range for each was 19–24.

and during a pregnancy. However, women reported that unintended pregnancy was a common occurrence among their peers, and that it often occurred before these expectations had been met. A white interviewee, who had never been pregnant, reflected multiple participants' views when she stated, "Maybe you took precautions. Maybe you didn't. But something happened, and you got pregnant." Numerous participants said that unintended pregnancy at a young age was a growing phenomenon. A white focus group participant, who had had one pregnancy, commented, "It's like a chain reaction.... I got pregnant, my sister got pregnant ... my cousins got pregnant.... There's something in the water.... I don't know what it is, but my whole family got pregnant."

One of the few areas where findings differed by race or ethnicity was male involvement and marriage. Black participants varied in their expectations regarding relationships and pregnancy, whereas expectations among their nonblack counterparts were more uniform. For example, a black focus group participant, who had never been pregnant, stated, "I think she should be grown and married," to which another participant with no history of pregnancy responded, "I say nowadays [readiness is] just based on the woman. She should have her own job and be on her own, because you can't depend on a man." A multiracial interviewee, who had never been pregnant, voiced the opinion, "You shouldn't [get pregnant] before you are … married or in a definite relationship." This sentiment was mirrored by several white participants in both focus groups and interviews.

A handful of respondents across focus groups and interviews expressed that young women within their communities chose to marry the men involved in an unintended pregnancy. An Asian interviewee, who had had no pregnancies, described how friends in high school had gotten married because they had accidentally gotten pregnant. In contrast, some black participants shared experiences and observations that men "disappear" when an unintended pregnancy occurs. In the words of a black focus group participant, who had been pregnant three times:

"When it comes to a relationship, I've been through it. High school sweethearts … get ready for college, he dumped me as soon as I told him I was pregnant. So, relationship status … don't mean nothing."

Common manifestations of social norms and stigma emerged from discussions when participants tried to reconcile community expectations about the circumstances of pregnancy with experiences of unintended pregnancy. Norms were conveyed through the anticipated emotional responses of individuals close to a young woman (family, friends etc.). If faced with an unintended pregnancy outside of the expected contexts, women described others' being "mad," "worried," "disappointed," "upset" and "unhappy." The conversations turned to common stereotypes of the "kind of woman" in that situation. Participants expected that unintended pregnancy happened because of poor upbringing, promiscuity, irresponsibility and lack of contraceptive use. Various women shared their attitudes that those who become pregnant unintentionally should have "known better," as expressed by a black focus group participant with no pregnancy history:

"I don't see why so many people are pregnant … when there's so much [contraception] out there that you can use.… Some people [are] just having baby after baby, and I'm like, you didn't get the gist the first time?"

Within participants' communities, young women faced with an unintended pregnancy were often deemed "fast" and labeled "heathens" or "whores." Participants described how women can be the target of accusations and gossip regardless of their pregnancy decision. Judgment and blame for getting pregnant can affect a woman's self-perception. A black focus group participant, who had never been pregnant, described her friend's experience: "Some people make [her] feel ... like a bad person because [she] had an unplanned pregnancy, [but she's] really not."

Furthermore, women who experienced unintended pregnancy may be shunned by friends and family members, even though they live in tight-knit communities. Several participants reported that when they had had an unintended pregnancy, and friends' parents found out, they lost those friends. For example, a black focus group participant, who had been pregnant once, commented, "Their momma snatch 'em up, [saying] 'It's in the water over there.'" Another black focus group participant, who had had four pregnancies, shared her experience: "My momma put me out [of the home]. You've got parents that just … won't even care what they child do after they get pregnant." Participants in the majority of discussions described how young women who have unintended pregnancies often try to keep their pregnancies secret for fear of backlash. A black interviewee, who had had one pregnancy, shared: "Before I had my first son,… I had not told anyone that I was pregnant. I did feel a little bit ashamed, but at the same time, I knew better."

Parenting

Participants believed that young women faced with an unintended pregnancy should choose to parent, and that most women within their communities did so. Accordingly, one black focus group participant, who had had three pregnancies, shared thoughts that were echoed by others: "My mama ... she'd say if you [had sex], you're gonna take care of [the baby]. She don't say nothing about no abortion [or] no adoption." A white focus group participant, who had been pregnant once, commented, "Everybody I know that's ever gotten pregnant, if they haven't lost it due to a miscarriage, have it." The perception of parenting as an inevitability repeatedly emerged in discussions of decision making following an unintended pregnancy. A black focus group participant, who had had no pregnancies, stated that women within her community "see no reason for … abortion [or] adoption [because parenting is] just so common." In fact, participants often used "pregnancy" and "have a baby" synonymously.

Parenting norms were also manifested in family and community reactions to the decision to parent, which most women described as positive, despite often mixed reactions to the pregnancy initially. In that vein, a white interviewee, who had never been pregnant, shared:

"My [relatives] would be happy that I kept the baby, because they definitely wouldn't want an abortion or [adoption]. I know all my church family would be very upset … that I got pregnant.… They would rather I had the baby than abort it."

Some women said that the decision to become a parent after an unintended pregnancy had occurred was more accepted and celebrated than it had been in the past. As a black focus group participant, who had had one pregnancy, described:

"In my community, [unintended pregnancy is] so common.… It's just like, 'Oh, she's pregnant, okay.' They're having baby showers, taking pictures, [there's] not even any shame in it at all anymore. Back when my mom got pregnant with me at 17,… it was kind of like, 'Okay let's try to conceal it for a while,' [and] she didn't even have a baby shower."

Participants in each focus group and in several interviews voiced their intentions to parent in the event of an unintended pregnancy, as did a white interviewee with no pregnancy history: "I would definitely keep the baby … no matter what the circumstances." Reinforcement of the norm to become a parent came from the expectation of personal fulfillment from overcoming the challenges of early parenting and, in some cases, of being a single mother. Moreover, participants commonly shared feelings that women who put a child up for adoption or have an abortion are at a disadvantage because they miss out on motherhood experiences. As one black focus group participant, who had had no pregnancies, shared:

"[Young mothers] feel accomplished, that they got through it, that they can take care of the child.… I had a friend in high school [who] got pregnant our 10th-grade year and … again our 12th-grade year, and she had both of her children.… Now she's finishing up in school, and she loves her children to death, and they motivate her to … continue to get her education, to work. [She] feels accomplished and independent, because the father is not really [there]."

Many women noted the trying socioeconomic circumstances that young mothers faced. Respondents often reported that such mothers experienced difficulty completing college because of competing responsibilities to earn a living and care for the child. For example, a white focus group participant, who had been pregnant at age 18 and again at age 19, while "going through school and working a full-time job and having to provide," said, "It's been tough. If I would have thought ahead, I think I would have finished school, and been on my feet, and then I would have gotten pregnant."

Most participants felt that the choice to parent was an act of selflessness, strength and responsibility, regardless of socioeconomic circumstances. However, a handful of participants shared their own and community judgments of young women who chose to parent outside of the expected contexts. In these discussions, participants expressed that it was selfish to bring a child into an unsafe home environment (e.g., one characterized by homelessness, parental drug use, domestic violence or food insecurity). They described how young mothers faced blame and judgment for having a child "too young," for lacking resources, for entrapping the man involved and for being unmarried. For example, a white focus group participant, who had had one pregnancy, shared the social consequences of her decision not to marry when faced with an unintended pregnancy: "Before I had [my son], people were already calling him a bastard [and] telling me that he's going to be raised in sin, [saying that] 'he's going to go to hell, and you made it that way.'"

Adoption

Participants described formal adoption as an option that was rarely visible within their communities. According to a black focus group participant with no pregnancy history, "Adoption is not really common.… A lot of girls where I live … don't really know ... anybody who ever had that kind of contact with [adoption]. So I would say it's almost not existent.… It's either abort or keep." In a few instances, participants divulged stories of friends who chose to place their child for adoption. In one focus group, a white participant, who had had no pregnancies, described a friend's situation:

"She thinks that's the best decision she ever made because she wanted better for that baby. And the people that adopted were able to give the baby everything that it needed.… She said that she knew it would hurt, but she knows that they're giving the baby a better life."

In contrast, multiple participants told of their experiences being placed with a family member or living in foster care, or knew of such examples. These participants differentiated those experiences from legal adoption, and described the circumstances as difficult and emotionally trying, particularly when the child was displaced from one or more homes. A black focus group participant, who had never been pregnant, shared her experience of being raised from birth by her grandmother, because her mother was unable to care for her. This participant characterized her circumstances as hurtful and "not good" because she became attached to her grandmother but was later moved back with her mother, whom she depicted as trying to "pop in and parent."

Some participants indicated that they would never consider (or could not support others who chose) adoption because of personal beliefs, an expectation of emotional connection to the fetus or concern about the well-being of the child. A black focus group participant, who had had three pregnancies, shared her perspective:

"If my child was to get pregnant, and she wanted to give the baby up for adoption, I wouldn't feel comfortable with

that.... Not saying it's wrong, but ... you never know what your child could be for you, and you might miss [out] because you feel like you can't do it."

Participants across multiple groups and interviews described adoption using diverse and sometimes contradictory terms, including "difficult," "brave," "beneficial," "damaging," "irresponsible" and "selfish." They expressed the belief that children are "a gift" and "a blessing," no matter the intendedness of the pregnancy or the woman's circumstances. Respondents generally viewed motivations for alternatives to parenting as "an excuse," as did a white focus group respondent, who had had one pregnancy:

"I don't get [adoption]. I was financially broke, didn't have no money, and my kid's well-tooken care of. [The father of another participant's child] don't help her, and that baby looks so healthy.… It might be hard, but there's [support] out there to help women to make sure their kid is tooken care of. So, I don't understand why women do that."

Other participants described how some women may have chosen not to disclose having placed a child for adoption to protect themselves and their families from shame, or to protect the child from emotional harm. A black focus group participant, who had had three pregnancies, expressed an opinion that was shared by others: "Never tell [children] that they're adopted [because they'll feel neglected], then they'll be wondering why.... What life could have been like with [the birth parents]. It'll mess them up."

According to many participants, women should cherish the ability to get pregnant, carry a pregnancy to term and have a healthy child, given that some women "can't have kids" and that some pregnancies end in fetal or maternal death. Many participants shared their own and community views that parenting primarily and adoption secondarily are viewed as morally acceptable options. In one focus group, a black participant with no pregnancy history described how adoption was perceived in her community:

"At least you're keeping the baby alive; you get points for that.… I feel like most communities, if not all communities, would still prefer that you keep your baby. But if you decide that adoption is the best option, they still give you points.… You didn't kill the baby."

Abortion

Abortion was perceived as being far less visible in participants' communities than parenting as a young woman. More black than white respondents thought abortion was a common experience. White participants were more likely than blacks to report that they did not know anyone who had had an abortion, but speculated that abortion may happen "more often than people realize." A white focus group participant, who had had two pregnancies, reflected, "There's probably more women that have had [an abortion], but it's something they might be ashamed of and don't tell anyone."

Numerous women said they would not consider an abortion if faced with an unintended pregnancy. A white focus group participant, who had had one pregnancy, offered this explanation:

"I'm completely against abortion. If I'm going to sit here and do something that's going to cause me to have a child, then ... I'm going to make it where I can afford and I can raise that child.... So that's not even an option for me."

A minority of participants indicated that they would consider abortion if they experienced an unintended pregnancy. A black focus group participant with no history of pregnancy explained:

"I wouldn't tell nobody to have an abortion,… but it would come across my mind, because ... I see women in my family, [going to] school, [getting] good grades, doing all this stuff, [but then they] had a child [and] all of it's over.... My momma did that, had a child when she was 19, was in nursing school. [She] quit to take care of her children."

For most participants, the choice of having an abortion was viewed as acceptable only in "real trying circumstances," which encompassed rape, drug abuse, severe mental illness and homelessness. Abortion was also deemed acceptable when a woman's life was in danger or when fetal anomalies were detected. A multiracial interviewee with no pregnancy history offered her perspective: "[If] my kid is going to have [a] crippling deformity [and] I can get rid of it beforehand, that might be okay.... Or [doctors can detect] Down syndrome now, so you can just quit the pregnancy."

Participants imagined that community members would react negatively to finding out that a young woman had had an abortion. For example, a black focus group participant, who had never been pregnant, stated: "Well, like I'm from deep in the South.... They kind of view it as a bad thing, like you're killing your child. That's why most people in my community do keep their children."

Young women who chose to have an abortion and those involved in the provision of abortion services were perceived as irresponsible, selfish, weak, cold-hearted and immoral. As noted by a white interviewee with no pregnancy history, "I think it's horrible. I just wish they never created abortion clinics. The word 'abortion' … I wish it never existed. I think it's ridiculous. I think it's all selfish."

Many white participants talked of their interactions with crisis pregnancy centers, which provided them with free diapers, cribs, bottles and "mommy money" for attending classes and watching 15-minute videos. A white focus group participant, who had had one pregnancy, described the message delivered by one such organization during a visit to her high school:

"They try to get every girl to think that abortion is horrible, and if you're going to have the baby, put it up for adoption if you don't want it. 'Do not, do not have an abortion.… Abortion is horrible; you'll get sick.'"

Multiple participants shared stories of friends and community members who had kept their abortions secret. They voiced suspicions that some women who reported having had miscarriages really had obtained "hidden" abortions. A white focus group participant, who had been pregnant once, offered a possible reason:

"I know plenty of people that have had abortions that don't even tell their doctors.... They're ashamed of it. They go [to abortion clinics] with a hood over their face.… They know it's wrong, but they think that's what's best for them or the child that they already have."

Finally, some participants described situations in which parents of young pregnant women forced them to have abortions, so that unintended pregnancies would not be disclosed. A black focus group respondent, who had had four pregnancies, shared her experience: "I done got pregnant in the eighth grade, and my momma, she made me have an abortion and then moved me to California, and didn't nobody know. My own daddy didn't even know." When prompted to discuss why parents might force their child to have an abortion, participants felt that the motivation might be the desire to maintain social approval. In discussing one such experience, a white focus group participant, who had never been pregnant, commented, "The parents are scared of what everyone else is gonna think.… 'Oh you have to have an abortion 'cause I don't want everyone in our community to think bad things of us.'"

DISCUSSION

Despite the importance of psychosocial factors in reproductive health behavior and decision making, we know little about how young women in the U.S. South perceive social norms and stigmas regarding unintended pregnancy. Our study revealed a number of themes related to social expectations as perceived by low-income young women.

Women in our study reported that unintended pregnancy was common within their communities, despite social expectations to the contrary. Similarly, in other studies, low-income adult women reported that ideal contexts for pregnancy were incongruent with their experiences, and often were shaped by social class and opportunity structures.[5,41] Our participants perceived stigma toward unintended pregnancy, confirming documentation of low-income adolescent and adult women's experiences in other settings.[11,12,17] The findings also support existing reports of a social expectation to parent following an unintended pregnancy.[4,5] Moreover, that women in this setting received social rewards for conformity to pregnancy and parenting expectations, and may be stigmatized for violating norms, also mirror findings among women of broader age ranges and in different settings.[17,42] Overall, our results indicate that young women in this setting share perceptions of reproductive norms and stigma that are similar to those held by other low-income women in the United States, regardless of age or location. However, the stigma surrounding nonnormative behaviors may be more salient in the South than in other regions, as evidenced by the hostile climate for access to abortion[43] and related public misinformation.[44]

Our findings also suggest some racial differences in expectations for male involvement following unintended pregnancy and in norms pertaining to abortion. More black participants than whites expressed expectations for single parenthood, whereas prior findings are mixed regarding racial and ethnic differences in expectations for commitment of the male involved in pregnancy.[4,45] In addition, white participants were less familiar than blacks with the occurrence of abortion in their communities, possibly because abortion is not disclosed or is infrequent among their social networks.[46] Moreover, only white participants discussed experiences with crisis pregnancy centers, despite reported efforts by antiabortion activists to discourage black women from having abortions.[47] Notwithstanding these differences, black and white women in our study perceived similar manifestations of stigma regarding unintended pregnancy and pregnancy decisions. These findings are unique, as previous studies have not explored racial variation in norms and stigmas regarding unintended pregnancy and pregnancy decision options in the South.

Understanding reproductive norms and stigma has important programmatic consequences for professionals who support women's pregnancy-related decision making. Minimization of reproductive stigma may prevent potentially harmful reactions to stigma, such as psychological stress and avoidance of health care services.[48] By learning about the manifestations of reproductive stigma, and employing compassion in interactions with clients, practitioners can use this research to counteract and help women cope with this stigma.[49] Individual-level interventions could include efforts to target women who experience reproductive stigma and offer them education and counseling to help restore their sense of integrity. Interventions targeting the broader community may involve educational approaches that incorporate critical thinking about the alignment of social expectations, women's experiences and related stigma.[50] These results are further relevant to research on the relationships among reproductive norms, stigmas, health behavior and health outcomes. We have employed the current findings to develop questionnaire measures of reproductive norms and stigma for use in future research.

Limitations

These results should be interpreted in the context of study limitations. First, our findings may not represent all young, low-income women in Birmingham. Our study included only women who utilized public health department services or attended community college, and mostly participants who identified as black or white. We may have missed themes unique to or disproportionately experienced by other populations. Furthermore, we did not screen for income or verify reported age, so our sample might include women who did not fit the study's targeted demographic attributes. Second, recent experiences of pregnancy and the presence of young children during some of the focus groups may have influenced participants' responses.[51] Lastly, we did not specifically ask focus group participants about their own unintended pregnancy or abortion history, which could have provided further context to findings.

Conclusions

Our findings suggest that young, low-income women in Birmingham perceive social expectations for pregnancy and parenting, and are rewarded for conformity to social norms. Violation of these norms makes women susceptible to social stigma, which can manifest itself as negative attitudes, stereotypes, blame and discriminatory behaviors. Thus, social norms and stigma may influence young women's health decision making, particularly the disclosure of an unintended pregnancy and nonconformist pregnancy decisions.

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Author contact: *jmturan@uab.edu*