[[1]](#footnote-1)

Using Data to Learn About Unplanned Pregnancies

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*Abstract*—The issue of unplanned pregnancy is among the more divisive in the United States. The mission of this project is to further investigate existing data sets to gain a new insight into this problem. Specifically, we focused on targeting the causes of unplanned pregnancy and identify at risk groups in order to identify potential interventions that may result in fewer unplanned pregnancies nationwide. We also use survey data to study how these at risk groups feel about current public health policy. Analysis of twitter data showed that public sentiment regarding terminating unwanted pregnancies was strongly negative, which led us to seek interventions to lower unwanted conceptions rather than just unwanted births.

*Index Terms*—Unplanned pregnancy, public health, sexual education

# Introduction

U

NPLANNED pregnancy has the potential to ruin a woman’s financial stability, educational goals, and her personal relationships. Nearly 50% of all pregnancies in the United States are unintended [5]. Beyond the impact to the women, an unintended pregnancy could have health impacts on the baby and economic impacts on the country.

\*\*\*We may want to exclude this \*\*\* In order to gain a basic level of insight into the historic trends of unplanned pregnancy in the United States, we examined a data set that summarized the number of unmarried births in the United States from 1940 to 2015 [1]. The trends are summarized in Figure 1. However, the assumption that all or even most of these unmarried births are unintentional is likely to be faulty. However,

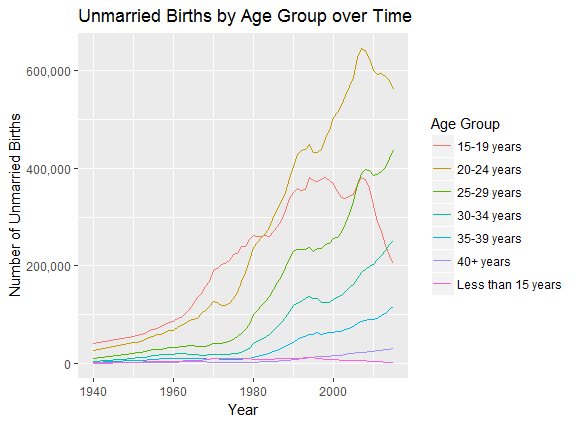


Figure 1: Trends in unmarried births by age group over time

Here is some background information. Here are some graphs that illustrate trends over time. We probably want a bunch of citations in this section. Heat map of where the unintended pregnancies are. Compare to other relative heatmaps. Look at rate of unintended over time.

# DATA

This study analyzed public data gathered from online sources

## Pregnancy Risk Assessment Monitoring System (PRAMS)

The PRAMS data is a surveillance system of the CDC which collects population-based based data from participating states reflecting maternal attitudes before, during, and shortly after pregnancy. The surveillance currently covers about 83% of all U.S. births. The surveillance includes a questionnaire sent to a random sample selected from birth certificates issued in participating states.

The results of this questionnaire, specifically the pregnancy questionnaire, were used for this study. The years 2009-2011 were included, which are the three years for Phase 6 of the survey. The nature of the data is population-based, as mentioned, and thus includes information about the number of respondents in a subgroup which answered a question in a particular way. There are questions pertaining to the intendedness of the pregnancy and well as many socioeconomic characteristics of the population, so we were able to use this data to identify key differences between the intended and unintended pregnancy populations.

As the sample is selected from birth certificates, this data does not contain information on unintended pregnancies which were terminated or resulted in fetal loss.

## Kaiser 1998

## Kaiser 2017

More political related polls regarding Medicaid

# Methods

. The analysis was for the most part exploratory and varied with the format of each analyzed data set. We used a number of mathematical techniques to model the

## Modelling Birth Control Efficacy with Markov Chains

We used a mathematical technique called a Markov Chain to model the probability of various birth control methods failing after a certain number of years. This was done to test the assumption that if one truly wishes to avoid having an unplanned pregnancy, the only truly “safe” bet is abstinence.

A Markov Chain shows how transition probabilities change over time and eventually converge. In order for the method to work, we must have a stochastic matrix. That is, the sum of all entries in any row must equal one.

We simulated a number of environments with varying assumptions. In each environment we tested the same methods of birth control: withdrawal, family planning (also known as the calendar method), intrauterine devices (IUD), condoms, injections, the pill, and implants. For all of these methods, the probability of having the birth control method fail within a year was provided by Planned Parenthood [2]. Those probabilities account for user error, so they were selected over the theoretical efficacy of a given method to simulate a more realistic environment. However, Planned Parenthood only provided two decimals of accuracy, and rounded down the efficacies of the implant and the IUD to 0.99. Because of the 100% efficacy of abstinence, this method was not included in the Markov Chain. The time step for all Markov Chains was one year.

Once the transition matrices were created, the matrices were raised to higher and higher powers until they eventually converged. However, as the converge occurs far beyond the fertile period or even life span of most women, this study was more interested in the intermediate states of the matrices particularly after five and 30 time steps. Thus, if **T** is a transition matrix, **T**5 would show how the probabilities changed after five time steps.

## Twitter Sentiment Analysis

Do we even want to include this??

Could be good for establishing public sentiment toward abortion 🡪 want to focus more on prevention

## Chi Squared Testing

### Two Proportion Tests

For the PRAMS data, we performed a chi-square test to determine whether significant differences occurred between the responses for each question in the Pregnancy survey for the group of respondents who said their pregnancy was unintended and those whose pregnancy was intended. This analysis covered only the questions with binary responses, which is 180 of the 220 questions in the survey.

### Tests for Association

## Variable Correlations

In order to find questions with highly correlated reponses, we assigned numerical weights to the qualitative responses of the Kaiser surveys. For example <Strongly Disagree, Somewhat Disagree, Don’t Know, Somewhat Agree, Strongly Agree> was translated to <-10, -8, 0, 8, 10>. For responses that covered ranges of values, such as for Age Groups and Income Brackets, the median was assigned. For Income, this was reduced down to the same order of magnitude. With a numerical interpretation of each response, correlations were calculated for each question.

## Association Learning

Table 1: Transition matrix for Markov Chain with absorbing pregnancy state and random switching after each step

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Withdraw** | **FAM** | **IUD** | **Condom** | **Injection** | **Pill** | **Implant** | **Pregnant** |
| **Withdraw** | 0.062 | 0.016 | 0.125 | 0.187 | 0.055 | 0.320 | 0.016 | 0.220 |
| **FAM** | 0.061 | 0.015 | 0.122 | 0.182 | 0.053 | 0.312 | 0.015 | 0.240 |
| **IUD** | 0.079 | 0.02 | 0.158 | 0.238 | 0.069 | 0.406 | 0.02 | 0.010 |
| **Condom** | 0.068 | 0.017 | 0.136 | 0.204 | 0.060 | 0.349 | 0.017 | 0.150 |
| **Injection** | 0.075 | 0.019 | 0.15 | 0.226 | 0.066 | 0.385 | 0.019 | 0.060 |
| **Pill** | 0.073 | 0.018 | 0.146 | 0.218 | 0.064 | 0.373 | 0.018 | 0.090 |
| **Implant** | 0.079 | 0.020 | 0.158 | 0.238 | 0.069 | 0.406 | 0.020 | 0.010 |
| **Pregnant** | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 1.000 |

# Results

Our results were awesome. You’re welcome, America.

## Modelling Birth Control Efficacy with Markov Chains

The first simulation (Sim. 1) assumed pregnancy to be an absorbing state (meaning that once an individual becomes pregnant she is removed from the population). It was also assumed that after each step in the Markov Chain a woman would randomly switch her birth control. The probability of switching to any given birth control method (including the method that the woman was using at the current time step) was proportional to the percentage of Americans who used that particular method of birth control. Those probabilities were calculated from statistics provided by the Guttmacher Institute [3]. The probabilities were scaled to account for the probability of being put in the absorbing pregnant state. The transition matrix is given by Table 1.

Under these assumptions, after five time steps (five years), the probability of having an unplanned pregnancy ranged from 0.354 to 0.504. Within 30 years, approximately the average length of fertility for a woman, the probability of unplanned pregnancy was over 0.95 in all rows. Thus, under these assumptions, most sexually active women would experience an unplanned pregnancy in their lifetimes.

However, to more closely simulate reality, we ran an additional trial (Sim. 2) that biased the random switching greatly to keeping the birth control method from the previous time step. For all methods, it was assumed that if the woman did not become pregnant, the probability to keeping the same birth control method was 0.99. The remaining probabilities were maintained to reflect their relative popularity, but additionally scaled to keep each row sum equal to one. The transition matrix is given by Table 2.

In this simulation, after five time steps, the pregnancy probabilities varied greatly with the lowest being at 0.057 for the implant (with the IUD at 0.058) and the highest being at 0.741 for the family planning method. After 30 time steps, the probabilities of pregnancy ranged from 0.374 (implant) to 0.994 (family planning).

To account for the rounding of birth control failure, we did a final simulation (Sim. 3) in which all assumptions were the same as the previous simulation, but the efficacies of the pill and implant were both assumed to be 0.999. The probability of having an unplanned pregnancy after 30 years is 0.206 and 0.184 respectively. All results for each of the trials are summarized in Table 3.

Table 2: Transition matrix for Markov Chain with absorbing pregnancy state and biased random switching after each step

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Withdraw** | **FAM** | **IUD** | **Condom** | **Injection** | **Pill** | **Implant** | **Pregnant** |
| **Withdraw** | 0.772 | 0.000 | 0.001 | 0.002 | 0.001 | 0.003 | 0.000 | 0.220 |
| **FAM** | 0.001 | 0.752 | 0.001 | 0.002 | 0.001 | 0.003 | 0.000 | 0.240 |
| **IUD** | 0.001 | 0.000 | 0.980 | 0.003 | 0.001 | 0.005 | 0.000 | 0.010 |
| **Condom** | 0.001 | 0.000 | 0.002 | 0.842 | 0.001 | 0.005 | 0.000 | 0.150 |
| **Injection** | 0.001 | 0.000 | 0.002 | 0.002 | 0.931 | 0.004 | 0.000 | 0.060 |
| **Pill** | 0.001 | 0.000 | 0.002 | 0.004 | 0.001 | 0.901 | 0.000 | 0.090 |
| **Implant** | 0.001 | 0.000 | 0.002 | 0.002 | 0.001 | 0.004 | 0.980 | 0.010 |
| **Pregnant** | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 1.000 |

Table 3: Summary of Markov Chain intermediate phases for n = 5 and 30 for all simulated environments

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Withdraw** | **FAM** | **IUD** | **Condom** | **Injection** | **Pill** | **Implant** |
| **Sim. 1, n = 5** | 0.491 | 0.504 | 0.354 | 0.446 | 0.387 | 0.406 | 0.354 |
| **Sim. 1, n = 30** | 0.965 | 0.966 | 0.955 | 0.962 | 0.958 | 0.959 | 0.955 |
| **Sim. 2, n = 5** | 0.705 | 0.741 | 0.058 | 0.553 | 0.269 | 0.377 | 0.057 |
| **Sim. 2, n = 30** | 0.993 | 0.994 | 0.391 | 0.981 | 0.851 | 0.930 | 0.374 |
| **Sim. 3, n = 5** | 0.705 | 0.741 | 0.015 | 0.552 | 0.269 | 0.377 | 0.014 |
| **Sim. 3, n = 30** | 0.992 | 0.993 | 0.206 | 0.979 | 0.848 | 0.926 | 0.184 |

The consequences of these results is that certain methods of birth control if used consistently are virtually guaranteed to result in many unplanned births given a reasonable amount of time (≤ 30 years). Even for more effective methods, improper use can dramatically increase the probability of having an unwanted conception. Thus, for a woman who wishes to avoid pregnancy, it is very important for her to be using an effective method of birth control, but also to be using it correctly.

## Chi Squared Testing

### Two Proportion Tests

Comparing the differences in responses to the PRAMS questionnaire between the unintended and intended pregnancy populations, there were significant differences in the answers to nearly every question. As the sample size is large, there are several statistically significant results that are not practically significant. As such, the questions which had the largest absolute differences in the proportions of each population which responded a particular way were examined more closely.

It was discovered that there are four main categories in which the unintended and intended populations differ: contraception use, economic, health/care, and personal relationships.

#### Contraception Use

Whereas only 6% of those intending to get pregnant were using birth control, 49% of those who labeled their pregnancy as unintended were using some form of birth control. Among unintended pregnancies, condoms, withdrawal, and Calendar rhythm methods are cited at much higher rates than the general population.

Of those who were not using birth control but still had an intended pregnancy, there may not be enough drive to actively prevent pregnancy as 31% did not necessarily mind getting pregnant. Another common reason given for lack of contraception use that occurs more prominently in the unintended group (P-value ≈ 0) is the belief that the respondent cannot become pregnant. 32% of the respondents with unintended pregnancies believed this to be the case compare to only 20% of intended pregnancies.

#### Economic

In the respondents who termed their pregnancy as unintended, the rates of usage of Medicaid for delivery and being enrolled in the WIC program when surveyed were significantly higher. The usage of the programs are indicators of low income. As these are federally funded programs, this serves as evidence that the economic burden on the country for an unintended pregnancy is greater than for an intended pregnancy.

In addition, when a pregnancy was unintended, 31% of the mothers reported they had difficulty paying bills in the 12 months before delivery compared to 17% of mothers with intended pregnancies.

#### Health/Care

When trying to become pregnant, many women will begin taking vitamins to ensure a healthy system in which to cultivate a baby. For unintended births, this habit of taking vitamins is not established, potentially impacting the health of the child. (maybe add more scientific reasons to take vitamins here) Without having the intent to become pregnant, these women would not have had conversations with their doctors to learn fundamental facts that could help ensure a health pregnancy. For instance, only 67% of women with unintended pregnancies had exposure to information that folic acid could prevent birth defects. 83% of women with intended pregnancies had heard this fact.

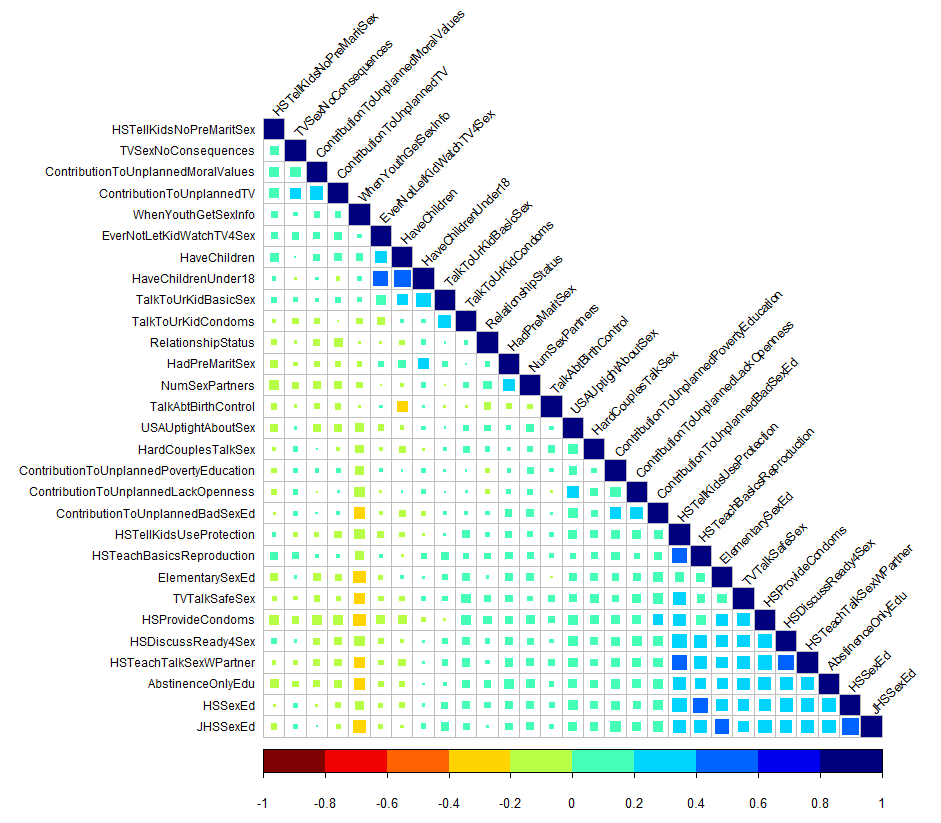
In the unintended pregnancies the women entered into prenatal care later than desired, or in some cases not at all, and commonly were not able to get into prenatal care as soon as they desired (56%). If Medicaid is needed to pay for health care during pregnancy, which was found to often be the case for unintended pregnancies, there is a two to four-week period to gain approval on qualification after submitting the required documentation.

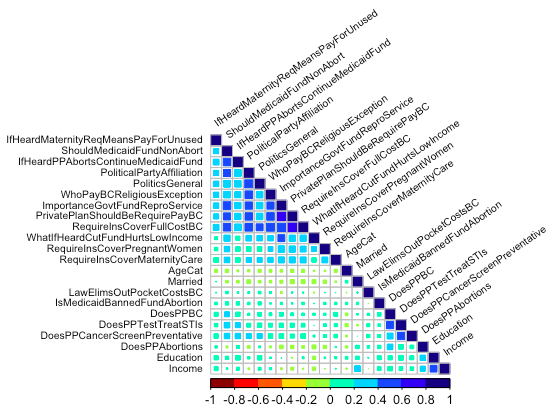
#### Personal Relationships

Partner related stressors were twice as likely to be reported in the women with unintended pregnancies (42%) versus intended pregnancies (21%). These women were more likely to argue with their partner more than usual in the 12 months before delivery (34%). This is an added source of stress which of course has many health impacts that could inversely affect the baby. (BE MORE SPECIFIC. FIND SOURCES)

## Variable Correlations

PARE DOWN PLOT TO VARIABLES WHICH SHOW HIGHEST CORRELATIONS





# Conclusions

In conclusion, by this time next year, unplanned pregnancies will be a thing of the past.

# Future Work

Check that research journal for future work ideas. I think we had a list of them in there.

# Acknowledgments

This work would not have been possible without the help and support of Dr. Amy Langville, Abhishek Mehta, Brittany Box, and the entire Tresata team. We would also like to acknowledge the 2018 spring Operations Research Class at the College of Charleston for their thoughtful input and advice throughout the course of this project.

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1. [↑](#footnote-ref-1)