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Coherence of pregnancy planning within couples expecting a child

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Background: joint planning and decision-making within couples have evident effects on the well-being of the family. The purpose of this study was to investigate the level of pregnancy planning among pregnant women and their partners and to compare the coherence of pregnancy planning within the couples.
Methods: pregnant women and their partners were recruited from 18 antenatal clinics in seven Swedish counties between October 2011 and April 2012. Participants, 232 pregnant women and 144 partners, filled out a questionnaire with questions about pregnancy planning, lifestyle and relationship satisfaction. 136 couples were identified and the women's and partners' answers were compared.
Results: more than 75% of the pregnancies were very or rather planned and almost all participants had agreed with their partner to become pregnant. There was no significant difference in level of pregnancy planning between women and partners, and coherence within couples was strong. Level of planning was not affected by individual socio-demographic variables. Furthermore, 98 % of women and 94 % of partners had non-distressed relationships.
Conclusion: one of the most interesting results was the strong coherence between partners concerning their pregnancy and relationship. Approaching these results from a social constructivist perspective brings to light an importance of togetherness and how a sense and impression of unity within a couple might be constructed in different ways. As implications for practice, midwives and other professionals counselling persons in fertile age should enquire about and emphasise the benefits of equality and mutual pregnancy planning for both women and men.

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Introduction

There is an ongoing trend of postponing childbearing throughout Europe. One influential factor in this development is the recent international economic recession (Lanziéri, 2013). Other more long term reasons are higher education for women, expanded female participation in the labour market, availability of effective contraceptives and advances toward gender equity (Mills et al., 2011). Clearly, family planning is not only a private issue but a question of equality on individual, community and policy level in combination (Cleland et al., 2006; Frejka et al., 2008; Kosunen and Rimpelä, 1996). Individuals' perception of responsibility for preconception health and pregnancy planning are affected by gender, culture, socio-economy, age and other demographic factors (Grady et al., 1996; Huang, 2005; Ekstrand et al., 2007).

Joint planning and decision-making within couples have evident effects on the well-being of the family. The expectant mother's experience of support from her partner is highly relevant for the outcome of the pregnancy (Stapleton et al., 2012). Pregnancies that are considered unintended by one or both parents have for example been associated with a higher risk of inadequate antenatal care (Waller and Bitler, 2008), preterm birth (Hohmann-Marriott, 2009), adverse health events, negative effects on breast feeding (Korenman et al., 2002), poorer psychological well-being among parents (Su, 2012) and more behavioural problems in children (Carson et al., 2013). However, unplanned is not always

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equal to unwanted and these two different aspects may have varying consequences for the pregnancy outcome (Carter and Speizer, 2005).

Sweden has currently one of the highest fertility rates in Europe, despite postponed childbearing, a liberal abortion law and reduced number of marriages (Oláh and Bernhardt, 2008). It seems as if women and men are equally affected by societal changes, as the mean age of having one's first child has increased with one year per decade for both sexes since the 1970s (Lanziéri, 2013). Even though postponed parenthood has not yet affected the national fertility rate, there are other negative consequences of delaying childbirth that needs attention, such as increased involuntary childlessness, pregnancy complications and adverse pregnancy outcomes (Balasch and Gratacós, 2011).

Theoretical framework

This article is based on the notion of social intersectional constructions of gender. This means that how we perceive a certain gender is based on societal norms, which varies over time just like the rest of society (Sociologists for Women in Society, 1991). Being a woman or a man has different implications for different social classes as well as for different racial, ethnic and religious groups. There is a strong tendency to constantly distinguish the two genders masculinity and femininity from each other in different practices and by categorisations. The social construct theory analyses the gender categories to see how different social groups define them, and how they construct and maintain them in everyday life and in major social institutions such as the family. According to West and Zimmerman (1987), gender is an integral dynamic of social order, which produces, reproduces, and legitimates the choices and limits that are predictable on categories of sex. What it means to be a parent is socially constructed and varies over time and by gender (Bergnéhr, 2008).

Aim and hypotheses

For the benefit of the family, it is relevant to ask whether pregnancies are planned and whether couples agree on if and when to have children. According to a Swedish study, childless couples seem to be quite consistent in their desire to have children or not (Schytt, 2014). Yet, there are, to our knowledge no studies on coherence within couples that already expect a child, although this information could be useful in antenatal care. The purpose of this article is to investigate the level of pregnancy planning among individuals that recently have become pregnant, and explore whether there is an association to socio-demographic factors, number of pregnancies and relationship satisfaction. Further, the aim is to compare the coherence of pregnancy planning within the couples.

Methods

Study design and participants

The present study was the pilot study of an ongoing research project on pregnancy planning and life-style habits among women and men in reproductive age. A power-calculation for sample size was therefore not relevant.

In Sweden, antenatal care is handled by midwives as long as the pregnancy is progressing normally. Participants for the study were recruited at 18 antenatal clinics in seven Swedish counties between October 2011 and April 2012. The clinics were located in larger cities as well as in smaller communities. Approximately 16% of the Swedish population is foreign-born and a large proportion of them (39%) are between 25 and 44 years old, i.e. in a common age for childbearing. Among the Swedish-born population, 23% are in the same age group (Statistical Database, 2014).

The study invited Swedish-speaking women and their partners, recruited at their first antenatal visit in gestational week 9–11. During the study period, 398 women were registered at the clinics. Among those, 293 women were given information about the study and were asked to participate. Partners were also invited to partake, regardless of whether they were biological fathers or not. If the woman was single the midwife could ask an accompanying friend or relative to participate.

Data collection and procedure

Women who accepted participation received an envelope with further information about the study and the rights of participants. The envelope also contained two questionnaires; one to the woman and one to the partner. Participants could complete the questionnaire on site, or at home and return it in a prepaid envelope. If the partner was absent, the woman was asked to bring the second questionnaire home to offer the partner.

The women's questionnaire contained 76 questions and the partners' questionnaire 62 questions. Questions in both questionnaires were grouped under headings such as demographics, relationship status, life-style before pregnancy, perceived health and the current pregnancy including its circumstances. Women were asked to fill out some background information about their partner as well, e.g. age and education. The questionnaires were study specific. Validated instruments, such as the Relation Assessment Scale (RAS), modified AUDIT, the London Measure of Unplanned Pregnancy (LMUP), the Edinburgh Postnatal Depression Scale (EPDS), the Perceived Stress Scale (PSS) and the Hospital Anxiety and Depression Scale (HADS), were used. The questionnaires ended with the question ‘Has your partner been present while you filled in this questionnaire?’

Questionnaires were coded with number combinations and personal data were removed before analysis to assure anonymity. Women and partner's questionnaires were given corresponding codes to enable comparisons within couples.

The questionnaire was completed by 232 (79%) pregnant women and 144 partners. The partners identified themselves as male ($n=141$), female ($n=2$) and other ($n=1$). This last person was however identified as a woman by the paired expectant mother. Among all answers, 136 couples were identified, paired and included in the analysis.

Measurements

Pregnancy planning was measured with a single-item questions ‘Is this pregnancy a result of a conscious decision to become pregnant?’ (yes/no), ‘Who took the initiative to become pregnant?’ (only me/mostly me/either or/mostly my partner/only my partner), ‘How planned was your/your partner's pregnancy?’ (very planned/fairly planned/either or/fairly unplanned/very unplanned) and ‘Have you considered an induced abortion?’ (yes, a lot/yes, a little/either or/no, not specifically/no, not at all).

Relationship Assessment Scale (RAS)

The RAS is a 7-item Likert scale used as an instrument for measuring satisfaction within a relationship. Each item can be scored from one to five, and higher scores indicate greater relationship satisfaction. Either the total score or the average score can be used for analysis. According to (Hendrick et al., 1998), scores above 4.0 would indicate non-distressed relationships, whereas 3.5 (men) and 3.5–3.0 (women) is the cut-off score for

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