

# Accepted Manuscript

Planning parenthood: Health care providers' perspectives on pregnancy intention, readiness, and family planning

Lindsay M. Stevens



PII: S0277-9536(15)30008-3

DOI: [10.1016/j.socscimed.2015.06.027](https://doi.org/10.1016/j.socscimed.2015.06.027)

Reference: SSM 10135

To appear in: *Social Science & Medicine*

Received Date: 12 January 2015

Revised Date: 17 June 2015

Accepted Date: 24 June 2015

Please cite this article as: Stevens, L.M., Planning parenthood: Health care providers' perspectives on pregnancy intention, readiness, and family planning, *Social Science & Medicine* (2015), doi: 10.1016/j.socscimed.2015.06.027.

This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

Planning parenthood: Health care providers' perspectives on pregnancy intention, readiness, and family planning

Lindsay M. Stevens

Rutgers University

Corresponding author: Tel. 5704662841; E-mail. [lindsay.stevens@rutgers.edu](mailto:lindsay.stevens@rutgers.edu), Address. 26 Nichol Avenue, New Brunswick, N.J., 08891, USA

## ABSTRACT

A major health care goal in the United States is increasing the proportion of pregnancies that are planned. While many studies examine family planning from the perspective of individual women or couples, few investigate the perceptions and practices of health care providers, who are gatekeepers to medicalized fertility control. In this paper, I draw on 24 in-depth interviews with providers to investigate how they interpret and enact the objective to “plan parenthood” and analyze their perspectives in the context of broader discourses about reproduction, family planning, and motherhood. Interviews reveal two central discourses: one defines pregnancy planning as an individual choice, that is as patients setting their own pregnancy intentions; the second incorporates normative expectations about what it means to be ready to have a baby that exclude poor, single, and young women. In the latter discourse, planning is a broader process of achieving middle-class life markers like a long-term relationship, a good job, and financial stability, before having children. Especially illuminating are cases where a patient's pregnancy intention and the normative expectations of “readiness” do not align. With these, I demonstrate that providers may prioritize normative notions of readiness over a patient's own intentions. I argue that these negotiations of intention and readiness reflect broader tensions in family planning and demonstrate that at times the seemingly neutral notion of “planned parenthood” can mask a source of stratification in reproductive health care.

## KEYWORDS

*United States; family planning; pregnancy intention; reproduction; health care providers*

## 1. Introduction

While planning pregnancy is a central objective of reproductive medicine, nearly half of all pregnancies in the United States are unintended (Finer & Zolna, 2011). Recent public health initiatives focus on expanding reproductive health services, encouraging individuals to engage in reproductive planning, and training providers to counsel patients on creating long-term reproductive plans (CDC, 2006; CDC, 2012; ODPHP, 2014). As part of its Preconception Health and Health Care initiative launched in 2006, the Centers for Disease Control (CDC) encourages people to take “individual responsibility across the lifespan” by making a reproductive life plan. With this plan, individuals should monitor health “from menarche to menopause” and map the number and timing of desired pregnancies to fit with other personal goals, like educational and

career plans (CDC, 2006; CDC, 2012; see Waggoner, 2013) In 2015, the Title X family planning program (the main federal funding source of family planning health care for low-income individuals) named “assessing clients' reproductive life plans” as one of its main priorities (HHS, n.d.).

While the focus on pregnancy planning has expanded and intensified in public health programs, in practice, the meaning of planning a pregnancy is varied and imprecise (Klerman, 2000). “Planning” can include setting an individual intention, taking action to conceive or avoid conception, and/or making broader life preparations to have or expand a family (Barrett & Wellings, 2002; Lifflander, Gaydos, & Hogue, 2007; Santelli et al., 2003). Furthermore, there is significant evidence that many U.S. women feel ambivalence about pregnancy and some do not find the idea of carefully planning their fertility as relevant, useful, or possible (Barrett & Wellings, 2002; Higgins, Popkin, & Santelli, 2012; Kendall et al., 2005). Investigations of attitudes about fertility planning typically focus on women, and to a lesser extent, men. Yet, little research examines reproductive health care providers (henceforth, “providers”), who can serve as medical experts, health educators, life counselors, and gatekeepers to medicalized fertility control. In this paper, I investigate how the goal that patients “plan parenthood” is interpreted and enacted by providers.

Providers practice in the context of broader discourses about reproduction, family planning, and motherhood. Feminist scholars have long noted the dual potential of family planning initiatives. These programs can give individuals, and women in particular, the necessary tools to control fertility, protect against sexually transmitted infections, and reduce the risk of maternal mortality (Lupton, 2012). Public family planning clinics in the U.S. often

provide respectful, confidential, and low cost care to meet the diverse needs of patients (Frost, Benson Gold & Bucek, 2012). Simultaneously, policymakers and medical establishments have historically treated women's reproductive bodies as vehicles to address larger social problems, like population growth and poverty. To this end, technologies like birth control and sterilization have been used to coerce and oppress women, especially poor women of color (Luna & Luker, 2013; Roberts, 1997; Ross, 2006; Solinger, 2005). Even when fertility is not directly controlled, women's reproductive autonomy is suspect when they make choices that are not considered “appropriate” and “responsible” (Ruhl, 2002).

This tension between family planning as an instrument for reproductive rights and as a tool for addressing larger social problems continually appears in public health programs and agendas. For instance, the 1994 International Conference on Population and Development in Cairo included a landmark articulation that reproductive rights, including access to family planning, are integral to human rights more generally. With this, RamaRao & Jain (2015, p 98) note that:

[t]he view of family planning shifted from being primarily a means to population and development ends to being a component of reproductive health, with the goal of facilitating individuals' ability to determine whether, when, and how many children to bear.

Still, they argue that contemporary initiatives often lose sight of these goals and lapse into focusing on numerically-driven, rather than patient-driven, benchmarks. The Office for Disease Prevention and Health Promotion cites improving family planning and reducing the proportion of unintended pregnancies as a top health priority as it allows individuals to achieve desired spacing and timing of births and because family planning is “cost-effective” for taxpayers and unintended pregnancy is correlated with negative health and economic outcomes (ODPHP,

2014). These dual purposes – to facilitate individual desires and to solve broader social problems – can conflict. Tension arises especially when marginalized women desire to have children even though they are likely to face financial and health-related hardships due to structural disadvantages. As Ross highlights in her conceptualization of “reproductive justice,” simple reproductive *choice* is inadequate to address the coercion and oppression that poor women of color have historically faced. Marginalized women also need “the necessary social supports in safe environments and healthy communities” to raise children with dignity and autonomy (Ross, 2006, p. 3).

Broader discourses about what it means to be a “good mother” also inform conversations about family planning. In the dominant discourse, good mothers are well-educated, financially secure, married or in stable relationships, and well out of their teens (Geronimus, 2003; Roberts, 1997; Solinger, 2001). They follow expert biomedical advice in reproduction (Rapp, 1999) and child-rearing (Hays, 1996) and actively research, plan, and manage their reproductive bodies (Avishai, 2007). According to these dominant ideals, children's health and well-being depend on their mothers' willingness to adhere to these expectations and women are successful only if they plan well. Yet, these expectations for good motherhood are stratified. Poor, young, unmarried women may desire or *intend* to become pregnant, but have fewer opportunities to *plan* a normatively good pregnancy. Previous research shows that establishing oneself financially, settling into a secure marriage and career, and maintaining peak physical health before having children require substantial material resources (Edin & Kefalas, 2005; Furstenberg, 2007; Geronimus, 2003).

### 1.1 Reproductive Health Care Providers

Providers are an important site of investigation, as reproductive health care in the twenty-first century has been marked by a curious blend of non-directive counseling, which seeks to emphasize patients' informed choice and autonomy (Schwennesen & Koch, 2012; Williams, 2006), and lingering paternalism (Bell, 2010; Lupton, 2012). Current scholarship finds a lack of engagement between providers and patients during contraceptive counseling. Dehlendorf et al. (2014) demonstrate how providers' "hands-off" approach to birth control counseling neglects patients' preferences, concerns about side effects, and medical histories. Alternatively, previous studies demonstrate how medical apparatuses exert control over birth control and sterilization (Roberts, 1997), prenatal care and childbirth (Bridges, 2011; Lysterly et al., 2009), and infertility treatment (Bell, 2010). In family planning clinics specifically, low-income women and minorities are more likely to report discrimination by their providers, encouragement to limit childbearing, and pressure to use specific methods of birth control (Borrero et al., 2009; Dehlendorf et al., 2010; Downing, LaVeist & Bullock, 2007; Thornburn & Bogart, 2005).

Some initial studies investigate the attitudes and practices of family planning workers, although most are limited to those who treat adolescent patients. Mann (2013) shows how reproductive health providers work to convince their mostly young, poor, Latina patients to use birth control even when patients are ambivalent or intend to become pregnant (see also Breheny & Stephens, 2007). Hawkes' (1995) investigation of family planning clinics in the U.K. demonstrates that providers frame young women's contraceptive decisions as "irresponsible," especially among lower-class patients. Yet, we know little about the perspectives and practices of providers in the U.S. who work with a broader range of patients.

Here, I draw on interviews with providers who teach and practice reproductive health

care in the United States to ask: How do they reinforce, resist, or transform dominant discourses about reproduction, family planning, and motherhood? My analysis begins by comparing providers who emphasized their patients' individual intentions in family planning with those who emphasized “normative readiness” – a term I use to refer to the non-medical criteria that providers cite as important for their patients to consider before getting pregnant. These normative expectations about family planning included factors like being married or in a long-term relationship, being out of one's teens, having sufficient financial means, completing an education, and holding a steady job. Standards of normative readiness tended to reflect dominant discourses about good motherhood and position family planning as a tool to prevent poverty or dependence on social welfare programs.

My interviews reveal cases where patients' individual intentions and normative readiness did not align. These examples illustrate the complexities of family planning, showing that providers sometimes judged intended pregnancies as “bad” and unintended pregnancies as “good,” depending on a patient's age, class, education, and relationship status. These examples call into question whether respecting a woman's intentions, plans, and desires is always the primary goal in reproductive health care. Finally, I examine the perspectives of providers who resisted the notion of “being ready” to have a baby. In this alternate conceptualization, providers recognized the utility of reproductive planning, but also pointed to significant limitations and drawbacks.

Ultimately, this paper works towards a larger project of interrogating the notion of “planned pregnancy” – a concept central to reproductive medicine – and revealing how it can simultaneously empower women to have bodily autonomy *and* leave them beholden to

sometimes impossibly high expectations about how to “correctly” and “rationally” build their families.

## **2. Methods**

Data come from 24 interviews with Nurse Practitioners, Doctors of Nursing Practice, Doctors of Nursing, Certified Nurse Midwives, and Doctors of Medicine who practiced or taught in the United States. I limited my sample to primary care providers who could practice independently and had multiple years of work experience in reproductive health care, especially birth control counseling. Most respondents specialized in women's health care or obstetrics and gynecology. They worked across a range of settings, including hospitals, private practices, non-profit and federally-funded clinics, and university and workplace health centers. Many simultaneously held positions at academic institutions. At the time of interview, twenty-three respondents were living and working in the northeastern, mid-western, southern, or western United States. One was living abroad, but her most recent clinical experience was in the U.S.

Although fairly homogenous, these providers served a broad range of patient populations. Most saw only women in their practices, but some saw men as well. Patients ranged from adolescents to elderly, although interviews focused mostly on the care of reproductive-age individuals. In Table 1, I use the type of insurance(s) accepted at the respondent's most recent practice as a proxy for the patient population it served. Generally, a high proportion of Medicaid patients signified a low-SES patient population, as this federal health insurance program requires that recipients meet a certain percentage of the poverty level to qualify for coverage. Most providers at practices accepting only private insurance described their clientele as predominantly white and high-SES. Those at practices accepting private insurances and Medicaid described

clientele that were socioeconomically mixed, but predominantly white. Most at practices accepting uninsured patients described their patient population as predominantly minority and low-SES. Having demographic information about the patient population each provider served helps to create a fuller and more complex analysis. However, because of a limited sample size, I cannot identify definitive patterns in providers' attitudes or practices based on the type of patients with whom they worked.

**Table 1**  
Description of interviewees in sample ( $N = 24$ )

Characteristic	<i>n</i>
<i>Provider Gender:</i>	
Female	22
Male	2
<i>Provider Race:</i>	
White	19
Black or African-American	2
Asian or Pacific Islander	1
Hispanic	1
Unknown	1
<i>Provider Type:</i>	
Certified Nurse Midwife (CNM)	2
Nurse Practitioner (NP)	11
Doctor of Nursing Practice (DNP) or Doctor of Philosophy (PhD) in Nursing	8
Doctor of Medicine (MD)	3
<i>Type of Insurance(s) Accepted on Most Recent Practice:</i>	
Private Insurance Only	7
Private Insurance and Medicaid	8
Private Insurance, Medicaid, and Uninsured	9
<i>U.S. Geographic Region:</i>	
Northeast	18
Midwest	1
South	3
West	1
Outside U.S.	1

I conducted all interviews in 2013. Interviews were semi-structured, open-ended, and covered a range of topics, including birth control, abortion, preconception care, pregnancy, and infertility. About half were conducted in-person and half by telephone.. I began recruiting

respondents through personal and professional contacts and then used references to gather additional interviews. I also recruited at a national conference for Nurse Practitioners and through an online forum for Nurse Practitioners in Women's Health. All participants gave both verbal and written consent before participation. The Rutgers University Institutional Review Board approved this study.

I transcribed all interviews, except for one where the respondent declined to be recorded, and coded them using QSR NVivo computer software. I engaged in thematic analysis to guide this research (Braun & Clarke, 2006). Because interviews were broadly focused, I adopted an inductive approach to identifying themes of how interviewees described family planning, pregnancy, and parenthood. I then used these themes to examine “the underlying ideas assumptions...and ideologies” contained in the interviews (Braun & Clarke, 2006, p. 13). For instance, I teased apart providers' accounts of what, if anything, makes a person “ready to have a baby” in order to understand the broader frameworks about planning and parenthood on which they drew. This theme included codes like “age or old enough,” “good relationship,” “job, house, and finances,” “it depends,” and “nothing.” Without prompting, some providers also gave examples of patients who they believed were or were not ready to have a baby. With further analysis, I found that these examples revealed complexities and contradictions in providers' appraisals of pregnancy intention and readiness.

Throughout, I take a constructionist approach and view interview data and the themes that arose as socially produced, rather than as fixed within individuals (Burr, 1995). This approach broadens the analysis beyond providers themselves to the way in which their accounts are situated in wider power relations, institutional structures, and cultural discourses. The themes I

have identified are also ideal types; in practice, they sometimes overlapped and co-occurred within the same interview.

In the results, I present both providers' accounts of their *attitudes* about reproductive planning and of their *actions* in clinical encounters. Although the latter more clearly demonstrate how providers enacted family planning provision, I take the former as informative as well: evidence indicates that patients can sense the judgments of providers, even when unspoken, and become reticent in environments where they sense disapproval (Katz & Alegria, 2009). Finally, I am attentive to the distinction between providers' expressions of their own perspectives and practices and their descriptions of their patients' perspectives and practices. This paper focuses on the former. When I draw on the latter, I am mindful that the talk of providers does not necessarily reflect patients' actual perspectives and practices, but providers' discursive construction of patients' experiences.

### **3. Results**

#### *3.1 Defining Planning: Individual Intentions and Normative Readiness*

Providers generally affirmed the goal of improving pregnancy planning, although two different discourses emerged in their explanations of what family planning entailed: the first focused on the importance of individual intention in planning, while the latter highlighted normative standards for readiness.

In drawing on the first discourse, providers characterized planning as a source of empowerment and agency for their patients. These responses reflected broader discourses about the centrality of family planning to reproductive rights and autonomy. For instance:

You can't have control of your life if you don't have family planning. It's either you never

have sex, which is unrealistic, or it's just the random unpredictable world. (Nurse Practitioner 1)

This provider echoed the reproductive rights discourse wherein women need access to family planning to avoid pregnancy, childbirth, and parenting at “unpredictable” times and to gain agency over their lives.

Another stressed the importance of formulating intentions to achieve the reproductive life you want:

R [Respondent]: What do I think that family planning means? I think it's being mindful of your reproductive health and desires.

I [Interviewer]: Okay, what do you mean by desires?

R: Do you wanna get pregnant, do you not wanna get pregnant? When do you think you wanna have children? When do you wanna prevent having children? When do you think it's the best time for you? Why is it the best time? How do you wanna plan your life around what you want and what happens when surprises come? (Doctor of Nursing 5)

Here, family planning meant internally answering questions about what one wants and how to put those desires into action.

In these discourses, providers sometimes explicitly rejected the idea they should encourage patients to time pregnancy around certain life markers. When I asked this provider if she advised patients to have certain things in their lives settled before trying to have a baby, she responded adamantly:

No, because I'm not in control of their lives! I mean, I could have a 22 year-old patient who's much more mature than a 33 year-old patient. (Nurse Practitioner 7)

Her response suggested that providing advice about meeting normative expectations would usurp patient agency and autonomy. She supported this view with an example of how qualifiers like age do not always map neatly onto parenting ability.

Nurse Practitioner 1, quoted above, began to give an example of a couple who would *not*

be ready to have a baby, saying:

I mean, if you're close to bankruptcy or they're not married and they're having relationship troubles and they have three other kids that they're struggling with and she's just like [*in carefree voice*] 'I feel like having another baby!'... (Nurse Practitioner 1)

Here, she paused for a moment to think about how she would react to this couple and then continued, “Okay...but, okay! Alright, then. It's totally up to you.” Although the first half of this quote indicated that the provider thought the characteristics of this type of couple – one who had relationship and financial troubles and already had multiple children – would make them poor candidates to get pregnant again, she stopped herself and reaffirmed her commitment to honoring patients' desires, even if they did not meet typical definitions of readiness. In essence, this discourse framed family planning as a tool to fulfill individual desires and aimed to be non-judgmental and patient-driven.

A competing discourse emerged that framed planning as a way for women to achieve normative readiness before starting a family. Unlike the previous discourse, which stressed that individuals should construct plans around personal desires and individual definitions of readiness, these plans centered around markers of a middle-class lifestyle. When I asked providers, “What, if anything, makes a person or a couple ready to have a baby?”, some said “desire” or “feeling ready,” but others alluded to traditional milestones like being out of one's teens, being married or in a long-term relationship, completing an education, and having a stable job. One provider defined “readiness” as follows:

See, I'm old-fashioned. I think you should be in a committed relationship, preferably a marriage, financially stable, with insurance and, you know, just stable with your partner, your spouse. I don't think anybody that's an adolescent is ready for...I don't care how mature you are. 18, 19; you're not ready for a baby. [...]. I get 19 year-olds telling me they're trying to get pregnant and I try to talk 'em out of it! I say, "You're young, you have your whole life, you have to get yourself set." I would try to talk them out of it...but, it doesn't always work, obviously. (Nurse Practitioner 4)

Here, planning a pregnancy involved a committed relationship, insurance, financial stability, and being old enough before having children. This Nurse Practitioner said that in her counseling she explicitly tried to convince patients under twenty that they were not ready for pregnancy, despite their expressed intentions.

Another provider emphasized the importance of maturity and financial independence in being ready to have a baby:

Maturity...being able to afford the baby. That they don't have to be on public assistance. They're capable of putting their own needs second to another little human being. (Doctor of Nursing 6)

For this Doctor of Nursing, public assistance was not a legitimate means to support children – individuals needed to ensure they could afford a baby *without* government support before they were ready.

The provider quoted below linked class to family planning even more explicitly, asserting that in contrast to her middle-class, professional patients, that “it's your uneducated, lower population [...]who just procreate. There is no family planning.” She noted that her counseling and education of these patients did not lead to changes in their behavior:

If you're raised in a welfare environment or your mothers and sisters and everybody got pregnant at 15 and popped a kid out and you just go on welfare and you get food stamps and you stay at home and have 4, 5 different baby daddies [...] then that's all you know. I'm finding you do all this teaching, you try to show them, you try to educate them and in two years they're pregnant and it's the same scenario. (Doctor of Nursing 8)

This provider did not argue that “there is no family planning” among lower-class patients, because they failed to set an intention or because they did not desire pregnancy at the time of conception. Instead, they failed to plan because they got pregnant at young ages, with multiple partners, and relied on welfare. The provider tried to intervene by educating patients, but found

her counseling to be ineffective. The term “baby daddies” also evoked racialized stereotypes about non-traditional black family structures (Edin & Nelson, 2013). Although interviewees infrequently addressed race and ethnicity directly, we know that stereotypes about poor mothers are racialized (Bridges, 2011; Roberts, 1997; Solinger, 2005) and that treatment in reproductive health care is stratified by race (Borrero et al., 2009), making race silenced, but nevertheless salient.

Defining “readiness” to have a baby as being old enough, establishing a career, settling into a stable relationship, and never relying on public assistance reflects dominant discourses about good motherhood and family planning as a tool to prevent poverty. It also excludes young, poor and working-class, and often minority women who are unlikely to meet these standards. This may help explain why, in their encounters with health care providers, low-income patients report receiving more advice on how to avoid rather than achieve pregnancy (Bell, 2010).

### *3.2 When Intention and Readiness Do Not Align*

Providers occasionally shared stories where a patient’s intention did not align with normative readiness. These examples illustrate a key tension in family planning: What happens when a patient desires a pregnancy, but is not deemed ready by providers? Alternatively, how do providers react when patients seem ready, but do not express clear intentions to get pregnant? This analysis suggested that when competing discourses were contradictory, normative readiness often outweighed individual intention.

#### *3.2.1 “Bad” Intended Pregnancies*

Some providers spoke of patients who expressed an intention to have a baby, but had not

achieved normative readiness. One provider who worked in a clinic serving mostly poor, minority youth suggested that “there is no such thing as an accidental or unplanned pregnancy,” because “in an adolescent's mind, it's all unplanned.” For this provider, the adolescents she worked with (who ranged from 15 to 22 years old) did not have the capacity to truly plan a pregnancy, regardless of their intention. She related stories about patients who had explicitly expressed intent to get pregnant and then described trying to get them to think through whether they were really “ready” or not:

It's the same conversation I have even with the people who say they don't want to [get pregnant] [*chuckles*]: "So what do you do? I mean, do you work? What are your plans? What are your future goals?" And then I move on to: "Well, what does your partner do? What are his goals? [...] Where are you gonna live? Are you gonna breastfeed? Bottlefeed?" And then trying to get them to see that there's more than just having a baby and to really get them to make sure that they've really thought through the whole process of being ready. (Medical Doctor 2)

In the provider's view, teenagers who expressed intent to get pregnant were not necessarily “planning” a pregnancy, because planning involved a much more complex process that included identifying goals and demonstrating that a baby would not interfere with plans to work and set up a two-parent household. Later in the interview, she added that she always encouraged couples who are thinking about having a baby to “get married or make it official in some capacity” and told them was “not a good idea” to have a baby outside of a long-term relationship.

Another more startling example brings to light the muddled nature of planning. This provider recounted a story of a patient who desired to get pregnant, but, in the provider's opinion, was not ready to have a baby. The patient, in her mid-twenties, came in to have her Implanon [a hormonal contraceptive in the form a rod, which is placed under the skin in the arm] removed, because she wanted to get pregnant. The provider objected because this patient already had four

children by four different fathers:

She said she wanted to be pregnant again. I said, “Are you in a relationship? Because that would be news to me.” She said, “Well no, but I'm thinking of it.” And what I said, this was the real conversation, I said, “You bring him in so I can look him over, because that's what I do with my daughters.” (Nurse Midwife 1)

The patient declined to have her partner “looked over” and threatened to remove the Implanon on her own. The provider did not yield because, as she put it, the patient was not having any “problems” with the Implanon and no other form of birth control worked for her – a response that seemed to overlook that this particular patient was not seeking birth control. Ultimately, the patient left, removed her own implant, and returned pregnant. (Implanon removal is a surgical procedure that should only be performed by medical professionals). At the story's conclusion, I suggested that this seemed like a planned pregnancy, given the forethought it takes to remove one's own implant, to which the provider responded, “No, it doesn't take any planning at all! What it takes is stubbornness.”

In this provider's view, intention and active preparation for conception did not constitute a planned pregnancy. There was likely nothing this patient could have done to plan a “good” pregnancy. Because the provider judged that the patient already had too many children (with too many different partners), she had effectively forfeited her right to plan. Here, normative standards for planning were directly at odds with the reproductive justice goal for women to be able to get pregnant and parent with autonomy and dignity (Ross, 2006). While this case powerfully demonstrated the difference between intention and normative readiness, it was the only instance where a provider reported using coercion.

### *3.2.2 Divergent Treatment of Unintended (Sub-Intended) Pregnancies*

Providers also talked about patients who did not communicate intention, but still demonstrated “readiness” to have a baby. I designate these pregnancies as unintended or sub-intended because many, at least in the providers' telling, lacked clear intention, though these patients were not averse to pregnancy. An example of this came in the following exchange:

*I: You said that sometimes [patients] having things settled in their lives can make them ready to have a baby. Could you give me an example of a person who you thought was settled and ready to have a baby and the types of things that she had in order?*

*R: I saw a woman who had a career and been with her husband about quite some time and was ambivalent about whether she wanted to start a family or not and asked for hormonal testing just to see if she was fertile, so I did that, and I said, "Yeah, you shouldn't have any problems" and then pretty much as soon as we finished the testing, she was pregnant [laughs].*

*I: Can you tell me more about her being ambivalent about starting a family?*

*R: I think that she was just – they had waited for quite a while and it was kind of now or never. She knew that she was getting older and wouldn't be as fertile in the future, but liked her lifestyle that she had currently. (Nurse Practitioner 9)*

Not demonstrating a clear intention to get pregnant, this patient expressed ambivalence about whether to start a family, in part because she liked her current lifestyle. But for the provider, this patient was the first example that came to mind as someone ready to have a baby, whether or not she intended to get pregnant, because she had the appropriate normative markers in place, including her finances (“had a career”), relationship (“been with her husband about quite some time”) and age (“was getting older”).

Similar sentiments about how people could be ready to get pregnant without formulating clear intentions emerged in discussions of whether patients expressed an “if it happens, it happens” attitude about pregnancy. Nearly all providers confirmed seeing patients who expressed ambivalent or unclear attitudes about pregnancy, but their examples typically split into two narratives: one about poor and/or young women who maintained a cognitive dissonance

between their birth control practices and fertility desires or seemed apathetic about their futures. The other was about women, usually older and in long-term relationships, who were unsure of their fertility or who already had children and were uncertain about having more.

One provider who saw patients with private and public insurance, talked about this “if it happens, it happens” attitude:

Well, I mean, there are a lot of people that that [‘if it happens, it happens’] works really well for them. You know, that “I’ve gotten married, I’ve always wanted to have a child, we’re not trying, but if it happens, it happens.” That’s pretty benign and you know that that’s okay [...] Or the woman who may be closer to 35 who hasn’t gotten pregnant yet and maybe she isn’t in a committed relationship, but if she has a child, fine... (Doctor of Nursing 3)

Here, the uncertainty of patients who are married or over 35 was “benign.” Providers were particularly sympathetic towards ambivalence about pregnancy when a patient was unsure of her fertility. They accepted that such women used ambivalence as a way to cope with the possible disappointment of being unable to conceive.

Yet, in instances where patients were young and/or poor, providers were hesitant to accept ambivalence towards pregnancy. In this example, a provider who worked with mostly low-income, adult women recounted the type of conversation she would have with her patients about unclear intentions:

*[Patient]: "If it happens, well, you know, he wants me to have a baby."*

*[Provider] "Do you wanna have a baby?"*

*[Patient] "Well, I guess I wouldn't mind."*

*[Provider] "Ma'am, do you wanna have a baby!?"*

*[Patient] "Well, not really right now."*

*[Provider] "Alright, then this is what you have to do..."*

And I talk about fertility awareness – cause I know she's not gonna use the pill! I give her a pack and I will, for free. And I'll say, "I'm giving you these pills for free [...] I'm giving them to you because you might change your mind tomorrow or the next day and this way you'll be armed in advanced." (Medical Doctor 1)

Here, the provider did not treat ambivalence as benign, but as a contradiction to resolve. This

provider repeatedly pressed patients to clarify their intentions and then ensured that they left with not one, but two forms of birth control just in case they changed their minds.

This dichotomy in how to approach ambivalence appeared when this provider reflected on patients who take an 'if it happens, it happens' attitude:

Usually it's an individual when maybe they've been married for like greater than five years, and they're not using birth control, so...if it happens, it happens, and they're possibly still in their 20s and so it's still okay for them, you know.... (Nurse Practitioner 10)

When I asked if she encountered younger patients who took the same type of attitude towards pregnancy, she responded:

They do and I say "But you've gotta think about this because..." You know, say they're still in, like just got out of high school and they're in a new relationship and they're just like "I don't care." They need to. (Nurse Practitioner 10)

While the provider did not comment on the validity of ambivalence for an individual in a long-term relationship who was in her twenties or older, she reported telling younger patients in short-term relationships that they needed to care more about whether they got pregnant.

Research shows that health care providers stereotype patients and provide disparate treatments (Smedley, Stith, & Nelson, 2009). van Ryn and Burke (2000) also demonstrate that physicians are less likely to view low-SES patients as rational, responsible, and independent when compared to their more affluent counterparts. Age, in addition to class, appeared as important factors in providers' assessments of ambivalence. In their accounts, providers seemed trusting of older and middle-class women to make responsible and rational decisions, even when they communicated ambivalence about pregnancy. Alternatively, they tended to view poor or young women's ambivalence as a sign of irrationality and an urgent problem to solve.

### 3.3 The Limitations of Planning

Providers' occasional acceptance of ambivalence indicated that they did not always fully embrace the dominant public health message that all pregnancies should be carefully planned. In fact, nearly half of providers interviewed suggested that planning was ideal, but not always possible or that too much planning could even be detrimental. These statements sometimes co-occurred with discourses about individual intention or normative readiness. For instance, one provider at first described markers for readiness in great detail:

*I: [...]do you advise patients to have certain things in their lives settled before they try to have a baby?*

*R: Yeah, I'm kinda old school: you graduate from high school, you go to college, later in college you meet that person that you're probably interested in [...] you settle down with that person, you both start building a career, you both start building a positive relationship that's supposed to sustain over a life period and *then* you start tryina' raise a family. That means you have to have some planning done, you have to have some ducks in a row [...] (Doctor of Nursing 4)*

For this provider, there was a specific order to planning a family that included a college education, meaningful careers, and a strong, long-term relationship. Yet, he added:

*Is that the answer of the way it happens in my house? [laughs] Probably not [...] We all live in this philosophical, theoretical, this-is-how-it's-supposed-to-be world. To me everybody's supposed to go to church, [...] you never get divorced, there is no crime, the government takes care of sick people like in Canada, [...] but that's not my [reality] -- so does that mean I'm schizophrenic because I don't live in reality? NO! [laughs] (Doctor of Nursing 4)*

This qualification of his answer moved into a third discourse, one that is not typically present in public health conversations: that careful planning is not always possible. While he strove to encourage his patients, mostly low-income black women, to achieve particular levels of normative readiness, he also recognized that the world did not always work this way. He laid out

clear, “old school” standards, but also indicated flexibility in his recognition that significant limitations exist.

Another provider reacted to the CDC's reproductive life plan initiative, which encourages individuals to work with their health care providers to make a long-term reproductive plan, by saying:

A long-term plan, you know, I think that's ideal for the people that are making the family, for the children of that family, [but] sometimes an “accident” happens or a “mistake” happens [...] and that ends up being the best thing for everybody. (Doctor of Nursing 3)

This provider recognized that many women adapt quite well to unintended pregnancies (Klerman, 2000) and an “accident” or “mistake” could end up being beneficial. Her response also indicated that preventing all unintended pregnancies was not necessarily a desirable goal.

Other providers discussed how extensive planning might not be useful, because people ultimately adjust their plans to unforeseen circumstances. One provider did not like the idea of encouraging her patients to formulate reproductive life plans, because their lives changed from year to year. She explained:

You have these great, grandiose ideas, but until you experience life, then you experience life and things change. Your relationships don't work. Your job doesn't work or it does or you get promoted and you're doing something else. Every day is a growth. How do you know really where you wanna be? (Doctor of Nursing 5)

This response indicated that people cannot truly plan for the future, because a combination of life experiences and changing circumstances alter what a person wants in life. This provider challenged the public health logic that careful, long-term reproductive planning could create ideal circumstances for building a family. While the dominant discourse tends to portray women who do not plan their fertility as naïve and irrational (Ruhl 2002), this provider's response suggested that the promotion of reproductive life plans could be understood as naïve as well,

because they would create an unrealistic blueprint for life.

Another provider who worked with a mostly low-income and undocumented Latina population worried that some patients *overplanned*, saying:

I get women in that say, "I'm gonna wait 'til I finish school. And then he needs to go to school. And then we wanna have a house. And we wanna have a savings." [*laughs*] It's like, well, then you'll never have a baby!(Nurse Midwife 2)

She went on to explain that structural barriers prevented her patients from achieving these life markers and that "perfect" conditions were not necessary to be a good parent.

This discourse on the limitations of planning, a theme that emerged from the analysis unexpectedly, challenges both individual intention and normative readiness discourses. First, it questions the dominant public health logic that all pregnancies should be intended and carefully planned. Second, it resists the idea that individuals need to have met middle-class life markers in order to be good parents. The final provider quoted, in particular, pointed out how unrealistic dominant normative expectations are for disadvantaged women and how strict adherence to them would prevent some individuals from ever having children.

#### 4. Conclusion

Conflicts over reproduction are, at their essence, political. Reproductive bodies become ideological battlegrounds to delineate the appropriate relationships between gender, sexuality, population, and family (Gordon, 2002). Joffe's (1986) seminal research asserts that reproductive health providers play a pivotal role in mediating political conflicts over what family planning should be. In this study, I have examined providers' construction of what it means for their patients to "plan parenthood" and considered those constructions in the context of public health agendas and dominant discourses about reproduction. Recent studies of family planning

professionals have found that providers monitor and moralize the reproductive behaviors of young women (Breheny & Stephens, 2007; Hawkes, 1995; Mann, 2013). In part, my research confirmed those findings. Providers often drew on discourses that emphasized normative standards in family planning. Moreover, this discourse included, but was not limited to adolescent patients. Yet, I also found more complexity in providers' accounts. Many interviews featured a strong discourse of individual intention, which emphasized patients' autonomy to make independent decisions about their fertility. At times, these discourses collided and created a very real tension. Finally, providers sometimes resisted the idea that reproductive planning was invariably useful – a finding that is novel in research on providers and that challenges the dominant public health narrative.

Identifying these varying discourses adds nuance and depth to the commonsense notion of what it means to “plan parenthood.” The present study also highlights instances where this seemingly neutral public health goal is laden with moralized expectations about family planning. Though contemporary medical ethics and practice have moved away from traditional paternalism and emphasized a respect for patients' rights and autonomy (O'Neill, 2002), this has not always been the case when these patients are reproductive-age women (Lupton, 2012). My interviews demonstrate that medical providers' respect for women's autonomy in reproductive decision-making is inconsistent. Sometimes providers adopt paternalistic discourses and view it as their role to warn or even prevent patients from getting pregnant when they are young, poor, undereducated, or unmarried.

I propose that providers' accounts demonstrated a tension between individual intention and normative readiness, in part, because they operated within a highly stratified society that

provides few social supports for poor, young, and single parents (Edin & Lein, 1997). Providers may have felt obligated to prepare patients for these broader realities, especially given health care initiatives that encourage providers to help individuals achieve their goals and plans. Those especially working with low-income populations had few tools to accomplish this large feat. Many talked at length about the need for more services, such as access to social workers, reliable transportation, affordable healthcare, and better educational systems, that were beyond the scope of their care. These broader critiques remind us that reproductive justice is not attainable when parenting with dignity and autonomy is a class privilege rather than a universal right (Luna & Luker, 2013; Ross, 2006).

## **References**

- Avishai, O. (2007). Managing the lactating body: The breast-feeding project and privileged motherhood. *Qualitative Sociology*, 30(2), 135-152.
- Barrett, G. & Wellings, K. (2002). What is a 'planned' pregnancy? Empirical data from a British study. *Social Science & Medicine*, 55(4), 545-557.
- Bell, A. V. (2010). Beyond (financial) accessibility: Inequalities within the medicalisation of infertility. *Sociology of Health & Illness*, 32(4), 631-646.
- Borrero, S., Schwarz, E. B., Creinin, M. & Ibrahim S. (2009). The impact of race and ethnicity on receipt of family planning services in the United States. *Journal of Women's Health*, 18(1), 91-96.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Breheeny, M. & Stephens, C. (2007). Irreconcilable differences: Health professionals' constructions of adolescence and motherhood. *Social Science & Medicine*, 64(1), 112-124.
- Bridges, K. M. (2011). *Reproducing race: An ethnography of pregnancy as a site of racialization*. Berkeley: University of California Press.
- Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.
- (CDC) Centers for Disease Control and Prevention. (2012). Preconception health and health care: My reproductive life plan. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. <http://www.cdc.gov/preconception/reproductiveplan.html>; Accessed 4/1/15.
- (2006). Recommendations to improve preconception health and health care-United States: A report of the CDC/ATSDR preconception care work group and select panel on preconception care. *Morbidity and Mortality Weekly Report: Reports and Recommendations*, 55(RR06), 1-23.
- Dehlendorf, C., Kimport, K., Levy, K., & Steinauer, J. (2014). A qualitative analysis of approaches to contraceptive counseling. *Perspectives on Sexual and Reproductive Health*, 46(4), 233-240.
- Dehlendorf, C., Rodriguez, M.I., Levy, K., Borrero, S. & Steinauer, J. (2010). Disparities in family planning. *American Journal of Obstetrics & Gynecology*, 202(3), 214-220.

- Downing, R. A., LaVeist, T. A., & Bullock, H. E. (2007). Intersections of ethnicity and social class in provider advice regarding reproductive health. *American Journal of Public Health*, 97, 1803-1807.
- Edin, K. & Kefalas, M. (2005). *Promises I can keep: Why poor women put motherhood before marriage*. Berkeley: University of California Press.
- Edin, K & Lein, L. (1997). *Making ends meet: How single mothers survive welfare and low-wage work*. New York: Russell Sage Foundation.
- Edin, K. & Nelson, T. (2013). *Doing the best I can: Fatherhood in the inner city*. Berkeley: University of California Press.
- Finer, L. B. & Zolna, M. R. (2011). Unintended pregnancy in the United States: Incidence and disparities, 2006. *Contraception*, 84(5), 478-485.
- Frost, J. J., Benson Gold, R., & Bucek, A. (2012). Specialized family planning clinics in the United States: Why women choose them and their roles in meeting women's health care needs. *Women's Health Issues*, 22(6), e519-e525.
- Furstenberg, F. F. (2007). *Destinies of the disadvantaged: The politics of teenage childbearing*. New York: Russell Sage Foundation.
- Geronimus, A. T. (2003). Damned if you do: Culture, identity, privilege, and teenage childbearing in the United States. *Social Science & Medicine*, 57(5), 881-93.
- Gordon, L. (2002). *The moral property of women: A history of birth control politics in America*. Urbana: University of Illinois Press.
- Hawkes, G. (1995). Responsibility and irresponsibility: Young women and family planning. *Sociology*, 29(2), 257-273.
- Hays, S. (1996). *The cultural contradictions of motherhood*. New Haven: Yale University Press.
- (HHS) Department of Health and Human Services. (n.d). Title X family planning program priorities. Office of Population Affairs: Department of Health and Human Services. <http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-priorities/>; Accessed 4/1/15.
- Higgins, J. A., Popkin, R. A., & Santelli, J. S. (2012). Pregnancy ambivalence and contraceptive use among young adults in the United States. *Perspectives on Sexual and Reproductive Health*, 44(4), 236-243.

- Joffe, C. (1986). *The regulation of sexuality: Experiences of family planning workers*. Philadelphia: Temple University Press.
- Katz, A. M. & Alegria, M. (2009). The clinical encounter as local moral world: Shifts of assumptions and transformation in relational context. *Social Science & Medicine*, 68(7), 1238-1246.
- Kendall, C., Afable-Munsuz, A., Speizer, I., Avery, A., Schmidt, N., & Santelli, J. (2005). Understanding pregnancy in a population of inner-city women in New Orleans - results of qualitative research. *Social Science & Medicine*, 60(2), 297-311.
- Klerman, L.V. (2000). The intendedness of pregnancy: A concept in transition. *Maternal & Child Health Journal*, 4(3), 155-162.
- Lifflander, A., Gaydos, L. M. D., & Rowland Hogue, C. J. (2007). Circumstances of pregnancy: Low income women in Georgia describe the difference between planned and unplanned pregnancies. *Maternal & Child Health Journal*, 11(1), 81-89.
- Luna, Z. & Luker, K. (2013). Reproductive justice. *Annual Review of Law and Social Science*, 9, 327-352.
- Lupton, D. (2012). *Medicine as culture: Illness, disease and the body*. (3<sup>rd</sup> ed.). Los Angeles: Sage.
- Lyerly, A. D., Mitchell, L. M., Armstrong, E. M., Harris, L. H., Kulka, R., Kupperman, M., & Little, M. O. (2009). Risk and the pregnant body. *Hastings Center Report*, 39(6), 34-42.
- Mann, E. S. (2013). Regulating Latina youth sexualities through community health centers: Discourses and practices of sexual citizenship. *Gender & Society*, 27(5), 681-703.
- O'Neill, Onora. (2002). *Autonomy and trust in bioethics*. Cambridge: Cambridge University Press.
- (ODPHP) Office of Disease Prevention and Health Promotion. (2014). Family planning. *Healthy People 2020*. <http://www.healthypeople.gov/2020/topics-objectives/topic/family-planning#eight>; Accessed 10/22/14.
- RamaRao, S. & Jain, A. K. (2015). Aligning goals, intents, and performance indicators in family planning service delivery. *Studies in Family Planning*, 46(1), 97-104.
- Rapp, R. (1999). *Testing women, testing the fetus: The social impact of amniocentesis in America*. New York: Routledge.

- Roberts, D. (1997). *Killing the black body: Race, reproduction, and the meaning of liberty*. New York: Pantheon Books.
- Ross, L. J. (2006). *Understanding Reproductive Justice*. Atlanta, GA: SisterSong.
- Ruhl, L. (2002). Dilemmas of will: Uncertainty, reproduction, and the rhetoric of control. *Signs*, 27(3), 641-663.
- Santelli, J. S., RoCHAT, R., Hatfield-Timajchy, K., Colley-Gilbert, B., Curtis, K., Cabral, R., Hirsch, J. S., Schieve, L. & Other Members of the Unintended Pregnancy Working Group. (2003). The measurement and meaning of unintended pregnancy. *Perspectives on Sexual and Reproductive Health*, 35(2), 94-101.
- Schwennesen, N. & Koch, L. (2012). Representing and intervening: 'Doing' good care in first trimester prenatal knowledge production and decision-making. *Sociology of Health & Illness*, 34(2), 283-298.
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds). (2009). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, D.C.: The National Academies Press.
- Solinger, R. (2005). *Pregnancy and power: A short history of reproductive politics in America*. New York: New York University Press.
- (2001). *Beggars and choosers: How the politics of choice shapes adoption, abortion, and welfare in the United States*. New York: Hill and Wang.
- Thornburn, S. & Bogart, L. M. (2005). African American women and family planning services: Perceptions of discrimination. *Women & Health*, 42(1), 23-39.
- van Ryn, M. & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science & Medicine*, 50(6), 813-828.
- Waggoner, M. R. (2013). Motherhood preconceived: The emergence of the preconception health and health care initiative. *Journal of Health Politics, Policy and Law*, 38(2), 345-371.
- Williams, C. (2006). Dilemmas in fetal medicine: Premature application of technology or responding to women's choice? *Sociology of Health & Illness*, 28(1), 1-20.

## Highlights:

- U.S. public health agenda aims to reduce unplanned pregnancy.
- This study examines how reproductive health care providers interpret “family planning.”
- Finds tension between patients' intentions and normative expectations about planning.
- Normative expectations are often based on middle-class life markers.
- Providers sometimes question the utility of reproductive planning.