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# Childbearing motivations and pregnancy desires among urban female youth: Does HIV-infection status make a difference?

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## Abstract

Despite a growing literature assessing pregnancy desires among HIV-infected women enrolled in clinical care, little attention has been paid to HIV-infected youth for whom pregnancy is a very relevant issue. In urban areas with high rates of teen pregnancy and HIV infection, further understanding of childbearing motivations and relationship dynamics influencing pregnancy desires among female youth is needed. This study compares the childbearing motivations, pregnancy desires, and perceived partner desire for a pregnancy among predominately African American HIV-infected (n=46) and HIV-uninfected (n=355) female youth (15-24 years). An HIV-infected status was not significantly associated with childbearing motivations or the desire for a future pregnancy, p> 0.10. HIV-infection was, however, associated with an increased likelihood to perceive that one's partner would have a *positive* response to a pregnancy (OR 2.7, p=0.03) compared to uninfected peers. While race was not associated with participants' own desire for a child, white youth were significantly less likely to perceive a positive partner response to becoming pregnant than their African American peers (aOR 0.23 (.09-.56), p=0.001). These data suggest that the desire for childbearing is not diminished by HIV infection among urban female youth, highlighting the need for routine, provider-initiated discussions about childbearing with urban youth to minimized unintended pregnancies and HIV transmission.

### Keywords

childbearing motivations; pregnancy desires; pregnancy intentions; perceived partner desire; urban adolescents and youth; HIV; African-American

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## Introduction

Adolescent girls in the United States have disproportionate rates of unintended pregnancy and HIV infection compared with their peers in other industrialized countries (CDC, 2007; Darroch, Singh, Frost et al. 2001). Eighty percent of teen pregnancies are reported as unintended (Chandra, Martinez, Mosher, et al. 2005). Rates of sexually transmitted infections (STI) and HIV infection have increased among adolescents (Hall, Song, Rhodes, et al. 2008; Weinstock, Berman, Cates, 2004). African American adolescent females disproportionally represent those experiencing these two public health challenges of teen pregnancy and HIV infection (Alan Guttmacher Institute, 2006; CDC, 2006).

Positive childbearing motivations (e.g. to experience motherhood or to share a child with partner) have been significantly associated with intentions to have children among women of reproductive age (Miller, 1994; Miller & Pasta, 1999; Siegel & Scrimshaw, 2001; Sowell, Murdaugh, Addy et al. 2002). Rarely, however, have childbearing motivations been directly compared by HIV infection status. Recent studies document fertility desires among women living with HIV in the US and globally (Finocchario-Kessler, Sweat, Dariotis et al. 2010; Nattabi, Thompson, Orach et al 2009, Stanwood, Cohn, Heiser Pugliese, 2007; Cooper D, Moodley J, Zweigenthal V et al. 2009), however; they focuses primarily on adult women. Few studies document pregnancy desires among HIV-infected youth. To our knowledge, no studies have compared childbearing motivations and pregnancy desires of HIV-infected youth to those of uninfected youth.

Given the shifting perspective of HIV as a treatable illness, infected youth may perceive fewer medical and stigma-related barriers to future childbearing. Furthermore, mounting evidence highlights the influence of partner dynamics on inconsistent condom use (Manning, Flanigan, Giordanco, Longmore, 2009), partner concurrency (Kerrigan, Andrionopoulos, Chung, Glass, Ellen, 2008), and increased desire for pregnancy (Crosby, DiClemente, Wingood et al. 2001; Davies, DiClemente, Wingood et al. 2003) among female adolescents. Given the importance of childbearing and the frequency of unplanned pregnancies among adolescents, it is important that all youth, but particularly those living with HIV, understand the importance of planning pregnancy—to protect their own health, that of their partner, and future child. Better understanding of childbearing motivations and desires among HIV-infected and at risk youth will inform interventions to reduce unplanned pregnancies among this population.

The purpose of this report is to compare childbearing motivations, pregnancy desires, and perceived partner desire for a child between HIV-infected and HIV-uninfected urban youth. We use the term youth in this study to include female participants between 15-24 years of age. Given the improved prognosis for living with HIV, we hypothesize that childbearing motivations and pregnancy desires will not vary significantly as a function of HIV infection status among female youth. We hypothesize perceived partner desire for a pregnancy will have a *higher* association with pregnancy desires among HIV-uninfected female youth relative to their HIV-infected peers given the potential risks and complications of pregnancy for HIV-infected female youth.

## Methods

### Study setting

This study was conducted in Baltimore, which has an HIV prevalence rate of 2.5% (Maryland AIDS Administration, 2007), five times higher than the national prevalence rate (CDC, 2008; US Census Bureau, 2006). Nearly 40% of incident HIV infections are among women; approximately 75% of whom are of childbearing age (15-44 years)(Maryland AIDS Administration, 2007). The neighborhoods surrounding the research clinics are more than 95% African American and experience high unemployment (Baltimore City Data Alliance, 2007; Baltimore Neighborhood Indicator Alliance, 2007). The birth rate among adolescents (15-19 years) in this setting is 1.6 times higher than the national average (Dixon & Sharfstein, 2008).

### Participants

We used two data sources for this study from the same urban setting. One was a representative urban probability-based sample of adolescents and adults (Neighborhood Influences on Adolescent and Adult Health - NIAAH) in an urban setting. The NIAAH study was conducted from April 2004 to April 2007 and inclusion criteria included English-speaking, sexually-active persons between the ages of 15 and 24 years who resided in 65 selected census block groups randomly selected among those with the highest STI prevalence. Detail regarding the sampling strategy is available for review (Jennings, Taylor, Iannacchione et al. 2010). From this household survey data we limited our analyses to all females between 15-24 years (n=367). All participants were sexually experienced and nearly all were HIV-uninfected (n=355); with the exception of 12 HIV-infected female participants.

Because the number of HIV-infected youth from the population-based survey was so low, and in order to identify HIV infected youth from the same community, we recruited patients from one of the few clinic-based Ryan White funded programs for HIV infected youth in the city. A convenience sample of HIV-infected women of reproductive age was surveyed about childbearing between August 2007 and April 2008. 181 HIV-infected women age 15 to 44 years were recruited from clinic settings to participate in a survey. From this clinic-based sample we limited our analyses to data from 15 to 24 year old HIV-infected (perinatally and behaviorally-acquired HIV), sexually-experienced female youth receiving clinical care (N=34). We combined the 12 HIV-infected female youth from the NIAAH survey with the 34 HIV-infected female youth from the clinic-based survey to comprise a total sample of 46 HIV-infected female youth

## Procedures

For the NIAAH survey parental/guardian informed consent and adolescent informed assent for participants under age 18 and informed consent for participants ages 18 years or older was collected at the time of the household survey. Trained research assistants administered an audio computerized-assisted self-interview (ACASI) in a private setting. Among other topics, the ACASI included questions about sexual and pregnancy history, sexual risk

behaviors, and attitudes about pregnancy. Oral swab specimens were collected for HIV-1 antibody testing using OraSure®, sensitivity of >99.2% and specificity >99.8% (OraSure Technologies). Depending on their year of enrollment, participants received between $25-$45 remuneration.

The clinic based sample participants completed an ACASI questionnaire assessing fertility desires and intentions, reproductive history, communication with HIV provider regarding childbearing plans, and contraceptive use. Study participants were recruited from two urban health clinics in the same neighborhood: a designated HIV clinic for adults 18 years and older, and a general medicine adolescent clinic serving patients up to age 24. Inclusion criteria included female youth who were not currently pregnant, had not had a hysterectomy, were sexually experienced and currently enrolled as a patient at the clinic. Participants were either referred to the study by their HIV provider, clinic fliers or at the fully designated HIV clinic, participants were approached by research staff in the waiting room. A $15 gift card was provided as remuneration. Additional detail regarding clinic setting and recruitment procedures are available for review (Finocchario-Kessler, Sweat, Dariotis et al. 2010). All study protocols were approved by Institutional Review Boards.

## Measures

To allow comparability, data collection methods and measures used in the clinic-based sample nearly paralleled those used for the NIAAH survey. Below we describe the measures and scales of interest.

**Childbearing motivations scale—**As part of the NIAAH study, Miller's Childbearing Motivation Scale (Miller, 1995) was adapted for use among urban female youth and demonstrated high internal consistency (Cronbach's alphas= 0.94 for positive and 0.85 for negative childbearing motivations), (M. Trent MD, written communication, May 2007). The 46-item adapted scale measured positive (e.g., “To have a child I can love and protect”) and negative (e.g., “The pain and discomfort of pregnancy”) childbearing motivations using a 4-point Likert scale indicating the degree to which a motivation was either negative or positive. A positive childbearing motivations (PCM) score was created by averaging 29-item responses with higher scores denoting more positive motivations. A negative childbearing motivations (NCM) score was created by averaging a different set of 17-item responses with higher scores denoting more negative motivations. The reliability statistics for HIV-infected and HIV-uninfected female youth were the same and very high: Cronbach's alpha for PCM (0.96) and NCM (0.92).

**Future pregnancy desires—**Future pregnancy desires were assessed among HIV-*un*infected female youth according to their response to the following statement, “I would like to have children someday.” Those who replied “strongly agree” or “agree” were coded as desiring a future pregnancy. HIV-*in*fected female youth were asked how many children they would like to have in the future. Responses greater than zero were coded as desiring a future pregnancy.

**Perceived partner desire for pregnancy—**Female youth in both groups were asked "How would your partner feel if you became pregnant?" Based on the bimodal distribution of the responses to the four-point Likert scale, responses in both groups were recoded as a dichotomy: happy verses unhappy for HIV-uninfected female youth and excited verses not excited for HIV-infected female youth. The responses "excited" and "happy" were treated as analogous in analyses; similarly "not excited" and "not happy" were treated as analogous.

### Statistical analysis

To compare the two samples we conducted bivariate analyses with Pearson's chi-square to compare proportions and t-tests to compare sample means. We conducted bivariate and multivariate linear and logistic regression analyses to identify predictors of childbearing motivations, future pregnancy desires, and perceived partner desire for a child. The multivariate regressions adjusted for a priori potential confounders including age, parity, race and relationship status to determine the association between HIV-infection status and the primary study outcomes.

## Results

### Sample characteristics

The participants in both groups were predominately African American, heterosexual female youth between 15-24 years (Table 1). The mean age of youth in both samples was nearly the same (19.5 years (sd=2.6) HIV-uninfected and 19.9 years (sd=2.7) HIV-infected). HIV-infected female youth were significantly more likely to live with their partner than uninfected peers.

### Fertility and contraception

Over half of female youth in each group experienced at least one pregnancy. HIV-uninfected youth were more likely to carry pregnancies to term compared to infected peers, with 41% and 35% respectively experiencing a birth. All participants included in the formal analyses had initiated sexual intercourse. Consistent condom use with primary partner was low; 24% among uninfected and 30% among HIV-infected female youth. Similar proportions were reported for hormonal contraceptive use including the pill, Depo Provera or the patch.

### HIV-related characteristics

Among HIV-infected youth recruited from the clinic setting (n=34), 44% were perinatally infected, living with HIV since birth. While some behaviorally-infected youth had not yet initiated highly active antiretroviral therapy (HAART) due to sufficiently high CD4 cell counts, 53% (n=18) of participants were currently on HAART among whom 28% had an undetectable viral load. A majority of participant (78%) reported an HIV-uninfected sexual partner.

### Childbearing motivations

Positive childbearing motivation mean scores were nearly equal between infected and uninfected female youth (3.23 vs. 3.28, p=.42); Table 2. In bivariate linear regression,

childlessness and perceived partner desire for a child were significantly associated with positive childbearing motivations, Table 3. In multivariate linear regression only perceived partner desire for a child retained statistical significance (β= 0.27, p=0.001).

Negative childbearing motivations did differ significantly by HIV-infection status, with HIV-infected youth reporting lower mean scores for negative aspects of childbearing compared to HIV-uninfected female youth (2.12 vs. 2.40, p=0.02). Both HIV-infected status and perceived partner desire for a child were negatively associated with NCM in bivariate regression analysis (p<0.05). In multivariate analysis, however; HIV positive status was the only variable at least marginally associated with NCM (β= ⁻0.30, p=0.06).

### Pregnancy desires

Future pregnancy desires did not differ significantly among female youth according to HIV infection status (Table 2). Childlessness and perceived partner desire for a child were positively associated with future pregnancy desires in both bivariate and multivariate logistic regression (p<0.05), Table 4. Female youth without a child were over three times as likely to want a child in the future (aOR 3.32, 95%CI1.5-7.2, p< 0.01), while those with higher PCM and those who perceived their partner wanted a child were twice as likely to want a future pregnancy (aOR 2.19, 95% CI 1.4-3.4, p=0.001 and aOR 2.24, 95% CI 1.1-4.6,p <0.05), respectively. HIV-infection status was not significantly associated with future pregnancy desires among urban youth.

### Perceived partner desire for pregnancy

The majority of female youth reported that becoming pregnant would please their partner. Significantly more HIV-infected youth thought their partner would be somewhat to very excited about a pregnancy compared to HIV-uninfected peers (83% vs. 65%, p<0.05), Table 2. The variables described below were significantly associated with perceived partner desire for a child in both bivariate and multivariate analyses. Table 5. White youth were 77% less likely to think their partner wanted a child compared to African American peers (aOR 0.23,95% CI 0.09-0.56), p=0.001). Higher PCM and future pregnancy desires were both positively associated with the likelihood of thinking your partner would like to have a child (aOR 1.61,95% CI 1.1-2.4, p<0.05 and aOR 2.25,95% CI 1.1-4.6, p=<0.05), respectively. For this outcome, HIV infection status was a significant predictor, as HIV-infected youth were 3.5 times more likely to think their partner wanted a child compared to uninfected peers (aOR 3.52, 95% CI 1.2-10.4,p< 0.05).

## Discussion

Two major findings emerged from this research. First, we found there are no differences in positive childbearing motivations and pregnancy desires among urban female youth by HIV-infection status. Second, and contrary to our expectations, we found HIV-infected adolescent females were *more* likely to report positive partner reactions to a future pregnancy compared to their uninfected peers. Furthermore, negative childbearing motivations were marginally *lower* among HIV-infected female youth, suggesting aspects of pregnancy - such as discomforts of childbirth and opportunity costs associated with having a

child – are not reported as negatively as by their HIV-uninfected peers. The considered variables, however, accounted for a very minimal portion of the variance attributed to positive and negative childbearing motivations.

These findings suggest that HIV infection status does not deter urban adolescent women from wanting a pregnancy and motherhood. Advances in medical treatment of HIV allow young women to live longer and healthier lives (Lohse, Hansen, Pedersen et al. 2007), and have dramatically reduced the risk of mother-to-child transmission (Cooper, Charurat, Mofenson et al. 2002). The attitudes and options of young women living with HIV today are in marked contrast to those of HIV-infected women in past cohorts who were advised not to become pregnant, and those already pregnant advised of termination options (Kass, 1994).

The high priority placed on future childbearing expressed by many urban at-risk adolescents (Trent, Millstein, Ellen, 2006) and African American women (Finocchario-Kessler, Sweat, Dariotis et al. 2010) may diminish concerns regarding the negative aspects of childbearing, and may also result in the projection of their own desire for a child on to their partner (Miller, 1981). It is possible that many HIV-infected female youth inflated their partner's positive reaction to a pregnancy because this reflected their own strong desire to have a child. While race was not significantly associated with participants' own pregnancy desires it was associated with how they perceived their partner's desires for a child. African American female youth were much more likely to perceive a positive partner response to pregnancy than their Caucasian peers. This is consistent with considerably higher pregnancy rates among African American youth (Alan Guttmacher Institute, 2006; CDC, 2006). Among female urban adolescents and youth, stronger adherence to gender ideologies related to emotional strength and caretaking may be linked to a heightened desire for male intimacy and tolerance of male sexual risk behavior (Kerrigan, Andrinopoulos, Johnson et al. 2007). Potential stigma and discrimination experienced by HIV-infected female youth may heighten this need for acceptance and intimacy from male partners, or future children.

## Implications for HIV prevention

Regardless of HIV-infection status, the desire for future childbearing among female youth in this urban setting is high. While most young women want to have children, they likely also have competing interests of finishing school and getting a job, which are important developmental milestones in adolescence (Muus, 1996). Increased use of condoms and secondary means of contraception are needed among this group to reduce mistimed pregnancies, prevent STIs and HIV, and increase the odds of educational and vocational attainment among urban female youth

These findings highlight the importance of open dialogue about pregnancy desires, family planning, and partner-related issues with female youth. Such conversations need to occur early given the majority of all female youth had experienced a previous pregnancy at the time of this study. Thus emphasizing the importance of provider-initiated discussions during routine health care and family planning services, particularly as discussing topics related to sexuality may be difficult with parents. By talking openly about the pros and cons of becoming pregnant, providers can encourage girls to think through the realities of such a decision and facilitate convenient access to contraceptives. Female youth with strong

pregnancy desires, particularly those living with HIV, need preconception counseling to evaluate this decision and minimize transmission risks to partners and infants. Such counseling is particularly important given the challenge of achieving and maintaining viral suppression among adolescents (Ding, Wilson, Modiarrad, et al., 2009), particularly among those infected since birth (Thurston IB, 2011), as evidenced in our sample.

## Limitations and strengths

The findings from this study must be considered in light of several limitations. This study occurred among female youth in a single urban community with limited racial diversity. While this may reduce generalizability to other dissimilar communities, the noted health disparities in teen pregnancy and HIV (Alan Guttmacher Institute, 2006; CDC, 2006) warrant study among this population. Because only a small number of HIV-infected youth were identified in the population-based sample, a clinic-based sample was needed to safely identify HIV-infected youth for contrast, requiring two different sampling methodologies. Limited by the lack of data regarding income and education, we acknowledge potential sociodemographic differences between samples may exist; however, the populations are technically drawn from the same community and so are comparable. While minor differences in survey items may have contributed to measurement error, we used the same childbearing motivation scale and ACASI method of data collection, for each group of female youth. Finally, males were not included in the study and partner data is not available to substantiate the perception of partner's feelings. This is, however, one of the few studies to compare childbearing motivations and pregnancy desires among adolescent girls based on HIV infection status.

These findings provide compelling evidence of the similarities and differences between childbearing motivations, pregnancy desires and perceived partner desires for pregnancy among female youth according to HIV infection status. These exploratory findings should be tested with larger sample sizes and a design that overcomes the general limitations posed by this project.

## Implications for future research

The importance of relationship dynamics, particularly in the context of economic and physical insecurity may illuminate the complexity of sexual and reproductive decision making of at-risk female youth. Qualitative research that explores positive and negative childbearing motivations and competing interests among HIV-infected and uninfected female youth may inform effective strategies for reproductive counseling. Awareness of preconception counseling services and perceived barriers to utilization are also needed.

## Conclusion

The desire for childbearing is not diminished by HIV infection among urban female youth. The perception that becoming pregnant would please a sexual partner appears to heighten the desire for future pregnancy among all female youth, but particularly among those infected with HIV and those of African American race. Strong desires for pregnancy coupled with low condom and contraception use leave many urban female youth at high risk for mistimed and unintended pregnancy as well as HIV and other STIs. To reduce secondary

transmission, the dynamics of sexual behavior and childbearing desires among female youth in minority communities cannot be ignored. Health care providers should openly and regularly discuss childbearing motivations, pregnancy desires, and associated risks with all female youth, most importantly with those living with HIV.

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## Table 1

**Characteristics of HIV-uninfected and HIV-infected female youth, Pearson's chi-square ($X^2$)**

| Characteristics | Uninfected (N=355) | Infected (N=46) | p value |
|---|---|---|---|
| *Sociodemographic* | n (%) | n (%) | |
| Mean age (sd) | 19.5 (2.6) | 19.9 (2.7) | 0.49 |
| 15-19 | 171 (48) | 23 (50) | |
| 20-24 | 184 (52) | 23 (50) | 0.81 |
| Race/ethnicity | | | |
| Black/Afr Am | 307 (87) | 42 (91) | |
| White | 33 (9) | 3 (5) | |
| Hispanic | 7 (2) | 1 (2) | 0.68 |
| Other | 8 (2) | | |
| Sexual orientation | | | |
| Heterosexual | 298 (93) | 41 (89) | |
| Lesbian | 16 (4.5) | 2 (4) | |
| Bisexual | 23 (6.5) | 3 (7) | 0.58 |
| Other | 14 (4) | 0 | |
| Relationship status | | | |
| Never married | 329 (93) | 34 (74) | |
| Not married, living together | 19 (5) | 11 (24) | <0.001 |
| Married | 7 (2) | 1 (2) | |
| *Fertility and Contraception* | | | |
| Ever pregnant | 191 (54) | 29 (63) | 0.23 |
| Parity (# of children) | | | |
| 0 | 210 (59) | 26 (56) | |
| 1 | 73 (20) | 10 (22) | 0.89 |
| 2 | 53 (15) | 8 (18) | |
| ≥3 | 17 (5) | 2 (4) | |
| Consistent condom use (always) | 86 (24) | 14 (30) | 0.36 |
| Hormonal contraception use | 80 (23) | 22 (48) | 0.32 |
| *HIV-Related* | | (N=34) [a] | |
| Mode of HIV Aquisition | | | |
| Hetero-sex | | 14 (41) | |
| Perinatal transmission | | 15 (44) | |
| Unknown | | 5 (15) | |
| Mean years infected (sd) | | 10.3 (8.1) | |
| Infected 1- 2 years | | 10 (29) | |
| Infected 3-14 years | | 9 (26) | |
| Infected >15 years | | 15 (44) | |
| Partner HIV status (n=35)[b] | | | |
| Positive | | 3 (9) | |

| Characteristics | Uninfected (N=355) | Infected (N=46) | p value |
|---|---|---|---|
| Negative | | 27 (78) | |
| Unknown | | 4 (12) | |
| Previous pregnancy while HIV-infected | | 20 (59) | |
| On HAART | | 18 (53) | |
| Undetectable < 50 copies/mL | | 5 (28) | |
| CD4 count <200 cells/μl | | 4 (22) | |

[a] HIV related data only available for 34 sexually experienced youth recruited from clinics.

[b] partner's HIV status was determined by the self-report of female participant

## Table 2

**Childbearing motivations, pregnancy desires, and perceived partner reaction to becoming pregnant among female youth compared by HIV infection status**

| | HIV-uninfected (n=355) | HIV-infected (n=46) | p value |
|---|---|---|---|
| Childbearing Motivations | | | |
| Positive CBM mean score | 3.28 (.67) | 3.18 (.77) | 0.42 |
| Negative CBM mean score | 2.40 (.84) | 2.06 (.79) | 0.01* |
| Future Pregnancy Desires | | | |
| Yes | 293 (85%) | 37 (80%) | 0.37 |
| Perceived Partner Desire for pregnancy | (n=334) | (n=37)[a] | |
| Excited/happy | 219 (65%) | 31 (83%) | 0.025* |

Higher positive CBM mean scores =more positive motivations

Higher negative CBM =more negative motivations

[a]Only 37 HIV-infected youth and 334 uninfected youth responded to the question about a partner

**Table 3**

Bivariate and multivariate linear regression to identify correlates with childbearing motivations (positive and negative) among urban youth, n=401.

| | Positive Childbearing Motivations (PCM) | | Negative Childbearing Motivations (NCM) | |
|---|---|---|---|---|
| **Variable** | **β (95% CI), p bivariate** | **β (95% CI), p multivariate** | **β (95% CI), p bivariate** | **β (95% CI), p multivariate** |
| Age | | | | |
| 20-24 yrs | 0.02 (-.12-.16), 0.75 | 0.01 (-.15-.17), 0.87 | -0.12 (-.301-.047), 0.15 | -0.07 (-.28-.14), 0.53 |
| 15-19yrs (ref) | | | | |
| Childless | -0.14 (-.28-.001), 0.048* | -0.13 (-.29-.03), 0.11 | -013 (-.28-.01), .072 | 0.15 (-.06-.36), 0.16 |
| Relationship status | | | | |
| Living together | 0.02 (-.23- .28), 0.82 | -0.03 (-.31-.24), 0.82 | -0.08 (-.40-.24), 0.62 | -0.01 (-.36-.34), 0.96 |
| Single (ref) | | | | |
| Race | | | | |
| Caucasian | 0.03 (-.21-.27), 0.79 | 0.16 (-.10-.42), 0.23 | 0.01 (-.30-.31), 0.97 | 0.02 (-.36-.32), 0.89 |
| African American (ref) | | | | |
| HIV-infected status | -0.09 (-.31-13), 0.42 | -0.17 (-.42-.08), 0.18 | -0.33 (-.60-.07), 0.01 | -0.30 (-.62-.02), 0.06 |
| Perceived partner desire | 0.25 (.096-.404), 0.001* | 0.27 (.11-.44), 0.001* | -0.21 (-.412-.019), 0.03 | -0.1.6 (-.37-.04), 0.12 |

* = p<0.05

## Table 4

Bivariate and multivariate logistic regressions to identify associations with future pregnancy desires among urban youth, n=401. An OR > 1 indicates the variable is associated with a greater likelihood of reporting pregnancy desires, while an OR <1 indicates a lower likelihood of reporting pregnancy desires.

| | Future Pregnancy Desires | |
|---|---|---|
| **Variable** | **OR (95% CI), p** | **aOR (95% CI), p** |
| Age | | |
| 20-24 yrs | 0.68 (.39-1.2), 0.17 | 1.12 (.53-2.3), 0.76 |
| 15-19yrs (ref) | | |
| Childless | 2.68 (1.5-4.7), 0.001 | 3.32 (1.5-7.2), 0.002* |
| Relationship status | | |
| Living together | 0.73 (.28-1.8), 0.52 | 0.74 (.23-2.4), 0.62 |
| Single (ref) | | |
| Race | | |
| Caucasian | 2.0 (.59-6.8), 0.25 | 1.63 (.44-6.1), 0.46 |
| African American (ref) | | |
| HIV-infected status | 0.70 (.32-1.5), 0.38 | 0.77 (.27-2.2), 0.64 |
| Childbearing Motivations | | |
| Positive | 2.29 (1.5-3.3), <0.001 | 2.19 (1.4-3.4), 0.001* |
| Negative | 0.84 (.60-1.2), 0.31 | 0.76 (.52-1.1), 0.16 |
| Perceived partner desire | 2.25 (1.25-4.1), 0.007 | 2.24 (1.1-4.6), 0.027* |

## Table 5

Bivariate and multivariate logistic regression to identify associations with perceived partner desire to have a child among urban youth, n=371. An OR > 1 indicates the variable is associated with a greater likelihood of reporting pregnancy desires, while an OR <1 indicates a lower likelihood of reporting pregnancy desires.

| | Perceived Partner Desire for a Child | |
|---|---|---|
| **Variable** | **OR (95% CI), p** | **aOR (95% CI), p** |
| Age | | |
| 20-24 yrs | 0.80 (.52-1.2), 0.32 | 0.64 (.36-1.1), 0.14 |
| 15-19yrs (reference) | | |
| Childless | 0.67 (.43-1.05), 0.08 | 0.66 (.36-1.2), 0.17 |
| Relationship status | | |
| Living together or married | 2.51 (.93-6.7), 0.069 | 2.15 (.73-6.4), 0.17 |
| Single (reference) | | |
| Race | | |
| Caucasian | 0.27 (.13-.57), 0.001 | 0.23 (.09-.56), 0.001* |
| African American (reference) | | |
| HIV-infected status | 2.71 (1.1-6.7), 0.030 | 3.52 (1.2-10.4), .023* |
| Childbearing Motivations | | |
| Positive | 1.71 (1.2-2.4), .002 | 1.61 (1.1-2.4), 0.016* |
| Negative | 0.74 (.57- .97), 0.032 | 0.91 (.67-1.2), 0.53 |
| Want to have a child | 2.25 (1.25-4.1), 0.007 | 2.25 (1.1-4.6), 0.024* |

Analyses restricted only to female youth reporting a current or very recent partner (334 HIV-uninfected and 37 HIV-infected).