Contraception xxx (2018) xxx–xxx

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/con

Original research article

Is pregnancy fatalism normal? An attitudinal assessment among women trying to get pregnant and those not using contraception

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ARTICLE INFO

Article history:
Received 16 February 2018
Received in revised form 15 May 2018
Accepted 16 May 2018
Available online xxxx

Keywords:
Fatalism
Pregnancy planning
Intended pregnancy
Contraception
United States

ABSTRACT

Objectives: To assess factors associated with pregnancy fatalism among U.S. adult women.
Study design: I used data from the Change and Consistency in Contraceptive Use study, which collected information from a national sample of 4634 U.S. women aged 18–39 at baseline (59% response rate). I assessed pregnancy fatalism based on agreement with the statement: "It doesn't matter whether I use birth control, when it is my time to get pregnant, it will happen." I compared fatalism among all respondents to fatalism among respondents who were trying to get pregnant and those who did not want to get pregnant but were not using contraception. I used logistic regression to assess associations between nonuse of contraception and pregnancy fatalism at baseline and whether respondents were trying to get pregnant 6 months later.
Results: Overall, 36% of the sample expressed some degree of pregnancy fatalism, and proportions were higher for respondents trying to get pregnant (55%) and those not using contraception (57%). The association between pregnancy fatalism and trying to get pregnant was maintained after controlling for other characteristics [odds ratio (OR) 1.4, p=.01], as was the association for nonuse of contraception (OR 2.08, p<.001). Contraceptive nonusers at baseline were more likely than users to be trying to get pregnant 6 months later, especially if they expressed a fatalistic outlook at baseline.
Conclusions: Pregnancy fatalism may be a common outlook among women who are trying to get pregnant. Associations between fatalism and nonuse of contraception may be more complex than previously recognized.
Implications: Gaining a better understanding of the dynamics of pregnancy planning might inform our understanding of why some women do not use contraception.

1. Introduction

Fatalism is the belief that life events are predetermined or controlled by outside forces such as God or fate [1, 2]. Many programs and policies aimed at improving health outcomes encourage individuals to engage in healthy behaviors and change unhealthy ones — to act with *agency* — and it is often assumed that a fatalistic outlook is a barrier to positive behaviors [2]. Research on fatalism in regards to health often focuses on its role in attempting to prevent outcomes that are relatively uncommon, such as specific cancers and HIV/AIDS [2, 3]. Childbearing, on the other hand, is experienced by the majority of women, and several studies suggest that fatalism — what might be thought of as the opposite of "family planning" — influences American women's pregnancy planning and prevention strategies.

Quantitative studies of fatalism using U.S. survey data have found that a substantial proportion of individuals expressed a fatalistic outlook in regards to pregnancy and contraception, including one third of all U.S. adult women [4, 5], 40% of young adults [6, 7] and more than half of women obtaining care at federally and state-funded health clinics [8, 9]. Some of these studies also found associations between fatalism and nonuse of contraception [4, 8], gaps in contraceptive use [4] and inconsistent use [5], although data limited to young adults typically did not [6, 7]. Researchers interpreted these associations to mean that skepticism about the ability to prevent pregnancy reduced the motivation for some (adult) individuals to use contraception.

But qualitative research suggests a more complex dynamic. Interview data reveal that fatalism about pregnancy and pregnancy prevention is common but does not necessarily remove, or even reduce, motivation to use contraception. In some cases, individuals relate that contraception can "slow down" or put off an inevitable pregnancy [10]. Others have expressed the view that pregnancy is largely under a woman's control but contraception is not perfect; larger forces such as fate and God can result in a pregnancy even when contraception is used [11, 12]. In some cases, pregnancies that occur even when contraception is used are a sign that the pregnancy was meant to happen [12, 13]. Several studies have found that fatalism was also expressed in regards to the ability to get pregnant insofar as there is no guarantee a woman will be able to achieve a wanted pregnancy and fate, chance or God may be seen as the determining factor [1, 12, 14].

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https://doi.org/10.1016/j.contraception.2018.05.015
0010-7824/

Taken together, prior studies suggests that fatalism can be associated with less effective use of contraception, but many individuals with fatalistic outlooks will use contraception. Additionally, fatalism may influence how women think about pregnancy in general, including the ability to get pregnant. This study uses data from a national sample of women to build on prior research. Specifically, I examined pregnancy fatalism among all women with a focus on its associations and potential roles among women trying to get pregnant and those not trying to get pregnant but not using contraception.

2. Materials and methods

I used longitudinal data from the Continuity and Change in Contraceptive Use (CCCU) study, which obtained information from a national sample of 4634 women at baseline. The online recruitment company GfK administered the survey using their KnowledgePanel, which is composed of approximately 50,000 individuals. While the sample is intended to be representative of the U.S. population, the (baseline) sample recruited for this study was older and more educated than what would be expected based on nationally representative data [15].

In order to best capture the experiences of women at risk of pregnancy, the baseline survey was restricted to women who had ever had vaginal sex with a man, who were not currently pregnant, who had not had a tubal ligation and whose main male sex partner had not had a vasectomy. Respondents were not asked if they were infertile for other reasons, such as hysterectomy, and this study includes these individuals. Over a 3-week period in November and December 2012, GfK invited 11,365 women to participate in the baseline survey. Of those, 6658 answered the 4 screening items, yielding a response rate of 59%; 4647 of those were eligible to participate, and 4634 completed the full online survey. GfK asked all 4647 respondents to participate in the follow-up survey 6 months later, and 3150 did so (68%). We obtained expedited approval for the study from the Guttmacher Institute's Institutional Review Board. More detailed information about the CCCU is available in previously published studies [5, 16].

The dependent variable, pregnancy fatalism, is based on responses to a single item adopted from prior studies [4, 6, 8]: "It doesn't matter whether I use birth control, when it is my time to get pregnant, it will happen." The five response categories ranged from "strongly agree" to "strongly disagree." This item was only asked at baseline, and I excluded the 46 respondents who did not answer the question.

The two main independent variables are fertility intentions and nonuse of contraception. I assessed prospective fertility intentions based on an item asking women: "Which of the following best describes your current plans regarding having a(nother) baby?" Response categories included "I am trying to get pregnant now," "I am not trying to get pregnant now but expect to try in the future," "I don't want to have any (more) children" and "I'm not sure if I want to have a(nother) baby." I excluded the 24 respondents who did not answer this item at baseline and the 18 who did not answer it at follow-up from relevant analyses.

We asked all respondents if they had used any of 6 prescription contraceptive methods in the last 30 days (the pill, the patch, the ring, the shot, an implant or an IUD), and, among women who had had sex with a man in the last 30 days, we assessed if they or their partners had used any of 5 coital or male methods (pulling out/withdrawal, condoms, natural family planning, spermicide or some other barrier method and vasectomy). Emergency contraception was not assessed at baseline. I classified as nonusers individuals who did not report using any of the listed methods. Analysis using this variable was limited to respondents who were at risk of unintended pregnancy, and did not include those who were postpartum, trying to get pregnant or had not had sex with a man in the last 30 days. I excluded from relevant analyses the three respondents who did not provide information about their sexual activity or contraceptive use.

Demographic variables, all measured at baseline, include age, union status (including cohabiting), number of prior births, race and ethnicity and education. I also included a measure of prior unintended pregnancy based on an item asking respondents: "Have you ever gotten pregnant when you were not planning or wanting to be pregnant (please include miscarriages and abortions in addition to births)?"

I examined a three-category measure of fatalism among all women by prospective fertility intention status and by nonuse of contraception. Using a two-category measure of fatalism (agree vs. neutral and disagree) as the dependent variable, I assessed unadjusted (χ^2) and adjusted (logistic regression) associations of this measure with demographic characteristics and fertility intentions. For this analysis, I used the full analytical sample. I next limited the analysis to woman at risk of unintended pregnancy. I used logistic regression to assess associations between fatalism and nonuse of contraception at baseline. I then examined associations between fatalism and nonuse of contraception at baseline with fertility intention at follow-up (6 months later) using cross-tabulations and logistic regression.

I conducted all analyses using Stata 15.0 (2017, College Station, TX, USA) and considered p values less than or equal to .05 to be statistically significant.

3. Results

Overall, 36% of the sample agreed with the pregnancy fatalism statement (22% strongly so, not shown), and a slightly higher proportion, 45%, disagreed (29% strongly so) (Table 1). When examined according to fertility intentions, a fatalistic outlook was highest, 55%, among the women who were trying to get pregnant and lowest among women who wanted no (more) children, 20%. Among women who were sexually active but were not trying to get pregnant (i.e., at risk of unintended pregnancy), 7% were not using contraception; 57% of this group expressed a fatalistic outlook compared to 33% among contraceptive users. It is worth noting that 89% of individuals at risk of unintended pregnancy who expressed a fatalistic outlook were using contraception (not shown).

All characteristics were associated with having a fatalistic outlook in the bivariate analysis (Table 2). In the multivariate model, characteristics associated with an increased likelihood of expressing a fatalistic attitude included having one or more births, having a prior unintended pregnancy and having a high school degree or less. While women of color were more likely than white respondents to express a fatalistic

Table 1
Pregnancy fatalism among all women aged 18–39, and by fertility intention status and contraceptive use (n=4601)

	Pregnancy fatalism[a]			Total
	Agree	Neutral	Disagree	
Total	1661 36.1 (34.7–37.5)	879 19.1 (18.0–20.3)	2061 44.8 (43.4–46.2)	4601 100
Fertility intentions				
Trying to get pregnant	54.7 (49.5–59.8)	18.8 (15.1–23.1)	26.5 (22.2–31.3)	362
Expect to try in future	42.0 (39.9–44.0)	18.5 (16.9–20.1)	39.6 (37.6–41.6)	2264
No (more) kids	20.4 (17.8–23.4)	18.0 (15.5–20.9)	61.6 (58.1–64.9)	783
Unsure/don't know	29.3 (34.7–37.5)	21.2 (18.0–20.3)	49.6 (43.4–46.3)	1168
Contraceptive use (among those at risk of unintended pregnancy)				
Nonuser	57.4 (51–63.5)	21.9 (17.1–27.7)	20.7 (16.0–26.3)	237
User	33.1 (31.5–34.7)	18.4 (17.1–19.7)	48.5 (46.9–50.2)	3404

[a] Based on item asking: "It doesn't matter whether I use birth control, when it is my time to get pregnant, it will happen."

Please cite this article as: Jones RK, Is pregnancy fatalism normal? An attitudinal assessment among women trying to get pregnant and those not using contraception, Contraception (2018), https://doi.org/10.1016/j.contraception.2018.05.015