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Couple Perspectives on Unintended Pregnancy in an area with high HIV prevalence: A Qualitative Analysis in Rakai, Uganda

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Abstract

Understanding how couples perceive a recent unintended pregnancy in the context of HIV infection and high levels of gender inequality may provide insights for prevention of undesired pregnancy. We used data from 24 in-depth interviews with 8 HIV-serodiscordant and 4 seroconcordant couples living in rural Uganda and interviewed separately; between 15–49 years and one or both identified the pregnancy as unintended. A dyadic analysis was performed to understand each partner's perspectives on experiences of a specific pregnancy. We used the social ecological model to guide the analysis. Issues of agency were commonly invoked in describing pregnancy. Women often cited factors that demonstrated a lack of control when making decisions about continuing the pregnancy. Men often expressed a lack of agency or control over preventing their female partner from becoming pregnant. There was much disagreement between partners about intentions regarding the specific pregnancy. Likewise, lack of communication about child-spacing and pregnancy intentions was common among couples. HIV serostatus played a role in some discussions of pregnancy intention among sero-discordant couples. This qualitative analysis supports prior quantitative research on the complexity of pregnancy intentions. A lack of agency at the individual level was compounded by a lack of communication between partners.

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Keywords

Unintended pregnancy; Dyadic analysis; HIV/AIDS

Introduction

Unintended pregnancy is a persistent, global issue with considerable impact on the health and well-being of mothers, babies, and families. The Institute of Medicine declared that “the consequences of unintended pregnancy are serious, imposing appreciable burdens on children, women, men and families” (Brown et al., 1995). Worldwide in 2012, an estimated 85 million pregnancies, or 40% of all pregnancies, were unintended (Sedgh et al., 2014). Demographic studies define the concept of unintended pregnancy to include mistimed births (wanted if occurred later), unwanted births (not wanted now or later), and induced abortions (most of which are mistimed or unwanted) (Sedgh et al., 2014). Women may express conflicted or ambivalent feelings about specific pregnancies, reflecting the complexity of their life circumstances (Santelli 2003).

Unintended pregnancy is also common in Uganda; more than half of pregnancies are classified as unintended (Guttmacher, 2013). The research on the relationship between unintended pregnancy and HIV status is mixed—some studies find that there is no difference in rates of unintended pregnancy for HIV positive and HIV negative women (Bankole et al., 2014), whereas others show a significant difference in rates of unintended pregnancy (McCoy et al., 2014). One qualitative study from rural eastern Uganda found that HIV positive women reported that most of their pregnancies came as a surprise, and many believed they were infertile because of HIV (King et al., 2011).

The consequences of unintended pregnancy in Uganda are potentially stark. Abortion is highly restricted in Uganda, illegal in almost all cases unless the health of the mother is at risk. Thus, unsafe abortion is common and maternal mortality is high (Guttmacher, 2013). Unsafe abortion and death from abortion are only two of many negative consequences of unintended pregnancy. Others include: infertility related to septic abortion, delay in initiation of prenatal care and infant care, increased risk of child mortality and increased risk of maternal depression and anxiety (Gipson, Koenig & Hindin, 2008).

Unintended pregnancy is associated with factors such as age and parity; interpersonal factors—namely marital status and partner preferences; social factors—including poverty and support from family; and organizational factors—such as access to reproductive health services, contraception and abortion (Santelli et al., 2015). Behavioral factors, such as failure to use contraception consistently and correctly, are also associated with unintended pregnancy (Singh, Sedgh, & Hussain, 2010). A recent Guttmacher report found that the most common reasons that women cite for not using contraceptive methods are: side effects/health risks, infrequent sex, and postpartum amenorrhea associated with breastfeeding (Sedgh, Ashford & Hussain, 2016). A small percentage of women report not having access to contraceptives (Sedgh et al., 2016). Intimate partner violence is associated with unintended pregnancy and abortion across diverse settings (Goodwin et al., 1996; Pallitto et al., 2013;

Silverman et al., 2007). Not surprisingly, predictors of unintended pregnancy vary based on whether a pregnancy is mistimed or unwanted (Gipson et al., 2008).

Commonly the pregnancy intentions of men, and therefore the joint feelings of the couple, are not measured. Specifically, little research has examined HIV positive men's understandings of unintended pregnancy; however, it is vital to include male partner perspectives. Becker and colleagues have discussed the importance of dyadic analyses—although often difficult to collect—especially when studying partner's attitudes and desires about fertility as there is often couple-level disagreement. An understanding of men's perspectives can be used to target interventions and to involve men in preventing unintended pregnancy, as couple-level interventions have been found to be more effective than interventions that only target men or women individually (Becker, 1996).

Due to the gap in the literature on male partner pregnancy intentions and the relationship to the intentions of the female partner, this paper uses data from cohabiting couples to explore agreements and disagreements around pregnancy intentions and the context within which unintended pregnancies occur. This context includes parity and child spacing, awareness or lack of awareness around partner's fertility desires, agency in decision making, and HIV status and risk. Using separate interviews of men and women, we explore if and when couples consider pregnancies to be unintended and how they describe these experiences. Acknowledging and understanding the nuances of 'unintendedness' may be helpful in understanding the impact of unintended pregnancy on health (Gipson et al., 2008). The main aim of this analysis was to contrast perspectives of unintended pregnancy between men and women in co-habiting couples in a setting with high levels of gender inequality and high HIV prevalence. We wanted to understand the impact of sero-concordance or discordance of the couple and agreement or disagreement regarding experiencing an unintended pregnancy.

Relevant Theory and Conceptual Framework in Context

The conceptual framework for this paper is drawn from the social-ecological model and theories on gender within the context of sub-Saharan Africa. The social ecological model takes into account the multiple levels of factors and the influence between an individual and their environment (CDC, 2015). There are multiple levels of the ecological framework that are situated within each other—including individual, interpersonal, community, organizational, and policy environment (CDC, 2015). Importantly, this theory emphasizes the idea that the interaction between levels is equally as important as the factors found within a level (WHO, 2016).

Figure 1 is the conceptual framework we used to understand the complex individual, interpersonal and organizational factors that influence discussions of unintended pregnancy. The conceptual framework examined *individual factors* (individual demographics, HIV status, parity, child-spacing desires, overall health and economic factors); *interpersonal factors* (relationship context, friends and familial influences, perception of reactions by partner, seroconcordance or discordance); and *organizational factors* (access to contraception, access to health systems, HIV treatment and prevention services). These three levels interact with one another and influence both men and women. Likewise, men and

women in couples mutually influence each other and this dyadic analysis examined this bi-directional influence.

Men and women's descriptions of their experiences with unintended pregnancy are influenced by and shaped by their perceived sense of agency, as well as gender inequality that exist within society. Agency is a complex phenomenon that is oft debated in the social sciences, especially in the context of fertility. In classic understandings of the demographic transition, fertility declines as education of women increases and individuals make 'rational' decisions about fertility control (Cater, 1995). Culture and agency are separated and pitted against one another in many descriptions of the demographic transition. Some writers suggest that this is a far too simplistic understanding of agency (Cater, 1995) and that agency is less of a one time event and more of a continuous process (Cater, 1995). Decisions are made at various points in this process and in the context of multiple sets of goals and concerns. This complex view of agency was used in this analysis; we treat agency not as a dichotomous variable of agency or lack of agency, but as a factor that affects decision making at multiple points within the larger context of discussions and explanations of unintended pregnancy

Many factors that arise from the gender norms and practices in Rakai not only place women at increased risk of HIV but also shape how they and their partners view fertility and pregnancy. The theoretical model includes the influence of gender norms on the entire process of understanding and discussing unintended pregnancy from the individual, interpersonal, and organizational influences to the exertion of agency or the lack of control regarding pregnancy decisions and outcomes. Focusing on the context and rationality behind men and women's actions allows a more accurate understanding of culture—this incorporates the reality of people's social worlds as fluid and multidimensional spaces, not as static and apolitical (Hirsch et al., 2009). It was vital to this analysis to examine how the influence of gender and high HIV prevalence affected the discussion of experiences with unintended pregnancy among females and males in couples in Rakai.

Methods

Setting

The data for the Linkages project was collected as part of a large cohort study in Rakai, Uganda (the Rakai Community Cohort Study or RCCS). The goal of the Linkages project (begun in 2012) was to explore the intersection of sexual and reproductive health and HIV infection and to identify mechanisms by which reproductive goals for men and women are realized within the context of considerable sexual transmission of HIV. The methods of the RCCS have been described in detail elsewhere (Sewankambo, 1994).

The data for this qualitative study of Linkages project came from in-depth interviews with xx seroconcordant (both HIV-positive or both negative) or XX serodiscordant couples completed in 2013. Couples were purposively identified from the RCCS. based on sero-status and were invited to be interviewed in the Linkages qualitative study. For this analysis, only couples where either the male, the female, or both identified a pregnancy as unintended were deemed eligible. Therefore, our sample included 24 interviews—12 with males and 12

with females. Eight of the couples in this analysis were serodiscordant and four were seroconcordant. The participants were all between 15–49 years old. Figure 2 shows this breakdown of couples included, as well as their serostatus and agreement or disagreement around an unintended pregnancy.

Institutional Review Board and Human Subjects

Institutional review boards in Uganda (the Research and Ethics Committee of the Viral Research Institute) and the United States (Western IRB and the IRB for Columbia University) approved the protocol and consent process. Because of the stigma of HIV in the community, potential participants were told that researchers were interested in goals about children, contraceptive use, and access of reproductive health and HIV/AIDS services in Uganda. To protect the participants, the consent forms did not discuss the sampling based on HIV serostatus, as the interviewers did not know the HIV status of the individuals and it was not the focus of the interviews. Only the qualitative researchers at the involved institutions (Columbia University and Rakai Health Sciences Program) had access to their HIV status. Interviewers were trained in protection of human subjects and protecting privacy. Participants received 5,000 Ugandan Shillings (about US \$2.00) to compensate participants for their time. Informed consent with written documentation (or a finger print if unable to write) was obtained from all research participants. If the participant was under 18 but were married or did not live with a parent they were treated as an emancipated minor and were asked to provide consent. Adolescents (15–17) who did live with a parent/guardian were asked to provide assent and consent was sought from parents or guardians.

Data Collection

The field guide was created and a team of trained interviewers were hired by RHSP. The field guide covered questions regarding fertility desire, pregnancy, HIV testing, disclosure and risk, contraceptive use, and relationship context. The main section of the transcript we examined was the question that asked directly about unintended pregnancy—“Were there times when you or your partner had a pregnancy that you did not want”. If the male or female answered yes, they would be asked further questions including how they reacted, how their partner reacted, what they decided to do about the pregnancy and who decided what to do. The data for this project were semi-structured in-depth interviews. Interviews were done by same sex interviewers, in private locations. Interviews were done in the native language of Luganda and were translated into English afterward. The interviews ranged in length from 45–90 minutes. The qualitative lead researcher at RHSP maintained the master list of potential respondents and the interviewers were blinded to the HIV status of all participants. RHSP interviewers were trained in protecting confidentiality while interviewing participants, especially when one member of the couple is HIV positive.

Data Analysis

The interviews were translated into English and summary statements were provided for each interview. The data were uploaded to Dedoose and coded and analyzed within this platform. Thematic analysis was used to analyze the data. There was also additional information available for each couple including the length of their relationship, how many children they have, and their HIV status. In order to leverage the uniqueness of this data, the data gives the

perspective of both the male and the female in a dyad. This structure allows certain themes to be highlighted, namely relationship dynamics and the differences/similarities between couples who are in agreement and those who are not in agreement.

The conceptual framework presented in the introduction to this paper was developed and acted as the basis for the creation of the codebook and framed the analysis. The parent codes in the codebook corresponded to the major sections of the conceptual framework. There were two additional parent codes for other aspects of the conceptual framework: agency and pregnancy outcome. Under the parent codes for the different levels of the social-ecological framework, there were many child codes—such as partner demographics, child spacing and personal reactions.

Data were then analyzed using the dyads and comparing what was said in the female versus male interviews for both couples where there was agreement around the experience of an unintended pregnancy and disagreement about the incidence of an unintended pregnancy.

Reliability and Validity

Intercoder agreement was tested with a second researcher who was familiar with the data and is a co-author on this paper. All disagreements were discussed and the main coder went back to the codebook to clarify definitions more clearly before finalizing the coding of the remaining transcripts.

Results

Of the 41 couples (82 interviews), in 12 couples either the man or the woman reported an unintended pregnancy. These were the 24 interviews that used for this analysis. Out of these 12 couples, only 3 couples were in agreement regarding the circumstance of having an unintended pregnancy. In the remaining 8 couples, 7 of the woman reported an unintended pregnancy while their male partner did not, and 1 couple had the man report an unintended pregnancy instead of the wife.

The analytic themes discussed throughout the analysis connect directly to the conceptual framework described earlier in the paper. The first section of the results explores agency as it was a force that was an overarching influence for both men and women in their discussion of unintended pregnancy and overlapped with the other themes presented. After an exploration of the influence of agency, the analysis moves to an exploration of common disagreement among couples around unintended pregnancy and the individual, interpersonal, and organizational level factors present in the socio-ecological model corresponding to the conceptual framework.

Issues of agency:

Issues of agency or lack of agency were often invoked by men and women in how they represent and perceive their experiences with unintended pregnancy. Agency, or often lack of agency, permeated discussions of contraceptive use, personal reactions to unintended pregnancy, as well as awareness of partner's fertility desires. A lack of agency or control was shown in reaction to an unintended pregnancy in multiple ways—both that the

pregnancy was out of their control (they were unable to prevent the pregnancy), and that once they found out they were pregnant there was nothing for them to do (they had no choice but to continue the pregnancy). For example, in one couple the male and female both discussed agency but in very different ways. This couple already had four children together, the male was 45 and female was 37 and they were both HIV positive. The female stated

“I did not want to get that pregnancy of my fourth child because the third born which this fourth born was following was very young and he was only three months old when I became pregnant for the fourth child with this partner of mine. I was not expecting to become pregnant at that time because my third born was still young but I had nothing to do and I had to continue with the pregnancy (Female, 37, HIV +)

Her partner, however, stated:

No. Before she becomes pregnant we sit and agree that we get a child. You can also see all our children are spaced properly. Whenever she becomes pregnant it is a wanted pregnancy. (Male, 45, HIV+)

These two responses from a man and woman in the same couple show striking differences in the perception of agency. The female lacked a sense of autonomy to be able to prevent the pregnancy in the first place but then also cited a lack of having any options once she became pregnant. The male partner asserted that each pregnancy was planned and assumed complete agency in each pregnancy. These two contradictory statements also demonstrate a lack of effective communication regarding family planning and ideal child spacing.

In some ways agency or control was used as a mechanism for blame. In another couple the man ascribed agency to his partner—agency that she very well may not have. In this case there was a large age gap in the couple (he was 48 and she was 38), the couple already had 4 children together (the male also had 3 additional children with another partner) and she was currently pregnant. He stated:

“It is usually her choice to abandon birth control and become pregnant. It was an accident that she failed to control (prevent) this pregnancy she is carrying” (Male, 48, HIV-).

In this way, the responsibility of pregnancy prevention is placed solely on the woman, even if she does not have the resources or ability to prevent pregnancy. The female in this couple seemed to assume this responsibility after the unintended pregnancy and exerted agency by saying that in the future she would prevent unintended pregnancy from occurring again:

“I am more than ready this time to ensure that I don’t get pregnant again. I have come to know the birth control methods that are effective and those that are not effective. So I now know a birth control method that cannot disappoint me and that which can work” (Female, 38, HIV+).

Lack of control or agency was often cited in the reaction to the pregnancy and also in terms of the outcome—many women felt they had no options once they found out they were pregnant. A female in another couple discussed a lack of options available to her and a fear of abortion (a procedure that is illegal and largely unavailable in Uganda). This couple was

33 (female) and 30 (male), had more than 4 children together and were serodiscordant (female positive; male negative).

“There is nothing I did when I had that pregnancy that I did not want. My friends advised me to abort it but I refused and I said that I might die during the process. I therefore had to continue with the pregnancy and I said that once I have produced my baby, I would go very fast and start using birth control methods” (Female, 33, HIV +).

This female’s partner had strong feelings about contraception and her partner’s refusal to use condoms due to feeling the condoms were being used to control him. He stated:

“They have to control the wife and not me. I cannot stop to have children, it should be the woman. I assure you I cannot permanently stop to have children. It should be the woman. Whether “family” works for 8 years or more, that is it. As long as we are together and it expires then we have a child”(Male, 30, HIV-)

Agreement/Disagreement Around Unintended Pregnancy:

The analysis of these transcripts was set up to explore differences and similarities within and between couples for whom there was agreement versus disagreement around experiencing an unintended pregnancy in how they discussed individual, interpersonal and structural factors affecting their fertility decisions. However, there were no clear distinctions between couples who agreed about unintended pregnancy and those that disagreed about unintended pregnancy; in fact, there was a lack of communication around fertility and pregnancy among all couples. The following section of the analysis explores the way men and women in couples discuss the impact of these intersecting influences on their fertility desires and experiences.

Individual Level Influences:

There was only one instance of which a man discussed an experience of an unintended pregnancy and his female partner did not mention a pregnancy being unintended. In this case, the male was 33 and HIV negative and female was 28 and HIV positive. The male stated: “I had drunk alcohol and had live sex with her an “accident” came and she became pregnant” (Male, 33, HIV-). This male went on to say that the reason he did not want her to get pregnant was because of her HIV status, “I replied to her that now she is HIV positive if she got pregnant, things would not be good. I further explained to her that if she got pregnant I would become uncomfortable because I no longer want to have a child”(Male, 33, HIV-). Interestingly, there was never a case when a female cited a demographic factor of her male partner as a reason for an unwanted pregnancy, although a demographic factor of the female was often cited (both by males and females) as reason for an unintended pregnancy.

Child-spacing was often invoked as an individual-level reason a pregnancy was considered to be unintended. One female stated:

“I got a pregnancy that I did not want and this was the pregnancy of my second born because my first born was still young and by that time I did not know anything about birth control methods because I was still young”(Female, 31, HIV-)

Her partner who was 43 and also HIV negative reported that he had never experienced an unintended pregnancy, and they had four children together.

Even among couples where there was agreement around unintended pregnancy, child-spacing was often invoked as the reason why it was unintended. In a serodiscordant couple (female positive) with two children together the male (age 30) and female (age 33) the female in the couple stated:

“My first born with him was still young and I became pregnant very fast for my second child with my current husband” (Female, 33, HIV+)

and her male partner stated:

“We say, our children are still young we need to space them. It is not good to have them not spaced. One child is 2 years and the one following is 7 months. If we have children in that order for 10 years, what would happen?” (Male, 30, HIV-).

Interpersonal Level Factors - Awareness of Partner Fertility Desires—The dyadic analysis also helped uncover an important interpersonal factor that was not originally in the conceptual framework—the impact of the awareness of partner fertility desires. We were especially interested in examining this theme within the couples where there was disagreement surrounding unintended pregnancy. One prominent example of this was within a couple where the female stated that they had an unintended pregnancy and the male stated that they did not. The male in this couple was 45 and the female was 37, they had 4 children together and were both HIV positive. Although the male stated that he did not experience an unintended pregnancy, he was aware that his female partner did not want any more children—making it a more ambivalent or unclear situation. When asked about his partner’s fertility desires he responded:

“I know she wants no more children but I am also trying my best to convince her to get me three more children. I do not want to have children with other women. If I fail to convince her about this I will give up and go by her decision. But she has only six. I feel she can be able to produce more children. My mother produced ten children and she told me her mother had twelve children. I am sure she can have more children...I told her I want three more children with her but she did not approve my suggestion saying she already have enough children. I tried to show to her that her first two children are old enough and do not need more support (care) from her but she insists she needs no more children” (Male, 45, HIV+).

This male’s female partner did not know the exact number of children he wanted to have, but did know that he wanted more children, she said:

“He has no actual number of children he wants to have with me because even now he wants a baby. I cannot give you a rough figure of how Many children he wants to have with me” (Female, 37, HIV+).

There was a clear disconnect between the male and female in this partnership, even though they said they had open conversations and did not argue about children.

Other couples also expressed that they were unsure of their partner's fertility desire. One sero-discordant couple where the male was age 29 and HIV+ and the female was 32 and HIV-, the male was asked if he knew his female partner's desire for children and he responded, "I do not know, you know I have never talked about it with her"(Male, 29, HIV +).

Although in most cases there was poor communication and lack of knowledge of the partner's fertility desire, there were a few cases where this was not the case. For example, in one couple where the female was 23 and male was 26 and they were serodiscordant (male positive), they had a clear discussion of fertility desires and reached an agreement. When asked if the male partner knew how many children she wanted he said:

"She also wants six children...she told me she wanted eight children and I told her things are no longer easy like they were in the past. I explained to her everything is expensive these days. She also changed her mind and accepted to produce children"(Male, 26, HIV+).

Structural Level Influences - HIV and Gender Norms

HIV did have an impact on unintended pregnancy—but not necessarily for the most obvious reasons. HIV tended to appear as a factor in unintended pregnancy when one member of the couple was afraid of contracting HIV from their partner, but did not appear in the common biomedical understandings of fear of transmission to the baby or fear of early death preventing a couple from wanting a pregnancy. In one serodiscordant couple (female positive), the male was 43 and female was 36, they had 5 children together and lived in a rural area. When asked if he and his partner had experienced an unintended pregnancy, the male partner explained that he viewed their last pregnancy as unintended because:

"We had discordant HIV test results and this made me get worried and thought that maybe I had acquired HIV and thought the test results to come next would be different. However, it is now 3 years, okay it is about 4 years and the results are okay" (Male, 43, HIV-)

This male viewed the pregnancy as unintended because he had not intended to have sex without protection as his partner was HIV+ and he was HIV-. This quote comes from the only couple in the data where the male stated there was an unintended pregnancy and the female did not. There is no quote included from the female partner, as she did not discuss any experience with unintended pregnancy.

Discussion

The main aim of this analysis was to explore perspectives of unintended pregnancy among men and women in co-habiting couples in Rakai, Uganda. We wanted to understand the impact of sero-status and couple agreement or disagreement regarding experiencing an unintended pregnancy on discussions of fertility. Through a thematic analysis we examined individual, interpersonal and structural/organizational factors that impact the way men and women separately describe their experiences or lack of experiences with unintended pregnancy. The most common individual factor cited by participants as a reason they considered a pregnancy to be unintended was less than ideal child-spacing. At the inter-

personal level, awareness (or more commonly, lack of awareness) of partner fertility desires led to many disagreements about the intendedness of past pregnancies. Finally, at the structural level, we wanted to explore the influence of HIV and seroconcordance or discordance on pregnancy intendedness. It was not common for participants to cite a fear of HIV transmission to the child as a reason why a pregnancy was unintended, but more common for participants to classify a pregnancy as unintended when they had unprotected sex with an HIV + partner and were afraid of contracting HIV.

One of the most common explanations for why a pregnancy was unintended in this paper was child-spacing—in that, the pregnancy in question was too close to the birth of their last child. Other research has shown that poor child spacing has negative outcomes for both mothers and children (Conde-Agudelo et al., 2012). If child-spacing is a driver of unintended pregnancy in this community, this could potentially be a target for intervention regarding unmet need for contraception and increased knowledge and access postpartum.

The lack of awareness of fertility desires stemmed from what appeared to be a lack of communication more broadly between many couples in this context. The importance of partner communication has been cited as a protective factor for HIV risk. A study by van der Straten and colleagues found that couple communication was associated with condom use, when that communication was specifically related to sexually transmitted disease risk and risk for HIV (Van der Straten et al., 1995). Our study found a real lack of communication around fertility desire and overall a large amount of disagreement around discussions of unintended pregnancy, HIV status and fertility desires. Not much literature exists that is couple specific; therefore, this paper adds a unique vantage point. The overarching concept that was found throughout the analysis is the issue of agency and the complex spectrum of control to lack of control referred to by both females and their male partners. Often in the literature, agency is presented very one-dimensionally and as if women are always lacking agency and men are always claiming it. It is often assumed in demographic literature that fertility declines when education increases and that choices are always ‘rational’ (Cater, 1995). However, this qualitative data of both men and women demonstrate that agency and feelings of control or lack of control are not one-dimensional. Both men and women assert agency at different times and both also describe lack of agency, although often for different ends. For example, it was common for a female to state there was nothing she could do about the outcome of the pregnancy once she found out she was pregnant, whereas men on multiple occasions stated the lack of agency not in reference to the outcome of the pregnancy but in the female getting pregnant in the first place. This lead to a potential explanation that men and women generally find it to be the women’s responsibility to not get pregnant and the man’s responsibility to decide or help decide what to do if she does get pregnant. Understanding this perception of agency may be helpful in interventions aimed at targeting conscious family planning practices. These findings are in line with previous research in sub-Saharan Africa that similarly demonstrate a lack of direct communication between females and males about contraception and family planning and the male dominated reproductive decision making (Harrington, 2014).

Quantitative studies of unintended pregnancy often describe multiple categories or classifications of unintended pregnancies – mistimed, unwanted, or ambivalent (Gipson,

2008). This qualitative exploration of understandings and discussion of unintended pregnancy confirmed the importance of having a nuanced understanding of unintended pregnancy. While participants did not generally use these exact terms, they described situations that fit within these large categories. There were many instances where one member of the couple classified the pregnancy one way and the other classified it either as intended or had a different explanation for why the pregnancy was unintended. Further research should capture both female and male classifications in quantitative research in order to understand different predictors for men and women and how men and women influence one another. An innovation of this study was that we were able to examine men and women in couples and look at the influence of their partner on their own reactions.

Limitations

There are some limitations to this qualitative study. These limitations include there being a single primary analyst, although there was supervision and the primary analyst worked with a partner who was also familiar with the data. While this research question was not a primary aim of the study, the interview guide did include a question about unintended pregnancy and the dyadic analysis set up was conducive to this research question. This question was limited in scope and further research should ask more nuanced questions about unintended pregnancy that will allow for a deeper understanding of this experience for men and women in this context. There were also a limited number of couples that reported agreeing upon an unintended pregnancy (4 couples agreed and 8 disagreed). The translation and back translation of the transcripts may have introduced some bias as translations don't always capture the participant's exact inflection, intention, or meaning.

Implications and Further Research

These findings have important implications for the community. They provide a more in-depth understanding of how men and women discuss unintended pregnancy in the context of Rakai, Uganda. Men and women in couples discussed their experiences of unintended pregnancy in ways that map on to the quantitative understanding of unwanted, mistimed, or ambivalent. However, we found a lack of communication between partners about fertility desire, HIV risk, and pregnancy intendedness. Further research should be done on partner communication and agreement/disagreement around major topics in relationships in this context in order to help inform couple-level interventions around pregnancy, child spacing, and risk of HIV. It is important that partner communication is addressed in family planning interventions in order to address this gap.

Although these findings are not generalizable, the method of dyadic analysis can be used in other contexts. Having the power in a qualitative study to examine two members of a dyad provided further insight into communication between partners and highlighted how important partner work is in any intervention. Future research should duplicate the dyadic analysis to understand factors affecting men's and women's experiences with unintended pregnancy elsewhere and can even expand to understanding fertility desire and other partner and relationship questions. Public health research and interventions aimed at sexual and reproductive health should not only focus on women as these results among others demonstrate the influence of the male partner as well.

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Figure 1.
Conceptual Framework for Understanding Couple Decision Making and Perspectives on Unintended Pregnancy in Rakai, Uganda

Couple Number	Male report of unintended pregnancy	Female report of unintended pregnancy	Seroconcordant or discordant
1	No	Yes	Serodiscordant (female positive, male negative)
2	Yes	No	Serodiscordant (female positive, male negative)
9	No	Yes	Seroconcordant (both negative)
10	No	Yes	Serodiscordant (female negative, male positive)
11	No	Yes	Seroconcordant (both positive)
21	No	Yes	Seroconcordant (both negative)
24	No	Yes	Seroconcordant (both negative)
25	No	Yes	Serodiscordant (female positive, male negative)
32	Yes	Yes	Serodiscordant (female negative, male positive)
37	No	Yes	Serodiscordant (female negative, male positive)
39	Yes	Yes	Serodiscordant (female positive, male negative)
41	Yes	Yes	Serodiscordant (female positive, male negative)

Figure 2.
Sampling Frame and Couple Characteristics Used to Understand Couple Decision Making and Perspectives on Unintended Pregnancy in Rakai, Uganda