

**“YOU’RE PLANNING A FAMILY, NOT JUST A PREGNANCY”:
THE MEANINGS, EXPERIENCES, AND UNEVEN BURDENS OF FAMILY
PLANNING IN WOMEN’S LIVES**

by

Jamie L. Manzer

A dissertation submitted to the Faculty of the University of Delaware in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Sociology

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ABSTRACT

Family planning has been a cornerstone of American public health policy for decades because of its potential to reduce unintended pregnancies, decrease related public spending, and improve family stability. Despite this prioritization, nearly fifty percent of pregnancies in the United States (U.S.) remain unplanned, suggesting there may be an unexplored disconnect between family planning as a public health goal and women's own family formation needs and experiences. However, given the purported benefits of family planning, few policymakers, scholars, and healthcare professionals critically examine the paradigm of family planning, instead focusing policy efforts and resources on simply encouraging women to better time and space their pregnancies in line with public health recommendations. Through the stories of 86 diverse self-identified women, whose lives I follow for five years, I set out to understand how women conceive of family planning and enact its tenets (or not) in their lives. In doing so, I demonstrate that family planning is not simply a set of objective, health-related decisions about when and under what circumstances to become pregnant. Rather, it is a deeply intimate social process of family formation, influenced by gender, race, and class-based ideologies around family, motherhood, and health. Through these findings, I cast a critical light on the paradigm of family planning by challenging the underlying assumptions about its relevance, neutrality, universality, and benefits. Further, by using a Reproductive Justice lens, I emphasize the unequal burdens of family planning

as currently conceived on women and families as well as its failure to support and stabilize families. I conclude by offering a new definition of family planning and use it to propose clear directions for future research as well as recommendations for social and public health policies that are both family and woman centered.

Chapter 1

INTRODUCTION

One of public health's unresolved but most pressing questions is why do nearly half of women in the United States (U.S.) fail to successfully plan their families? In other words, why are one in every two pregnancies in the U.S. characterized as “unplanned,” “mistimed,” or “unwanted,” and what should be done to reduce such rates? Currently, the most popular approach is for local and state governments to implement numerous “family planning” initiatives that focus on increasing women's access to and use of effective contraception (Choi et al., 2020; Higgins, 2014; Secura et al., 2010) so that women may “anticipate and attain their desired number of children through the intentional spacing and timing of their births” (World Health Organization [WHO], 2007). To assess the efficacy of such efforts, a team of researchers and I set out to understand women's attitudes, beliefs, and behaviors around contraception. Central to our inquiry is to understand how women conceive of family planning and enact its tenets (or not) in their lives.

Three years into our study and as a part of her second interview, I sit with Lauren, a White woman of low socioeconomic status (SES), to discuss her definition of family planning and its relevance in her life. In her definition, Lauren conveys that family planning represents more to her than the intentional timing and spacing of a

pregnancy, rather, “[p]lanning is more like planning a family, not just planning a pregnancy.” As such, Lauren does not prioritize family planning objectives as currently constructed; instead, she describes prioritizing the consideration of “lots of other life factors—family factors” such as sibling relationships and her husband’s desires for children. Lauren’s response is notable because it identifies an often overlooked feature of family planning—the family. By focusing on timing and spacing pregnancies, definitions such as those purported by the WHO, overemphasize *pregnancy* planning and neglect the social, embedded process of *family* formation that Lauren so clearly describes. Lauren’s definition, then, reveals a noteworthy conflict between family planning as a medical paradigm and family planning as a social endeavor—the consequences of which, I set out to explore.

Although the U.S. has historically encouraged the idea of family planning, what is novel about family planning today is its institutionalization and social acceptance as a model medical framework for improving pregnancy outcomes (Centers for Disease Control and Prevention [CDC], 2006; Office of Disease Prevention and Health Promotion [ODPHP], 2014; Waggoner, 2017). Experts argue that family planning interventions are needed to reduce high rates of unplanned pregnancies because such pregnancies are associated with a range of social, economic, and health problems, including poverty, public healthcare and social assistance expenditures, as well as adverse pregnancy outcomes (Finer & Sonfield, 2013; Sonfield, Kost, & Finer, 2011; Trussell et al., 2013). This has led policymakers to adopt a medical solution—family planning— as the most effective strategy for

addressing these problems (Finer & Sonfield, 2013; Sanger-Katz, 2018; Sonfield, Kost, & Finer, 2011).

Indeed, the WHO's definition of family planning as the intentional timing and spacing pregnancies vis-à-vis contraception situates it almost entirely within the medical realm. Additionally, linking poor health outcomes to family planning and "treating" this with primarily medical interventions by healthcare providers who prescribe contraceptives further locates family planning under the medical umbrella. Most contraceptive methods, the WHO's recommended form of family planning, are medicalized as they require a provider's prescription or medical procedure to place (Daniels, Daugherty, & Jones, 2014).

This medicalization of family planning, or its transformation from a natural life event into a problem that requires medical intervention (Conrad, 2007), extends medicine's involvement in women's reproductive lives and the ability for healthcare professionals and policymakers to dictate appropriate reproductive activities as well as determine who is "fit" to mother (see, Armstrong, 2003; Conrad, 2007; Litt, 2000; Roberts, 1997; Waggoner, 2017). Healthcare providers, pundits, policymakers, and even women increasingly understand family planning to be a set of health behaviors such as using effective contraception and always being mindful of pregnancy risk despite pregnancy intentions. Yet, as my findings reveal, this medicalized approach involves numerous social considerations around family, motherhood, and "life factors" that make it inapplicable and inappropriate for public health intervention. Instead, poorly aligned and problematic family planning interventions may actually exacerbate

the very problems they are purported to address, such as child and maternal mental health disorders and intergenerational poverty (Mark & Cowan, 2022).

Other scholars have raised similar concerns about family planning, but rather than question the applicability and effects of the paradigm family planning more broadly, their critiques are limited to the related, but narrower construction of “unintended pregnancy.” For instance, they question unintended pregnancy as metric, critiquing its definition and measurement (e.g., Santelli et al., 2003). In doing so, they note that many factors contribute to whether a pregnancy is unintended, such as ambivalence and fatalism about pregnancy and the complex emotions that some feel when experiencing an unexpected pregnancy (Aiken, Dillaway, & Mevs-Korff, 2015; Arteaga et al., 2020; Blake et al., 2007; Gomez, Arteaga, & Freihart, 2021; James & Rashid, 2013). Researchers also question if unintended pregnancies are inherently problematic, arguing that such social problems are better understood as a symptom of structural inequalities (Bell et al., 2018; Geronimus, 2004; Geronimus & Korenman, 1992; Gomez, Arteaga, & Freihart, 2021; James & Rashid, 2013; Kavanaugh, 2008; Kelly, 2014). This work focuses on upstream social factors driving the disproportionately higher rates of unintended pregnancy among economically and racially marginalized women and argues that ignoring the social contexts in which such pregnancies occur in favor of individualistic approaches to prevention is itself a problem. Taken together, this collective work importantly raises questions about the usefulness and validity of unintended pregnancy as a construct, yet still neglects the

broader implications of family planning as a necessary medical paradigm and allows it to go largely unchecked.

Therefore, I recast the oft-posed question of why women fail at family planning to, how might family planning be failing women.¹ To do so, I apply a sociological lens to introduce the sociocultural values and assumptions underlying family planning expectations that not only shape women's experiences as they form their families, but also the role of such assumptions in the development of family planning as a public health agenda. Like scholars critical of unintended pregnancy who question the link between pregnancy intendedness, poor health, and broader social problems (see, e.g., Geronimus, 2003), it is imperative that we take a step further to also question how the generalized acceptance of these standardized family planning goals shape women's family formation experiences as well as their conceptualization of the "ideal family" (in comparison to their own).

As I demonstrate in the chapters that follow, family planning guidelines are often at odds with women's family planning considerations because simply put,

¹ Throughout this dissertation, I use the term "women" or "woman" to refer to participants as they self-identified as women as a condition of participating in the study and were presumed cisgender (i.e., non-transgender) women. I do so because they are the focus of efforts to encourage family planning via contraceptive use. However, there are transgender and gender expansive people who do not identify as women but do have the capacity to become pregnant and may use contraception to prevent pregnancy and/ or to achieve other aims, such as suppressing menstruation. Family planning and related issues are of relevance for these individuals as well.

women prioritize family goals, of which pregnancy planning is merely a part. This conflict affects how women see themselves as mothers and the social acceptability of their families. In this way, for Lauren and the other 85 women in this study, family planning influences what it means to be a “good” mother as well as what it means to be a “good” family. Lauren, for instance, has a “*definite* idea of what a good mother or a good family is,” and her decision-making takes into account the need to “give it your all because you’re not just pregnant, you’re a mom now.” Indeed, to meet the social obligations of ideal womanhood, it is no longer sufficient to simply mother, but to mother well, and as I argue, family planning is yet another yardstick with which to measure “good” motherhood against (Thurer, 1994). As Lauren highlights, subsumed within this public health imperative to plan one’s *pregnancy* is also a set of social norms that inform the cultural (and medical) appropriateness of women’s *family* formation decisions as well as the gendered, raced, and classed expectations that women are responsible for such decisions (Armstrong, 2003; Geronimus, 2003).

Using a Reproductive Justice (RJ) lens throughout, I show that family planning as a public health aim and dominant medical discourse has a uniquely stratifying effect that obligates its reconceptualization. For instance, by labeling some pregnancies as planned, unplanned, wanted, or unwanted, family planning produces a pregnancy hierarchy in which some pregnancies, and by extension some families, are more medically *and* socially desirable than others. Given that marginalized women have disproportionately higher rates of unplanned pregnancies, their pregnancies and families are inherently devalued and even, discouraged (Dehlendorf et al., 2010;

Gomez & Wapman, 2017; Manzer & Bell, 2021; 2022; Secura et al., 2010). This “stratified reproduction,” or the systematic devaluation and regulation of the fertility of marginalized populations by those in positions of power, is legitimated and even necessitated by family planning logic that prioritizes health outcomes over women’s reproductive desires.

Additionally, the RJ framework shifts the priority from appraising the acceptability of some pregnancies over others to the right for all women to “have a child, the right not to have a child, and the right to parent the children we have” (Ross, 2006, p. 14). This framework is particularly useful in challenging and redefining the family planning paradigm because it centers structural rather than individual failures. The U.S. is one of few fully industrialized countries that prioritizes family planning to reduce its population. This is largely due to persistently poor maternal and child health outcomes and the relatedly high social costs incurred despite spending the most on healthcare of any country in the world (Bodenheimer, 2005; Lesthaeghe & Neidert, 2006). Women of color, low-income women, and young women are more likely to experience these poor outcomes. Yet rather than address the structural causes of these outcomes, family planning focuses on individual women’s decision-making which increases the stigma surrounding their pregnancies and fails to address the root causes of their poor outcomes. Indeed, through their family planning guidance, the WHO promulgates a universal, medical blueprint to family formation. This conception of family planning neglects the embedded power dynamics and privilege needed to achieve such standards.

My goal for this study, then, is to cast a critical light on the current paradigm of family planning by challenging the underlying assumptions about its relevance, neutrality, universality, and benefits and in doing so, propose a new paradigm of family planning that centers family formation and its many sociocultural considerations. As I demonstrate throughout, by shifting the family planning paradigm accordingly, it is possible (and necessary) to address reasonable public health concerns while also supporting women's family formation aims. Through the women's stories, I reveal that family planning is not simply a set of objective, health-related decisions about when and under what circumstances to become pregnant. Rather, it is a deeply intimate social process of family formation, influenced by gender, race, and class-based ideas around family, motherhood, and health. By using a Reproductive Justice lens, I emphasize the unequal burdens of family planning as currently imposed on women whose pregnancies, and by extension, families, fail to meet middle-class markers of acceptability. Indeed, reproduction is often at the center of power, privilege, and marginality. Family planning, I argue, is an arbiter of all three.

Structure of the dissertation

I accomplish these goals through three empirical chapters in which the women's stories demonstrate both the complexity of family planning and the need to redefine it. In Chapter 4, I illustrate the women's definitions of family planning and the family values contained within. In doing so, I demonstrate the often conflicting objectives of family planning as a public health paradigm with women's own family

planning priorities. Rather than pregnancy timing and spacing, the women prioritize stability which they hope to achieve by being of a stable age, having a stable home, income, and relationship. To do so, the women find ways to balance numerous external factors like partners, social norms, and access to resources with their own deeply held family ideals. In this way, family planning cannot be simply defined as a public health objective but rather, a social enterprise, encompassing ideals of motherhood, family, and stability.

Chapter 5 focuses specifically on these ideals of motherhood where I further tease out the inherent conflicts that arise between women's motherhood ideals and pregnancy-focused family planning guidelines. Indeed, the medical construction of family planning emphasizes women's individual decision-making, responsibility, and risk specifically related to unplanned pregnancies—a responsibility women have taken on and internalized—but must also balance against women's desires for motherhood. I show that this focus on individual decision-making serves to justify the stratification and devaluation of some pregnancies and families over others. Consequently, women must often choose between the “unchoosable”—mother well by family planning standards or not at all. Therefore, I demonstrate the need to incorporate family values around motherhood into a new family planning paradigm as well as center women's right to be mothers in the first place, whether they intentionally plan their pregnancies or not.

In Chapter 6, I illustrate how family planning, as currently constructed, fails to make good on its many promises to improve the health and social outcomes of women

and families because it overemphasizes individual-level health behaviors while neglecting the structural factors that create poor outcomes for women and children. To do so, I show that women's outcomes are predicated on (in)equality rather their family planning status. Just as Reproductive Justice looks upstream to understand the root causes of inequality, I demonstrate that the same is necessary in reconceptualizing family planning.

Chapter 2

LITERATURE REVIEW

Introduction

At present, women's childbearing decisions are most often viewed through two lenses, either family planning *or* family formation. Paradoxically, although both capture the same process of pregnancy decision-making, their definitions and perspectives vary markedly. Family planning is the intentional timing and spacing of pregnancies through contraception. Therefore, most research in its regard examines women's decisions about contraception use and pregnancy "intendedness". Family formation, meanwhile, is a process that includes union formation, fertility, and their timing and order. Given this definition, most family formation research tends to study these processes as larger patterns at the population level, often neglecting important contextual factors that inform women's childbearing decisions. Given their distinct but important viewpoints, I propose integrating family planning and family formation perspectives to reimagine family planning as a more nuanced and family-oriented paradigm. Accordingly, after reviewing how family planning and family formation examine childbearing, I then use a final section to demonstrate how these two distinct perspectives, when taken together, can help researchers better understand women's needs, desires, and lived experiences around childbearing.

Family planning and medicine

It is widely accepted in public health and medicine that family planning is the solution to unplanned pregnancies. Defined by intentionally timing and spacing one's pregnancies vis-à-vis contraception, family planning is (equivocally) associated with improvements in pregnancy outcomes as well as reductions in poverty rates and related public expenditures like Medicaid and welfare (Birgisson et al., 2015; Finer & Zolna, 2016; Sonfield, Kost, & Finer, 2011; Trussell et al., 2013). Despite the questionable associations of these benefits, family planning remains a national public health priority (Healthy People, n.d.).

This prioritization of family planning positions it a “good practice of life” (Zola, 1976, p. 211). As such, U.S. public health institutions offer detailed and prescriptive recommendations for how women can and should ideally implement family planning in their lives. For example, the WHO and CDC recommend women be between 18-35 years old, have a 24-month interval before attempting a subsequent pregnancy (but no more than five years) and ideally, not exceed four children (CDC, 2006; WHO, 2007). Additionally, women should conduct themselves as if potentially pregnant from menarche to menopause (Waggoner, 2017) by taking folic acid, maintaining a healthy weight, exercising regularly, quitting tobacco use, refraining from excessive alcohol consumption, talking with their doctors about pregnancy risks and age, managing chronic health conditions, and above all, using contraception “correctly and consistently” (CDC, 2006). As evidenced by both the definition of

family planning as pregnancy-related and the guidelines as health-specific, family planning is primarily conceived of as a medical construct with pregnancy as its focus.

Unsurprisingly, most research regarding family planning, then, is derived from demographers and public health scholars who focus on population and community health. A key area of scholarly debate among them is about which metrics to measure, how to adequately define them, and which models best capture family planning trends and outcomes (see, Barrett & Wellings, 2002; Klerman, 2000; Santelli et al., 2013). Perhaps a product of its medicalization, researchers focus extensively on the measurement of key terms like pregnancy intention rather than bigger picture questions of whether and how family planning is relevant to or a universally desirable goal for women (Barret & Wellings, 2002; Borrero et al., 2015; Hall et al., 2017; Lifflander, Gaydos, & Hogue, 2007; Moos et al., 1997).

This is not to say that all research neglects women's perspectives, it is simply that within this body of research, relatively few scholars question the broader medicalized construction of family planning. However, the field does increasingly acknowledge the complexity and potential limitations of family planning research. For instance, studies find that people's pregnancies do not necessarily fall within these common dichotomies of wanted/unwanted, planned/unplanned, timed/mistimed, intended/ unintended (Aiken et al., 2016; Klerman, 2000; McQuillan, Greil, & Shreffler, 2011; Moos, et al., 1997). In fact, surveyed couples do not readily use researchers' own terminology when asked to describe the intendedness of their pregnancies (Barret & Wellings, 2002). Such findings beg questions about the futility

of capturing the desirability of and decision-making around planning pregnancies as a primary means of understanding family planning considerations, especially when using survey or other quantitative methods that traditionally lack nuance (Aiken et al., 2016; Barrett & Wellings, 2002). Indeed, researchers have found that women can be ambivalent about a pregnancy, feeling “okay either way,” (Higgins, 2017; McQuillan, Greil, & Shreffler, 2011), feel a sense of dread or joy at the news (Aiken, Dillaway, & Mevs-Korff, 2015), or feel fatalistic about trying to plan their pregnancies (Borrero et al., 2015).

A smaller body of sociological research does offer some contextualization of women’s family planning decisions (or lack thereof), by pointing out that external factors may prevent simple black and white pregnancy decisions. They find, for instance, that relationship status, economic conditions, number of current children, partner desires, and career ambitions can inform pregnancy desire (Aiken & Trussell, 2017; Upadhyay, Raifman, & Raine-Bennett, 2016). Knowing this, work continues to establish terms, variables, and methods that successfully measure individuals’ childbearing decisions and how these decisions are made in conjunction with other life course priorities. But within these efforts, researchers largely neglect the construct of family planning itself, instead studying and refining microcosms of the broader family planning process. In other words, scholars study these important sub-areas like pregnancy intendedness or contraceptive use, positioning their work within broader conversations about family planning, but rarely conceptualize or challenge family planning as a social construct itself (see, Aiken et al., 2016; Klerman, 2000;

McQuillan, Greil, & Shreffler, 2011). Doing so neglects the function of other important structures and norms that underlie the questions we ask about what it means to enact family planning—one of which is family.

While these findings make important contributions to the field of family planning, especially in terms of highlighting the multifaceted nature of family planning decisions, they fall short epistemologically. Dehlendorf and colleagues (2018) argue that efforts to understand pregnancy decision-making may unintentionally validate family planning objectives and the public belief that limiting pregnancies among some populations is acceptable and even necessary. While these authors do not take up the issue of family planning directly, they do acknowledge that researchers inquiring about related issues of unintended pregnancy risk and prevention inevitably insinuate that unplanned pregnancies are undesirable, and, in doing so potentially advance stereotypes about whose pregnancies are problematic and thus necessary to prevent. As the authors suggest, failing to question the epistemological assumptions embedded in the research about pregnancy intention can be harmful to women. I contend that such critiques can and should be extended to family planning more broadly.

Certainly, epistemological assumptions have real world implications for women and families which further necessitates a critical examination of family planning as a paradigm. This is particularly true of research that identifies specific populations of women as more “at risk” of unplanned pregnancies than others. As Irving Zola (1976) illuminates, how a medical condition (e.g., unplanned pregnancy)

is understood is how the solution is crafted (e.g., pregnancy prevention). So, although the number of unplanned pregnancies is on the decline across all women, disproportionately high rates among young women, poor women, women of color, and unmarried women continue to be central to on-going family planning research and interventions. Consequently, these “at-risk” women are often targeted by family planning initiatives because they experience worse health and social outcomes than well-resourced women (see Daniels, Daugherty, & Jones, 2014; Finer & Zolna, 2011; Frost & Darroch, 2008).

In this way, categorizing family planning as a public health objective has significant policy implications for women and families. Indeed, the dominant approach to improving pregnancy outcomes is to treat individual women, establishing family planning guidelines, and then modifying women’s behaviors to meet them by offering contraceptives. In other words, medicalizing family planning inherently individualizes decisions and subsequent responsibility for poor outcomes as is typical of health promotion programs (Conrad & Schneider, 1992). This individualization is apparent in the names of family planning interventions such as the St. Louis “CHOICE project” and the South Carolina “Choose Well” program (Secura et al., 2010).

As these family planning initiatives proliferate, so too does the practice of family planning. Indeed, thanks in large part to these initiatives and concerted efforts by stakeholders, family planning is increasingly a part of the American vernacular and is becoming a widely accepted reproductive norm, especially among healthcare

professionals, policymakers, and their White, middle- and upper-class constituents. Through such efforts, women are encouraged to use public health guidelines, rather than their personal desires and needs, when making decisions about their childbearing. To educate women about and encourage such thinking, women's health providers are now trained to offer birth control within the context of broader family planning aims and to counsel women about their reproductive life plans-- a protocol that aims to encourage women to reflect on their reproductive intentions and to find strategies for successful family planning, (Lindo & Packham, 2017; Peipert et al., 2012; Upstream, 2020). Moreover, thirty U.S. states now educate their healthcare providers to ask women about their pregnancy desires and counsel about contraceptives and pregnancy intentions despite the reason for the appointment. By promulgating metrics-oriented family planning guidelines, these initiatives promote pregnancy planning, not as a complex, familial process, but as a universalized and individualized medical outcome. In doing so, women are encouraged to prioritize family planning as currently conceived over and above any other planning considerations.

Taken together, conceiving of family planning as a medical phenomenon influences how it is defined, measured, and remedied. It is imperative then, to examine family planning in relation to medicine, challenging the medical objectivity and legitimacy underlying frequent claims that family planning is "the" reproductive ideal women for which should strive. Doing so highlights how such assertions are in fact arbitrary, neglecting the social construction of the family and of planning these families (Conrad, 2007; Conrad & Barker, 2010; Geronimus, 2003; Waggoner, 2017).

In the following section, I discuss the social construction of the ideal “American” family and how it has been simultaneously challenged and privileged by sociological research. I do so to interrogate the taken-for-grantedness of the traditional “family” implicit within “family planning.” Doing so challenges the conventional wisdom that favors public health guidelines around family planning. Using these insights, this study goes on to explore the consequences that emerge from having created such a widely accepted discourse around family planning and the implicit social messages about appropriate families.

Family planning and family formation

The family is a foundational social institution (Thornton & Fricke, 1987). Although the definition of “family” is socially constructed, varying by location and time, there is a dominant “family” idealized, promoted, and institutionalized within U.S. law and ideology (Coontz, 1992). Dorothy Smith (1993) famously coined this preferred family form the “Standard North American Family” or SNAF—a small, nuclear family characterized by a later marriage, working father, stay-at-home mother, and approximately two or three intensively parented children (Hays, 1996; Smith, 1993). Incentive schemes (and disincentive schemes) like tax policies, welfare caps, and marriage promotion, institutionalize this family structure while (conservative) political discourse frequently refers to its centrality as a part of American family values (Cherlin, 1992; 2003). For instance, former President Ronald Reagan notably stated, “A strong family with a husband and wife has always been the cornerstone of

American society. Our families nurture, preserve, and pass on to each succeeding generation the values we share and cherish, values that are the foundation of our freedoms” (Cherlin, 1988, p. 16).

Many Americans agree with these assertions. So much so, seventy percent of Americans currently believe that a “good family life” is a prerequisite for the American Dream, and 76% feel that family is most important to them (Pew Research Center, 2015). Yet, the “good” family life is increasingly unattainable for most Americans as income inequality erodes the opportunity and stability often promised by but is ultimately required to achieve such a life (Cherlin, 2019; Coontz, 1992). Moreover, few families align with this culturally idealized nuclear family structure (Cherlin et al., 2008; Coontz, 1992; Pew Research Center, 2015). At present, nearly a quarter of children are now raised in single-parent households (up from 6% in 1970); fewer adults are choosing marriage and of those who do, more than 50% will end in divorce (Pew Research Center, 2015). Many Americans interpret these shifts as problematic and worry that the family and their American dream are in decline (Furstenberg, 2008b).

This rhetoric of family decline is a key area of overlap between family planning and family formation as well as where research agendas, although rarely combined, intersect. Indeed, policymakers and pundits regularly blame tertiary social problems like poverty and crime on this changing family structure, and increasingly, policymakers promote “family planning” as a “cheap and easy” way to reverse this destabilization (Cherlin, 2003; 2008; 2019; Sanger-Katz, 2018; Sawhill, 2014). These

depictions of family decline in relationship to social problems continue to stoke widespread social anxieties, many of which are centered around ideas of changing family structure, childbearing, and parenting—particularly mothering—and are reflected both in family studies as well as family planning research. Families, then, are seen as both the root of many social problems and therefore, a solution to them.

For example, moral panics about family decline and the rise of teenage childbearing rates emerged at about the same time in the early 1970s. This decade marks one of the first times in which family planning, as a public health objective, was specifically implemented as a quasi-family policy. Historian Stephanie Coontz (2010) suggests that Americans feared for the fragility of family values, of which “out of wedlock births”, commonly associated with teenagers, was a key concern. Similarly, there were concerns about “White racial decline” as White middle-class women’s fertility rates dropped and perceptions of higher or hyper-fertility rates among immigrant families and African Americans became prevalent in popular discourse (Hansen & King, 2013; Roberts, 1997). To combat these changes, politicians simultaneously drafted tax and social policies to incentivize a “return” to the nuclear family and promote childbearing among White, married, and middle-class women while simultaneously implementing family planning and population control programs to reduce less desirable pregnancies (Gomez, Fuentes, & Allina, 2014; Lesthaeghe & Neidert, 2006). In this way, family planning was conceived of as a family policy—ultimately to “save” the family. Consequently, family planning, though a medical construct, must also be understood as a family construct. Indeed, family planning

guidelines and programs discouraging births to marginalized women became central in defining and justifying a need to reduce deviant pregnancies as well as deviant families.

Although childbearing trends have changed significantly since the rise of these initial moral panics in the 1970s, family decline rhetoric persists (see, e.g., Sawhill, 2014). In fact, due to factors like the Great Recession and the COVID pandemic among others, U.S. birth rates are falling below replacement levels for the first time (Guzzo & Hayford, 2020) which begs the question, why do these moral panics persist and why is family planning such a centerpiece of U.S. public health policy? Family scholarship helps to answer these questions. Concerns are not necessarily related to decreasing population-level fertility rates per se, but rather, the perceived quality of the childbearing that is occurring. That is, of women who have children, women of low SES have children younger, on average, relative to women of high SES. Additionally, their births are often unintended and nonmarital (Guzzo & Hayford, 2020).

These socioeconomic differences in the context of childbearing have grown since the 1970s, i.e., at the outset of moral panics about family decline and have strengthened stereotypes about marginalized women's childbearing (Hayford & Guzzo, 2015; Hayford, Stykes, & Guzzo, 2014). For instance, marginalized women are still more likely to be mothers and have more children, on average, than women of higher SES (although these differences are smaller and continue to decrease) (Hayford, 2013; Livingston, 2018). Despite sociodemographic differences between

women researchers find that women's desires for family and their family formation goals are markedly similar. Regardless of background, women value similar family sizes; however, life events and career prospects simply create more instances of childbearing postponement for higher SES women who subsequently have fewer children and have them later in life (Morgan & Rackin, 2010; Musick et al., 2009). Similarly, most women prefer to delay childbearing until they are in stable partnerships, if not married and are aware of the downsides of early childbearing (Bute & Jensen, 2010; Rackin & Gibson-Davis, 2017). Taken together, such findings highlight the similarities across women and contextualize childbearing that either lives up to or falls short of prescribed family planning guidelines. Doing so helps challenge persistent stereotypes about who mothers and to what quality.

In sum, family planning, though conceived of as a public health goal, is in many ways a family construct and family policy. Therefore, understanding women's family planning considerations through the lens of family formation rather than through the lens of family planning as currently conceived can more accurately capture women's family planning experiences, needs, and desires. Below I detail several opportunities to apply this family formation perspective to family planning research and show its potential benefits.

Integrating family formation and family planning constructs through research

As I demonstrate, although research on family formation and family planning are not explicitly combined, the social construction of both terms contributes in meaningful ways to the conceptualization of the American family ideal. Given the medicalized conceptualization of family planning, most research generated in its regard ultimately falls short of capturing women's experiences and considerations as they plan and form their families. Therefore, given the range of relevant family issues already covered within family scholarship, I see many ways in which the research around family planning and its conceptualization can benefit from an integration of family formation research and methods. I offer several examples below.

First, family planning guidelines assume a high degree of homogeneity among women and largely enforce uniform childbearing through prescriptive recommendations that emphasize everything from age at conception to relationship status (CDC, 2006; WHO, 2007). Although imperfect in its methodology (Manning, 2015), family formation research is poised to capture heterogeneity across women as they make family planning decisions in ways that can inform these guidelines and encourage more scholarly debate about them. In fact, in many ways, family scholars have already made great strides. For instance, in the last decade, they have concluded that women's childbearing decisions are closely tied to other life course processes, such as education, employment, and relationship formation (see Guzzo & Hayford, 2020 for a summary). In other words, family scholars already measure what family

planning scholars have only recently begun to advocate for including in research (Kavanaugh, 2008; Dehlendorf et al., 2018).

Second, family researchers have designed new surveys and mixed-method studies to capture greater diversity in what factors shape family formation decisions. For example, there have been new efforts to better identify different family forms and their effects on childbearing decisions through improved survey data that directly inquires about relationship histories and desires for children (Manning, 2015). In doing so, nationally representative family surveys can explicitly examine the relationship between complex family behaviors and more diverse family forms in ways that provide key insights into family needs and family trends. Such studies can expand family planning research beyond dichotomous thinking as it pertains to pregnancy intendedness as well as in terms of a singular family form.

Third, women's family planning activities and subsequent decisions may be better understood if conceptualized through the lens of "doing family" (Hertz, 2006) where the routinized day-to-day family life, often thought of as unremarkable, is highlighted. As an example, Christopher Carrington's (1999) study of lesbian and gay relationships, demonstrates ways daily family routines are the means through which families are constructed and maintained. In a similar, but as yet discussed way, fertility work like contraceptive use and pregnancy prevention subsumed within family planning is itself routinized and expected (Bertotti, 2013). Consequently, women's family planning decisions are often understood as single point in time considerations of things like contraceptive use during intercourse, or the decision

about which method to select at the doctor's office (Littlejohn, 2021). Through methodologies and considerations more typical in family formation research, family planning can be better understood as a processual family activity, and thus, consequential to family formation.

Finally, as family planning and family researchers emphasize, there is a need to consider more intersectional approaches in the study of family formation decision-making and outcomes. For instance, as conceived, family planning promotes a heteronormative and homogenous family form that privileges middle-class and White women (Luna & Luker, 2013). Similarly, both bodies of family formation scholarship continue to produce findings that often neglect the role of structural inequality in shaping opportunities and oppressions for different populations (see, e.g., Few-Demo & Allen, 2020; Geronimus, 2003). Doing so can reproduce harmful stereotypes and influence equally harmful policies. For example, family planning research that differentiates between planned and unplanned pregnancies unintentionally creates a hierarchy of pregnancies and pregnancy-related decisions in which some pregnancies and some decisions are more desirable and socially accepted than others—ultimately further stratifying reproduction (Colen, 1986). Meanwhile family research about childbearing that overemphasizes women's pregnancy decisions while neglecting men's roles reinforces gendered inequalities. In these ways, both family planning and family formation scholarship can benefit from exploring how to integrate Reproductive Justice approaches within their research to better prioritize individual

decisions to parent or not and in what way rather than compare such decisions against hegemonic norms of traditional family formation.

In the chapters that follow, I demonstrate the many ways in which women's family planning considerations are rooted in family values around stability and motherhood. In doing so, I explicate reasons why reconceptualizing family planning can more successfully capture these values.

Chapter 3

RESEARCH DESIGN

Data

To understand women's conceptualizations of and considerations around family planning, this study draws on secondary data obtained through the mixed-methods evaluation of the Delaware Contraceptive Access Now (Del-CAN) initiative. In 2015, Delaware launched a statewide initiative to decrease the state's unintended pregnancy rate by increasing women's access to and use of contraception with an emphasis on long-acting reversible contraception (LARC), including the intrauterine device (IUD) and sub-dermal arm implant. To do so, Del-CAN implemented a multi-level effort to reduce women's barriers to all contraception by offering most methods the same day as a woman's health appointment, LARC free of cost to women, transportation vouchers, and improving Medicaid reimbursement to providers for immediate post-partum LARC placement (Choi et al., 2020; Markell, 2016). The intervention also trained more than a thousand women's healthcare providers, clinic administrators, and support staff on contraceptive options and counseling strategies, supported method preceptorship and certification, as well as offered troubleshooting and support to clinics so they could offer same-day access to all contraceptives to women.

Part of a larger effort to evaluate the effectiveness of the Del-CAN initiative, a research team of which I was a part, conducted qualitative interviews assessing the

attitudes, beliefs, and behaviors around contraception of 86 women, 17 of their male partners, and 51 women’s healthcare providers from 2016 to 2021. In brief, the two primary objectives of our portion of the evaluation were to understand to what extent and how Del-CAN affected the attitudes, behaviors, and beliefs about contraception, including the use of implants and IUDs in particular among these participant groups. The 2016 interviews represented a “baseline” year in which we gathered attitudes, beliefs, and behaviors prior to or soon after the intervention began. Wave two, conducted in 2018, assessed for any changes because of the intervention, while wave three in 2020 served as a final interview where changes and reflections were assessed after the evaluation had concluded.

My dissertation sample consists of all three waves of data, 2016, 2018, 2020, and specifically draws on the women’s interviews². I combined all waves into a single, large data set collected at three points in time. I did not conduct comparisons between the three waves, instead, I used their data collectively. I elected to use the three waves because the 2016 year collects substantial background and contextual information from women including their experiences being parented, details about their family relationships, personal background, and the effects of each on their intentions to form their own families. While coding these data, I inductively observed an important

² More details about other participant groups including healthcare providers and women’s partners can be found in a summary of the evaluation at <https://popcenter.umd.edu/delcaneval/>.

relationship between these backgrounds and how women conceptualized their own family intentions and subsequently pursued these goals. In 2018, our team further explored these initial findings by probing about this relationship. Finally, in 2020, we more extensively explored issues of family planning, unplanned pregnancies, and their relationships to women's future reproductive goals. For example, we specifically asked women to define family planning and compare it to their personal desires for a family (past, present, or future).

In addition to substantive reasons for using these data, the qualitative, in-depth interviews used to collect them successfully capture women's personal experiences as well as their attitudes and beliefs about such experiences—a key goal of my study as it relates to family planning (Weiss, 1994). Capturing both women's feelings and actions helps me understand the relationship between the social processes informing women's understanding of family and its impacts on women's decisions and experiences around family formation.

Recruitment and Sample Characteristics

Our team sought to recruit up to 100 self-identified women between 15-44 years old currently residing in Delaware, with diversity and data saturation as our endpoint (Morse, 1995; Small, 2009). Recruitment ended in June 2017. This age range mirrors that of the National Survey of Family Growth (NSFG) which is the largest national dataset on family planning and family formation processes. It also allows younger teens to participate in the study which is imperative because teens are central

to family planning discourse and frequently a key demographic for family planning research and interventions (Furstenberg, 2008a). We recruited self-identified women who were also Delaware residents because this group was the primary target of the intervention. We reached data saturation after our team conducted 86 participant interviews. We determined saturation through an iterative approach that included memoing after each interview to critically engage with interview content (Birks, Chapman, & Francis, 2008) and regularly meeting as a team to discuss emerging interview themes.

We recruited participants in wave one through fliers posted in medical clinics and at public venues and organizations frequented by women such as public libraries, public community event boards, social service agencies, pharmacies, and retail stores. Researchers selected participants using four primary criteria—age, race/ ethnicity, socioeconomic status (SES), and whether women were recruited from the general population or health clinics. This strategic recruitment allowed us to explore how such factors shape family planning experiences and needs related to contraception and reproductive health more broadly.

In year one, we recruited White women and women of color in equal numbers. Forty-two (49%) women identified as White/ White non-Hispanic, 27 (31%) as African American or Black, 10 (12%) as Hispanic, four (5%) as Asian, and three (3%) identified as multiracial. We also sought an even distribution of women by low- and

high-SES³. Forty-four (51%) women were of low SES and 42 (49%) women were of high SES. We also sought to capture relatively equal numbers of women within each of the following age groups—15-17, 18-24, 25-34, 35-44. We use this age breakdown because these ranges represent population level trends in contraceptive use and pregnancy risk (Finer & Zolna, 2016). The average age of the women respondents was 30 years old, ranging from 16-44. Finally, we recruited women about equally from the general population and healthcare clinics. Forty-five (52%) women were recruited from the general population and 41 (48%) women were recruited from health clinics. Among women recruited from healthcare clinics, we sought women from both Title X and private clinics. Title X clinics are important to the Del-CAN intervention as they receive federal family planning funds designated by the Public Health Service Act, administered by the U.S. Department of Health and Human Services' Office of Population affairs. The purpose of such funding, and the clinics that provide related services, is to offer patients comprehensive family planning and preventative health services. These goals are consistent with those of the intervention, therefore, comparing women's perspectives and experiences from these clinics relative to private clinics is imperative to understanding the unique needs of women and the clinics they seek care from.

³SES was determined by the participant's joint family income, their highest degree obtained, and their mother's highest education level achieved.

As a result of this intentional quota sampling, women in wave one of this study were diverse across age, race, SES, and the clinic type where they sought care. In reviewing other demographic details, the women were also diverse in terms of family composition, childbearing histories, contraceptive types used, and relationship status at the time of the interviews. Such diversity is important as research indicates women's family planning desires and practices are influenced by their demographic traits and personal backgrounds (*see* Craig et al., 2014; Edin & Kefalas, 2005; Finer & Zolna, 2011; Geronimus, 2003; McCormack, 2005).

To support retention for years three and five interviews, we maintained contact with the women in years two and four ("off years" where no interviews were conducted). We did so by sending out \$10 gift cards and thank you notes reminding them of the study, their participation, and our plans for future contact. In response to these efforts, 59 women participated in wave two interviews. Of these participants, the average age was 30-years-old. Like other health-related longitudinal studies of its kind, higher SES and White women were more responsive to re-recruitment, with higher rates of attrition among low SES women and women of color, particularly those in more precarious social contexts such as housing instability and joblessness (Gilliss et al., 2001). However, across each wave (*see* Appendix "Participant Characteristics, 2016, 2018, 2020), we were able to maintain about equal percentages of women in each sampled sociodemographic background like SES, race/ethnicity, recruitment location, and age. Where wave one women were split about equally along the demographic lines of age, race, SES, and general versus clinic recruitment, wave

two women were slightly less diverse. Thirty-five (53%) women were high SES and 24 (47%) were low SES with 26 (44%) women identifying as White, 19 (32%) as Black or African American, seven (12%) as Hispanic, four (7%) as Asian, and three (5%) as multiracial. Of the second wave, 26 (44%) came from clinic settings and 33 (56%) were from the general population.

In wave three, 49 women participated. Of these women, the average age was 31-years-old, with an age range of between 21-49. Twenty-five women (51%) were of high SES and 24 (49%) were of low SES. Twenty-one women (43%) identified as White, 16 as African American or Black (33%), six as Hispanic (12%), 3 (6%) as Asian, and 3 (6%) as multi-racial women. Finally, 27 (56%) women were originally recruited from the general population and 22 (44%) from clinic settings.

Data Collection

Our team held most interviews in public library study rooms. Interviews lasted on average, 66 minutes in wave one, 73 minutes in wave two, and 95 minutes in wave three. The increased length of the interviews likely reflects increased rapport between interviewers and respondents as the team made every effort to partner women with the same interviewer year over year (Weiss, 1994). The interviews inquired about women's family histories, reproductive goals, family planning history, and contraceptive use, among other related topics. Interviews also asked women to describe their experiences growing up, being parented, and how these experiences informed their own desires to form and plan their families. Each wave asked about

women's attitudes and use of contraception. At the completion of the interviews, the women received \$40 grocery store gift cards. Prior to the interview, participants completed a demographic questionnaire and provided written informed consent. In 2020, all interviews were conducted either via video chat or by phone due to COVID research restrictions and safety considerations. In this wave, consent was provided orally after the consent form was read verbatim to participants by the interviewer and understanding of the information and participant rights were confirmed.

Data Analysis

Researchers audio recorded all interviews. Each interview was then professionally transcribed verbatim. I have access to all transcript files, audio recordings, and demographic data where pseudonyms have been assigned for confidentiality purposes.

There were two distinct but complementary analytic periods relevant to this study. The first was a team-based analytical approach. In this phase, our research team of four conducted and analyzed all of the interviews. Because interviews were broadly focused, we adopted an inductive and deductive approach to identifying codes and engaged in thematic analysis (Braun & Clarke, 2006) through an iterative process of reading transcripts to identify common patterns, many of which centered around questions we posed to participants such as their definitions of family planning and experiences planning for and forming their families. Using this codebook, our team split into pairs, where each pair coded half of the interviews to test for interrater-

reliability. Throughout coding, each pair met to reconcile inconsistencies. We then entered codes such as “desires for children” and “background-family” into a qualitative research software program and further refined them into hierarchical coding schemes using line-by-line coding. We then ensured all examples fit the codes and subcodes. The researchers continuously wrote memos throughout the coding process about relevant themes and reflexivity considerations. These themes and challenges were regularly discussed.

The second analytic period, where I independently analyzed the data for this individual project, was more tailored to my study topic and entirely inductive. In this phase, I unilaterally re-coded each wave of interview transcripts with open coding, using themes or “codes” I developed around issues of family planning and family I observed in the data. For this study, I utilized each of the three interview waves for analysis. I did so because each set of data offered unique but complementary analytical value for this study. In this phase, I used the same qualitative software program to note preliminary patterns. From these preliminary patterns, I developed a more focused code list centered around inductive themes related to family formation and family values. I did so after a detailed review of the transcripts as well as relevant literature related to these topics (Braun & Clarke, 2006). As I coded, I took a constructionist approach, viewing the data and themes that arose as socially produced rather than fixed within individuals. This allowed me to see the way attitudes, beliefs, and behaviors were situated in wider cultural discourses and structural factors that buoy my research as well as to broaden my analysis beyond the women themselves to

the way in which their accounts are situated in wider power relations, institutional structures, and cultural discourses around family.

For me as a researcher specifically and given the focus on family formation and motherhood in this study, I was particularly mindful of my position not only as a White, middle-class woman of reproductive age, but of my personal decision not to mother. While this can be a limiting factor in some ways, especially given that I cannot fully relate to mothering experiences in the traditional sense, it did foster a sense of sociological imagination and general curiosity about the very idea of family planning and values related to family formation. Indeed, as a person who is “child-free by choice” (Blackstone, 2019), I regularly encounter dominant discourses about the motherhood mandate (Russo, 1976) that have likely influenced some of my analytical interest in this topic.

The State and University’s institutional review boards reviewed and approved each wave of Del-CAN research.

Limitations and Strengths

The interpretation of these findings should consider the strengths and limitations of the study and its design. While our sample was diverse, the authors’ identities as White women of high SES meant that concordance between interviewer and participant was not always achievable. Although the authors engaged in reflexivity throughout the study, demographic discordance may have influenced interview outcomes.

Further, this study (by chance, not design) relies predominantly on the experiences of heterosexual women through which to explore the normative assumptions underlying family planning goals and family formation. In doing so, this study neglects the diversity of family structures, however, the study's primary purpose is to understand assumptions of normative family planning. By examining assumptions underlying family planning I include the primary audience for such expectations and policies although I acknowledge that the questions and challenges I pose throughout have relevance for other people forming families in the U.S.

As mentioned, we did experience attrition among participants who had instability in their lives from years 1 to 5. Overall, the retention rate was 60% from year 1 to year 5-- 69% from Y1 to Y3 and 83% from Y3 to Y5 suggesting that women who were willing to participate a second time were more likely to participate a third time. Participants were also self-selected into this study and may have particularly strong views toward relevant topics such as pregnancy readiness and planning.

In terms of strengths, these data are from a large and diverse sample where I was able to attain rich complexity, nuance, and diverse perspectives. The longitudinal nature of the study resulted in some degree of attrition, especially among unhoused women, those with limited financial means (less consistent access to phone/ email) or those with active substance use disorders at the time of their interviews. However, the study duration and interview lengths supported high degrees of rapport building. This promoted comfort with sharing details about difficult topics such as pregnancy desires and histories. Each year our average interview length increased – from Y1 to Y3 the

average interview length increased by more than fifteen minutes, and by more than twenty minutes from year 3 to year 5. This allowed for greater detail and use of probing questions to understand experiences fully, improving our richness and rigor.

Chapter 4

MORE THAN A PREGNANCY: THE FAMILY VALUES OF FAMILY PLANNING

Introduction

Family planning is now a reproductive norm in the U.S. thanks in large part to its medicalization (Bertotti, Mann, & Miner, 2021; Geronimus, 2003; Littlejohn, 2021; Zola, 1976). As Irving Zola (1976) describes, medicine's shift toward disease prevention has legitimated and medicalized certain forms of social intervention, one of which is the universal adoption of family planning as regular practice. In 1937, for instance, the American Medical Association declared family planning a medical issue on the grounds that "the intelligent, voluntary spacing of pregnancies may be desirable for the health and general well-being of mothers and children" (Engelman, 2011, 169). Further, in 1995, the Institute of Medicine (IOM) reinforced the widespread adoption of family planning by calling for a "cultural shift" in reproductive practices such that there becomes "a new consensus" among women "that pregnancy needs to be undertaken only with clear intent" (IOM, 1995). That is, every pregnancy should be *intentionally planned* by every person. In a 2016 op-ed, then Delaware Governor Jack Markell expressed the state's involvement in encouraging this intention by increasing women's access to contraception and training healthcare providers to encourage the use of the most effective varieties. He writes, "By helping women choose when to

become pregnant, we can improve health, save millions of dollars, and help restore economic opportunity to more of our citizens.”

Despite being derived from the White middle-class, this model of intentionally planned childbearing has been projected as natural, universal, and the image to which all women should aspire (Glenn, 2016). Indeed, most American women are routinely exposed to family planning as a norm (Aiken et al., 2016; Geronimus, 2003; Waggoner, 2017). Women’s reproductive life plans are now prioritized in all women’s health care appointment types, in sexual education courses, in parent-child socialization experiences, as well as in media portrayals about the consequences of unplanned pregnancies in popular television shows and movies, e.g., ‘Teen Mom’ and ‘Sixteen and Pregnant,’ ‘Juno’ and ‘Unexpected’ (Fennell, 2011; Hust, Brown, & L’Engle, 2008; Martin & Luke, 2010). However, this rhetoric combined with calls for a “cultural shift” neglects the existence of other norms that may shape pregnancy decisions and even compete with family planning guidelines.

Indeed, despite the proliferation of this expectation and its advertised benefits, nearly half of all women will have at least one unplanned pregnancy in their lifetime (Finer & Zolna, 2016; Pew Research Center, 2015). In response, hundreds of studies ask why women fail to meet family planning guidelines, seeing such outcomes as incongruous with what women should desire, namely the healthy, well-spaced, and adequately cared for children promised by family planning (Hall et al., 2017). Rather than add to this vast body of scholarship that asserts women’s decisions as potentially flawed, I question if the family planning paradigm is itself, flawed. In the chapter that

follows, I demonstrate that what appears to be a failure of women to adequately family plan, is in fact demonstrative of the limitation of the paradigm and its measures to adequately capture the totality of women's family planning desires and considerations—particularly those related to family.

By medicalizing family planning, related research seldom considers sociocultural factors that inform the process. Doing so is imperative because, family planning, as a means of family formation, is itself inherently both a social and cultural process (Conrad & Leiter, 2019). Indeed, these norms and medicine cannot be disaggregated “because [these] norms are replicated in biomedical ideologies about the nature and treatment of disease” (Becker & Nachtigall, 1992, p. 456). Therefore, I take a sociocultural approach to examine family planning in women's lives to understand what other values and norms may be at play or prioritized as they navigate family planning and, in some cases, which norms may be in conflict with family planning guidelines.

To date, only a handful of scholars incorporate sociocultural norms into family planning studies despite such work being impactful in other reproductive fields like abortion, pregnancy, and preconception care (see, e.g., Becker, 2020; Hays, 1996; Luker, 1984; Waggoner, 2017). In particular, limited has considered family norms, values, or processes such as marriage, kinship, or motherhood, as factors in family planning (Guzzo & Hayden, 2020). Instead, most studies highlight social or cultural factors on a limited basis, namely when women's lack of planning may be explained by their divergent social or cultural values (Aiken, Dillaway, Mevs-Korff, 2015;

Aiken & Potter, 2013; Geronimus, 2003). Other studies reveal that “culture” is often used to explain why some women deviate from and do not “value” family planning with the assumption that they should (Manzer & Bell, 2021; Stevens, 2015). In other words, these assertions reinforce hegemonic family planning norms by emphasizing the ways in which social and cultural norms *differentiate* women—those who comply with medical guidelines and those who do not.

Rather than fail to comply with family planning specifically, I find women simply balance many sociocultural values and norms as they navigate their family formation. In particular, they underscore how and in what ways family norms, values, and processes, though absent from most family planning research, are constructive of their family planning ideals through the central themes of age, marriage, home, and financial stability. The women’s stories illuminate a set of inherent conflicts between the medical ideals around family planning relative to the women’s *family* planning considerations. For instance, Lauren, one of the participants in the study, conveys this potential for conflict quite plainly when she explains, “Planning is more like planning a family, not just planning a pregnancy.” Consequently, Lauren weighs

...lots of life factors—family factors...not just birth control...like whether my son should have a sibling...[or] if my relationship is stable enough for another kid...or if I can afford another kid, and definitely, what will my parents think. And of course, within that, if or when I should get pregnant.

As Lauren reveals, subsumed within this public health imperative to intentionally plan one’s *pregnancy* is also a set of important “family factors.” Indeed, while pregnancy

planning is currently centered within medical guidelines around family planning, it is often secondary in women's overall family planning. Rather, socially and culturally constructed family norms, values, and processes like those raised by Lauren, appear integral to women's conceptualization of and desires around planning a family.

White picket fences or unplanned pregnancies: Constructing contradictions

As mentioned previously, the WHO in tandem with the CDC offer a prescriptive set of guidelines for women to follow as they intentionally time and space their pregnancies. These organizations recommend women be between 18-35 years old, have a 24-month interval before attempting a subsequent pregnancy (but no more than five years) and ideally, not exceed four children (CDC, 2006; WHO, 2007). Additionally, women should conduct themselves and if potentially pregnant from menarche to menopause (Waggoner, 2017) by taking folic acid, maintaining a healthy weight, exercising regularly, quitting tobacco use, refraining from excessive alcohol consumption, talking with their doctors about pregnancy risks and age, managing chronic health conditions, and above all, using contraception "correctly and consistently" (CDC, 2006). The sheer number of guidelines and the expectation that women follow them for more than thirty years of their lives suggest a high probability that some women may choose not to or be unable to adhere to them. Indeed, most family planning research seeks to understand who these women are and how to intervene (Finer & Zolna, 2016; Hall et al., 2017). This chapter, on the other hand,

begs the question of whether and to what extent such expectations are actually applicable to women.

Admittedly, in relying on the current family planning paradigm, our research team, like many others, originally sought to understand who did not follow these guidelines, why they did not, and subsequently, to make suggestions about how to modify their family planning practices. In doing so, we assumed there was a contradiction between women's pregnancy desires and their behaviors. So much so we developed an analytic code called "contradiction" and defined it as an "inconsistent belief relative to a behavior, such as when women do not desire children but engage in unprotected sex." For example, we labeled Unique's discussion about her contraception use as a "contradiction" when she explained that she and her partner "have an understanding that we don't want any more children. So yeah, he knows what's up and so do I. But we also have the understanding that we are playing Russian roulette with the whole pulling out instead of using a stronger birth control thing."

We also noted a contradiction if women felt they were unready to have a child (for myriad reasons) but would be okay becoming pregnant. Libby explains that she "feels a little insecure financially" but "would probably keep the child" if she becomes pregnant because she is "at that age where I should...I'm not some teenager...or homeless...and if I'm going into having sex, it's a possibility to become pregnant. That knowledge should be used to know that you should be able to take care of your child." Of the 86 women in wave one of the study, we coded 102 instances in which women's attitudes appeared to conflict with their actual or hypothetical actions around

family planning. However, upon looking more carefully at the nature of these contradictions, such conflicts arose not because the women failed to adhere to family planning guidelines but because the guidelines, themselves, failed to fully capture women's family planning considerations.

As an example, neither Kathy nor Samantha report planning their pregnancies. Their experiences and backgrounds are markedly different. Kathy is from a difficult background with abusive parents and a family she describes as “not close.” Kathy is also of low SES. Meanwhile, Samantha is from a stable, middle-class family and describes her family members as “some of her closest relationships.” However, despite these differences, they share many similarities. It is in these similarities *between* women rather than their differences that reveal the limitations of today's family planning paradigm to integrate the diversity of norms women juggle—in particular, around family. As Kathy explains, “Family planning? Yes! Every family should plan to have the mom, the dad, the daughter, and the son, and that's it. Oh, and a little dog and a house with a white picket fence. I want that to feel complete. Who doesn't?” Similarly, Samantha defines her ideally planned family as one with “the house, the finances, the husband, the 2.5+ children. Trying for the dream...” and recognizes that “if you go outside of those, you feel as if you failed somehow.” They also identify that parents, “society,” teachers, and “television” have taught them what is, as Kathy remarks “right and wrong in terms of family.” In other words, the participants are guided by their sense of family norms rather than medical guidelines. In fact, both Samantha and Kathy, despite such different upbringings, describe nearly identical,

ideal family structures. Family historian, Stephanie Coontz (1992), calls this “family nostalgia” in which Americans have idealized and sought out the traditional family structure and values portrayed in the 1950s and 1960s. So, while there are certainly distinctions in Kathy and Samantha’s backgrounds, their family planning ideals reflect dominant and influential ideals around achieving the traditional American family.

In fact, the pregnancy intention premise on which family planning is based may create a distorted or overstated sense of conflict between women’s family planning behaviors relative to their desires. For example, Kathy is a White, 35-year-old, who has been pregnant four times and using the “withdrawal⁴” method, often critiqued by physicians for not being as effective as other methods (Bertotti, Mann, & Miner, 2021). She is from a poor family and describes her current income as “inadequate.” To make ends meet, she receives social benefits for her two children. She has a history of addiction and relationships she describes as “totally messed up.” All of Kathy’s pregnancies have been unplanned or as she says, “definite surprises. Some more of a surprise than others, but all surprises.” She explains that she “was homeless on the first [pregnancy]. But my second and third one, I wasn’t.” However, she goes on to express how she has “always wanted to be a mother” and “having

⁴ The withdrawal method of contraception (coitus interruptus) is the practice of withdrawing the penis from the vagina and away from a woman's external genitals before ejaculation to prevent pregnancy. The goal of the withdrawal method — also called "pulling out"—is to prevent sperm from entering the vagina.

children, even though they were surprises” was a lifetime “dream realized.” For women like Kathy, researchers identify this phenomenon as “the blessing I can’t afford” paradox (Aiken, Dillaway, & Mevs-Korff, 2015). While Kathy’s narrative certainly reflects this contradiction, the outcome of an unplanned pregnancy is not actually in conflict with her personal *family* plan. Her experience calls into question whether it is a paradox or if the conflict simply reflects an incompatibility between Kathy’s desires and dominant family planning metrics.

Similarly, Samantha is a White, married, 29-year-old woman who describes her childhood as “messy but happy” and her husband as “supportive.” They have a “very adequate” income with one child and “one on the way.” At the time of her first pregnancy, Samantha did not have a regular doctor and was relying on natural family planning—a fertility awareness method where women track their reproductive cycles to monitor pregnancy risk. From an evidence-based medicine perspective, fertility awareness methods are considered lowest-efficacy and often not recommended for women to prevent pregnancy (Bertotti, Mann, & Miner, 2021). In fact, Samantha explains that few doctors even talk to her about contraception, knowing that she’s “happily married.” Like Kathy, Samantha is not sure she was ready for pregnancy. Although she is married, she and her spouse were not planning to try for a child for some time. But once she found out she was pregnant, “the joy just overtook us. We wanted a family and we got one, but it did shock us.” Here again, while Samantha’s pregnancies are, indeed, unplanned, they are not antithetical to her family planning goal of having 2+ children after marriage.

Many aspects of their stories overlap—both have multiple unplanned pregnancies, both use the least effective contraceptives, both were married for at least one pregnancy, and both are similar in age. Additionally, both reflect that their ideal family circumstance includes marriage, stability, and two or more children. However, because of their sociodemographic backgrounds, Kathy and Samantha would rarely, if ever, be included in the same research study about unplanned pregnancies because the vast majority of family planning research focuses on pregnancy planning among “high-risk” and marginalized women, ostensibly erasing Samantha’s story, and amplifying Kathy’s (Dehlendorf, et al., 2018). Indeed, although rates of unplanned pregnancies have fallen across all demographics, they remain highest among young women, cohabitating, but unmarried women, women of color, and low-income women of all racial and ethnic groups (Finer & Zolna, 2016). These also happen to be the women most likely to rely on social support once becoming pregnant and are thus the target of unplanned pregnancy reduction efforts seeking to reduce welfare costs (Becker & Tsui et al., 2008; Thomas & Monea, 2011; Trussell et al., 2013). Moreover, despite numerous similarities, family planning metrics emphasize Kathy’s and Samantha’s differences such as Kathy’s risk of unplanned pregnancies based on her history of abortion, her income level, her childhood as a single mother now raising children as a single mother, her status as unhoused and so on (Bertotti, Mann, & Miner, 2021; Littlejohn, 2021; Mann, 2022; Thomas & Monea, 2011). However, such a correlation, while possible, also creates an artificial degree of “difference” between Kathy and Samantha even though they both have unplanned pregnancies.

By zooming out to look beyond Kathy's and Samantha's pregnancy planning status and instead to their family planning ideals, their similarities overshadow their differences. Both Kathy and Samantha want four children and base this desire on their own the family values they learned from their upbringings—even though they had different family circumstances. Samantha describes how she would “love to have four [children] just like we had growing up in my family.” However, after marrying that desire shifts because as she notes, “of course you bring someone else into your life and things are influenced. Like you have to compromise on everything so I do have one son and then one on the way. And then we may or may not stop there.” When asked why she would change course she says “they’ll just see what happens. How the boys get along. If they need another sibling. Whatever gives us that family feeling we had as kids.” In other words, Samantha weighs kinship considerations in determining the number of children as well as her partner's desires rather than strict medical guidance about spacing or pregnancy totals. She adds:

It's kind of—like I said, I would love to have four again, but [my husband] actually would have just been happy with just one. He is that way. Like his family dynamic, he's the oldest of three, but there's like an eight-year gap between him. Yeah, so he was like the only child and wants that again for his son.

In line with past research, Stephanie's partner influences her pregnancy decision-making (Borrero et al., 2015), however, beyond just her husband's influence, we see that their family backgrounds subsequently shape such an influence. Both Samantha and her husband draw on their unique family histories and experiences, which in turn,

shape their family values and family planning considerations rather than simply their pregnancy decisions.

As with Samantha, Kathy also desires four children like she had growing up. She has had four pregnancies but is only raising two children after placing one child for adoption and having an abortion. While four is her ideal number, she is most concerned about “being a mom first and foremost.” Not only that, but she is also “scared of repeating the mistakes my parents made” and of not living up to her standards of “being a good mom.” It is with these complex and multifaceted concerns in mind that Kathy makes decisions about each of her pregnancies. Kathy’s decisions illuminate an important connection between pregnancy and motherhood identity. While this observation has been made in other areas of reproduction research (see, Becker, 2020; Bell, 2014) it has been overlooked in most family planning scholarship that focuses on childbearing rather than mothering. Indeed, Becker (2020) finds that decisions like abortion and adoption appear antithetical to motherhood, however, as in the case for Kathy, are often made in support of current or future children and family ideals. In the same way, unplanned pregnancies are not necessarily antithetical to ideals of motherhood. Indeed, Kathy desires “a girl and a boy” but she prioritizes

[...] whatever it takes to have a better relationship with my kids than I had with my parents. If that means adoption or single motherhood, so be it. But I’m not having a kid when I’m not ready and I’m not staying with my ex-husband just because I’m told I should.

As evidenced in the narratives above, *family* planning is complex and fraught with what appears to be contradiction and conflict. In fact, my first conceptualization

of this project was to understand the differences between women rather than note their similarities. My hope was to create a fuller, more nuanced picture of these differences and subsequent experiences than was currently available in the literature. However, by shifting away from *pregnancy* outcomes to *family* outcomes as a measure of family planning, it becomes apparent that such differences are a social construction and founded on the homogeneity of medicalized family planning guidelines. Further adding to the need to examine the sociocultural aspects of women's family planning ideals, it is also important to question if differences between family planning practices are so problematic. By focusing on family ideals, should some difference be expected or even preferable? Indeed, the U.S. is a large, heterogeneous nation comprised of diverse cultures, social norms, and people, including the forms families take and their accompanying traditions (Cherlin, 2016; Coontz, 1997; Coontz, 2016). As I detail in the next section, women apply family norms, values, and processes to their conceptualization of family planning that while varied, have a common attribute—they do not prioritize the dominant, medicalized family planning guidelines.

“Trying for the dream...”: Family planning as a family ideal

Although most family planning research seeks to understand family planning dichotomies, such as outcomes of planned versus unplanned pregnancies or who plans pregnancies versus who does not (e.g., Finer & Zolna, 2016; Thomas & Monea, 2011), women's ideas about family planning suggest these binary categories may oversimplify their family planning considerations (Aiken, Dillaway, & Mevs-Korff, 2015; Callegari et al., 2016; McQuillan, Greil, & Shreffler, 2011). Like Samantha and

Kathy above, when asked to define family planning each of the participants, despite social strata, discuss prioritizing attributes of the traditional American family in their planning considerations—particularly, the overarching goal of stability (Kavanaugh, 2008). In examining these priorities, I complicate these dichotomies and reveal the social rather than medical construction of family planning in women’s minds.

“I always just felt like that was the right age”: Age as a family value

Age has long been a sociocultural metric by which women gauge the acceptability of their pregnancies. As such, it is not surprising that it is a prominent consideration among participants as they express their family planning ideals. The women are particularly concerned about being either too young or too old to have children. Historically, the age at which bearing children is acceptable or ideal has varied considerably. Although teenage childbearing was common in the first half of the 20th Century, by the 1970s, reproductive health advocates and critics of permissive sexual standards labeled “teen pregnancies” as an “epidemic” of the American family (Furstenberg, 2008b; Moseson et al., 2019). This public discourse and general condemnation effectively stigmatized teenage childbearing, and the participants in the study consistently reflect this social and reproductive norm in mapping their personal family planning ideals. In fact, all women reflect Piper’s concern of “having kids too young to properly care for them.” Piper elaborates saying:

[O]ne of my best friends, she had a baby when she was 15. And that was her first time [having sex] with her boyfriend. And she, like me, was like a straight A student and even to this day she is one of the smartest people I know and her child is like 13 now?...so yeah, it was

totally unexpected that she got pregnant. Doesn't happen to girls or teens like her. I mean that was like a fairly sad part of her life when she had the baby and everything... But when I first started becoming sexually active, I was like embarrassed because of that. I didn't want my mom to find out that I wasn't her perfect daughter and that we weren't a perfect family. And I didn't want that to happen to me...you know...teen mom and all that.

For Piper, as with most participants, the negative salience of teenage pregnancy follows easily from the dominant culture's particular esteemed version of "family values." As she suggests, teen pregnancy as well as sexual activity contrast with such values. Piper's reflection also offers insights into who is presumed to have teen pregnancies—not "straight A students", not smart students. In other words, considerations related to age at which to become pregnant entail both family *and* broader social values.

With the clarity of hindsight, teenagers of the 1970s were merely the leading edge of a significant change in family formation whereby childbearing outside of marriage became increasingly commonplace (Furstenberg, 2008a). Indeed, marriage rates and childbearing practices have been in substantial flux throughout much of the last two centuries (Cherlin et al., 2008). Women often make sense of these shifting family planning ideals through their own families. For Lindsey, not only does she desire to be married prior to having her first child, but in doing so, plans to delay childbearing, which is in line with her family's own pregnancy history. She indicates, "I would say til like 30-32, which is probably more common now that it used to be so I feel okay about waiting like my grandmother did." She goes on to say that "it's kind of the thing now...to wait...but my grandma actually waited until she was 32, so I

always just felt like that was the right age even though it was super uncommon back then for her.” Lindsey acknowledges the shifting tides of childbearing age and within that, still aligns her preferences not just with social and cultural standards that encourage delays, but also with lessons learned from her grandmother. In this way, Lindsey reflects the intersection of two social constructions—those of family planning guidelines and family formation.

Sociocultural values around mothering have changed alongside family formation norms. Consequently, the participants often associate age with their mothering ideals. For instance, some women associated youthfulness with their personal desires to be an “active” and engaged mother. Meanwhile, others associated slightly older parenting ages with maturity and being more apt at juggling the stressors of work and parenting. Indeed, delayed childbearing is associated with greater stability in terms of employment, relationships, and living arrangements but for other women, it can put themselves and their pregnancies at risk (Geronimus, 1992; 2003). As demands for more intensive forms of motherhood increase, especially among middle class White women, so too has the ideal childbearing age (Hays, 1996; Zelizer, 1985). For some of the women, this means significant delays in childbearing and for others, it means waiting “some” but “not too long” as Latoya remarks; “[i]t’s a really balancing act.” This balancing act is on display for Libby who desires to have a career prior to having children, but also feels “a lot of pressure to have children” before she is considered “too old.” Libby reflects:

I kind of was hoping to have kids like in two or three years, but I really want to focus on my career and I thought I would be further with photography and into a career base right now. So until I feel like I have reached my pinnacle of my career, I didn't want to have kids because I worry I can't provide the life I want for them like so they can do activities and go to a good college. So maybe I'm pushing it off to like 35-40. But there is that stigma as a woman that after 40, it's almost impossible to have kids. What do they call it? Geriatric pregnancy or something. And that makes me nervous. Like my biological clock is ticking—I feel pressure at from all directions—I just turned 30. I'm going to be 31 this year...Like by 30 the world tells you that you are supposed to have somebody to settle down with...And like that I should be there, I should have a house and not just an apartment, I should be further into my career instead of just have—my parents consider this like a job [as a barista] and not a career. Which is true, but I guess all of the above between family, social aspects, and my own. And now it's like even though maybe I don't—like I know what I want, it's that outside pressure that's making me to feel like I need to want that. Kids by this age. A house. A husband. Do you know what I mean? I don't know where it comes from other than to say “society”, but I feel it.

In the same way that Libby feels constrained by aging, Latoya prefers to space her children in line with her childhood, but balance that with being “an active parent”—something she believes aging will compromise. She explains:

To make decisions, I would use my family as a guide, like our age differences, like my sister that's five years apart from me, that is—I feel like that's a good age, but I still don't want to really wait that long though...I'm like, “I'm 30. Then I'll be—35” I think about, “The baby's this age, then I'm going to be this age.” Like I want to be able to mother my children my way...and raise my kids and be able to do stuff with 'em. I don't want to be like old and tired with the kids and stuff like that where other people play with them. I want to be an active mom...involved...playing an all that. Not no geriatric pregnancy or whatever they call it now. But I would also like my kids to be at least three years apart like we was. So they get along together. If I have two more kids, at least three years apart, and then the next one...oh brother I'd be old, but the kids can watch each other and play with each other while I am away at work.

Comparing both Latoya and Libby's family planning decisions reveals that they similarly prioritize age, seeing it as a significant factor in how they can mother and provide for their children. However, it is also clear that they see the relationship between age and parenting quite distinctly based on their social class. Indeed, Annette Lareau (2003) finds, parenting styles and resources used in parenting vary by social class, where middle-class families focus on providing financially for their children—a prerequisite for concerted cultivation that Lareau defines as a parenting style or practice marked by a parent's attempts to foster their child's talents by incorporating organized activities in their children's lives. Comparatively, parents from working-class backgrounds (and typically with lower incomes) favor a natural growth parenting style in which parents engage less with their children due to structural disadvantage. As such, their children usually have more unstructured time and therefore, create their own activities to occupy themselves. In line with Lareau's (2003) framework, Libby, who is from a middle-class family, focuses on age so that she has more resources with which to providing financially for her children, Meanwhile, Latoya, from a working-class family, connects aging to her capacity to play with her children as well as to the spacing of her children so the children can play and engage each other. In this case, Latoya hopes to space her children to occupy and monitor each other so that she can continue to work.

Additionally, Latoya's preference, central to her family ideals, may have its roots in the collective health uncertainty of African American women in the U.S. As a

Black woman in poverty, Latoya experiences legitimate worries of leaving her children orphaned or of becoming compromised in her capacity to provide for them as they age (Bound, Shoenbaum, & Waidmann, 1996). In line with Arlene Geronimus' (1992) "weathering" theory, African American children may fare best if their birth and pre-school years coincide with their mother's peak health and access to social and practical support provided by relatively healthy kin. Moreover, the maternal mortality and morbidity rates among U.S. African American women is significantly higher than that of White women, a risk that increases as they age (Matoba & Collins, 2017).

In sum, women's family planning desires may overlap with medical guidelines, especially as they reflect on concerns about teenage childbearing and geriatric pregnancies. However, their "compliance" with such guidelines is predicated not on ideas of adherence, but rather, the compatibility of these guidelines with their own family planning considerations.

"I would want to buy a house to make a home": The family value of "home"

In addition to age shaping family planning decisions, broader sociocultural discourses about the home inform many women's family planning ideals. Certainly, the concept of the home as the family's place of refuge has changed over time; however, women's idealizing about the link between home and family remains closely tied to the traditional nuclear American family and popular images emerging from new suburbs built after WWII (Hareven, 1991). For instance, most women echo Becky who idealizes a "single-family home. You know, your own home like the Brady

Bunch.” Although Becky, her husband, and their two children live in an apartment, they aspire to move. “It’ll give the girls that backyard. We want a swing, a place to play, space to spread out and just do all the things families do.” Indeed, family scholars routinely link “the home,” both physical and symbolic, to the construction and enactment of family as do the participants (Hareven, 1991). To Ariel, a home signals stability and family “because homes are where everything happens. Birthdays...holidays...you draw height charts on the closet molding...[y]our family *lives* there.”

The home is also a symbol of the “private sphere” or the “feminine sphere” in which women cultivate domestic happiness and carry out gendered expectations around motherhood (Hays, 1996). For instance, Jessica believes strongly in “a stable home.” She attributes this desire to having learned “to be a mom” by “watching my stay-at-home mom take care of all of us kids and then have dinner ready when my dad got home from work” She adds,

I grew up in the same house and I still go to the same house and I mean my room is not there anymore but it’s—I know it’s my house...But so a house, a stable house. And ideally, both parents...Well, like my mom did everything around the house. Just like I do now. My dad was there. Every night like he came home...from work...to us. But that was pretty much it. He ate at the same table as us growing up and we actually eat at now and that really means a lot to me.

Jessica describes the phenomenon of the “cult of domesticity” (Kraditor, 1968) in which the home is a space governed by women. For many of the participants, the imagery around a stable home draws on these deeply embedded, often implicit,

notions of motherhood that are played out in these physical spaces. In this way, the ideal “home” often represents ideal motherhood and by extension, ideal family life.

Relative to a measure like age, the link between home and family planning may seem more ambiguous. However, though it is not a formal family planning metric, health care providers routinely reflect similar norms by connecting stable housing to family planning. They argue the home is a marker of pregnancy readiness (Stevens, 2015). Stevens (2015) finds that family planning providers, in fact, make contraceptive counseling considerations based in part on women’s housing status—encouraging pregnancy prevention for those they feel do not meet these readiness standards to which housing is connected. In this way, housing status is both a social and medical means of distinguishing who should have a family by estimating who can adequately provide for children (Stevens, 2015). As Stevens (2015) finds, such concerns are premised on White middle-class markers of success that are increasingly unattainable not just for marginalized women, but for middle-class families as well.

Here again, family planning metrics, whether WHO guidelines or social ones asserted by health care providers, create the appearance of difference across women. That is, women’s conceptualization of family planning does, indeed, indicate distinct preferences for and needs around housing, but fundamentally, the role of the home is largely the same—a place to enact family ideals. In nearly every mention of a home, the women desire something stable and what that physically looks like simply varies across women just as ideals of housing vary across cultures and countries (Hareven, 1991). For Megan “...[I]t is preferable to have a safe place to live” and more ideally,

that living arrangement does not require “living off of someone else. Like you shouldn’t get pregnant, live at your mom’s house or something, which I did that. It’s difficult and you don’t really feel like you’re a fully functioning family until you’re out on your own.” In Steph’s case,

[I]t’s great to have your own actual house, it’s good to have all of that. But you make do with what you have at the time and you figure out how to make it work. We were in a two-bedroom, 1,200 square foot apartment, with two kids, and a dog, and it worked. We made it. We’re still here 13 years later.

Steph goes on to describe the memories they have made in their small apartment:

I breastfed my daughter here. I educate my children in the living room. We watch movies on our couch. I cook nutritious meals in our kitchen. We eat dinner at our dining table, albeit a small one. We just live together and that has been enough. Not everyone’s dream but enough.

Even though Steph does not have a single-family home, her apartment (large by many standards) is sufficient (Coontz, 1988). Not only is the physical space where many mothering tasks are accomplished, Steph is, herself, at the center of home where the apartment allows her to engage in the gendered mothering role of social reproduction, e.g., breastfeeding, educating, and socializing.

Like other aspects of family, the women often seek to replicate or reverse their childhood experiences vis-à-vis their homes. Steph grew up in an unstable living arrangement and although small in size, she is “grateful” to have lived in the same apartment for 13 years. To have “been a mom here.” Indeed, Steph acknowledges that a different physical structure (single-family home) is preferable, however, she can

achieve her family planning ideals “just fine.” Other women prefer to have a larger home, but again, cite the core principles of stability and family. Devyn explains that the bigger the house, the more children they can have. She reflects,

I would love to have a bigger house. Like we live in—I call it my apartment house... I think it's like 1,000 square feet maybe. But like we make it work. So eventually I will love to have a bigger house for them, to make room for more children, but at this point, like we're doing okay. So yeah, I would love to have a big house with a big old backyard for them, but we're just we're making this work for now and it is working for now.

As with Devyn, living arrangements can determine women's family planning considerations. Kathy, quoted in the section above, elects an abortion because she did not feel “okay starting my family out in a homeless shelter. That's no place to raise a child.” Candace similarly finds herself unhoused and opts for an abortion. She explains:

I had an abortion...I was pregnant and there was a possibility that there was two of 'em. And my boyfriend and I—we were together five years at the time...And he left the decision up to me and said, “We raise 'em as our own.” But I couldn't do it...It wasn't fair to bring them into a world where they were possibly brought into a broken home and literally a broken, rundown home. And I just wasn't going to do it...I was living in a motel and a motel is not a home. It's definitely not safe.

For both Candace and Kathy, the physical structure they desire to bring their children home to is reflective of their capacity to care for their children. Indeed, Candace goes on to discuss how her inability to provide such an environment makes her feel as though she has failed as a mother. She describes her current situation, parenting from a

homeless shelter saying “I mean I am a good mom to my kids. And we do have a roof over our heads. But it is not how I saw myself or my family.”

Like Candace, countless scholars associate the physical home with motherhood by connecting women’s role in the family to their responsibility to care for the household (Hays, 1996; Lareau, 2003). In her article on Australian housing in the 1950s’, Carla Pascoe notes a frequent conflation of home with a caring mother figure and explains that “[w]omen and children have traditionally been associated with the home as a place of shelter” (Pascoe, 2017, p. 185). This notion of a caring mother figure who resides in and creates a “homely home” (Blunt & Dowling 2006, p. 26) is a persisting, powerful image carried on into the 21st Century. Indeed, numerous women’s narratives reflect this imagery.

The persistence of a nuclear “household” extends to how women conceive of ideally planned families. For Zee, she and her husband first “bought our house, we got married, and then we had our children.” As a couple, the two desire home ownership followed by marriage as a means to establish “ourselves as a couple. As adults. We didn’t want to start a family living with my parents and we wanted to show each other we were committed by getting married.” Zee adds, “We kind of did everything that we wanted to do before having kids...then we became our little family unit.” In other words, Zee’s home symbolizes the establishment of their nuclear family (Hareven, 1991).

Among higher SES women, the home is also a place for their children to thrive, harkening back to Lareau's (2003) notion of concerted cultivation. Nia describes:

I knew ideally I would want to buy a house to make a home. And I bought my home keeping in mind that children could live in it so it has enough rooms, and sufficient space, a safe, nurturing environment, a place for us to do homework together, to cook together, those type of things. Maybe room for a swing set to play on together. You know, ideally that home sweet home kind of thing. Everyone's dream.

Nia suggests that this housing arrangement and its function on behalf of the family is "everyone's dream." Hays (1996) argues that the mothers in her study took primary responsibility for every child-rearing duty—including watching, feeding, disciplining, cleaning up after, and playing with children. These duties are performed in the home where women not only idealize to live with their families, but to fully enact their role as mothers.

The health care providers quoted in Lindsay Steven's (2015) article claim that housing stability is integral to readiness. While the article does not clarify how they define that metric, women share that desire. However, the propensity to link middle class norms around housing to family planning outcomes and pregnancy readiness risks not only constructing a false or exaggerated sense of difference between the women's family planning preferences, but it also risks dictating for which women pregnancy, and by extension, family, is a socially, culturally, and medically acceptable undertaking.

“Can I afford to have a kid?” Calculating family and financial stability

Like the idea of the “home,” “financial stability” is not a formal family planning metric. Stevens (2015) calls social measures like financial stability “markers of normative readiness” that she defines as the non-medical criteria medicine says is important to achieve prior to pregnancy. Policymakers frequently use financial stability to justify family planning promotion. In doing so, family planning proponents cite controversial but widely accepted research that finds unplanned pregnancies *cause* poverty (see, e.g., Sawhill, 2014; Thomas & Monea, 2011). In this way, family planning is both a set of medical guidelines and a solution to the social problem of poverty. Then Governor Jack Markell captures this thinking well in his 2016 op-ed when he writes:

I have witnessed countless ways in which unplanned pregnancy disrupts people’s lives. So one of the best ideas I’ve seen for how to help everyone reach the next rung on the [economic] ladder is providing access to effective contraception. Enabling women to become pregnant only when they want to is a shortcut to prosperity.

Indeed, all 86 women stress that financial stability is their number one family planning consideration but not as it relates to the use of contraception. Rather, they seek stability to facilitate other family planning ideals like marriage and the home—both of which are often unaffordable for women, particularly those of low SES (Edin & Kefalas, 2005).

According to the U.S. Department of Agriculture, the federal department charged with tracking inflation, reports that the average family will spend upwards of \$12,000-\$14,000 per year annually per child (Lino, 2020). This excludes the cost of

college and is expected to climb in the coming years. U.S. social policies offer little by way of financial support to families, spending the least, for instance, on childcare subsidies and pre-K education than any other industrialized country (Cherlin & Seltzer, 2014; Lino, 2020). Indeed, Sally says, “financial stability is the number one consideration for all of it. Do I have a house?...Do I have a good job?...[C]an I actually afford my kids?” Sally is right to beg such a question. Children are expensive; climbing inflation coupled with increases in income inequality and insecurity makes affording them even more challenging especially for low SES families, though all families are affected.

The women’s measures of financial stability vary based on their own personal ideals and backgrounds. Shauny conceptualizes financial stability as being able to provide the necessities to her children. She explains:

You’re never really ready for a kid, but one of the first and number one thing is finish high school so you have a good job for sure...because it’s expensive to take care of a child. You’ve got to buy diapers and formula and toys and clothes stuff like that. The basics.

Meanwhile, Cassandra also desires financial stability which she defines as to save enough money to pay for private school, specialty daycare, and college. Until that time, she manages her desire for children saying:

Kids are not off the table...[but] we know we’re not really going to think about kids for another three years until we’re in a financially responsible place, but we still—after we’ll visit our friends with babies or his sister just had a baby, we’ll always be like, “Where are you on the baby scale?”...[W]e check in. “Are we like 100% no babies or 0% and want all the babies?” And we’ll usually be like, “60 or like

80”...But we’re responsible...financially it’ll be three years before kids...Because of the stock portfolio. At that point we’ll have enough money. I know super romantic...I mean I think nowadays the conversation about kids has to be a lot different than it used to be financially. Like private high school, even nicer daycares we want for our children are astronomical in cost, not to mention activities, sports, oh and college can cost almost \$300,000 now and that’s like not a light consideration especially if our child doesn’t go instate tuition. And so it’s definitely not like, “Pop out as many as you can because you’re happy about it.” It’s like, “Like how many can I afford?”

Cassandra’s and Shauny’s vision for financial stability and readiness may not align in the details, but they do in their function—provide for their desired children.

Directly comparing Cassandra and Shauny reveals how financial stability is a highly visible area to draw comparisons between women’s family planning desires relative to sociocultural norms. As Cassandra says, “you can only dream of the number of children you can afford.” However, Molly disagrees. In fact, her statement illuminates just how problematic (and stratifying) aligning family planning decisions to middle-class markers of success can be. She says,

I think people worry too much about being financially stable. They worry too much about their stage in life. And this is something my husband and I talk about all the time, but we have friends who wait a really long time to worry about getting their—they want their career. They want their education and they want their career, they want a certain number of years in their career, a certain amount of money. And then they worry about trying to get pregnant but then you’re in your upper 30s and your fertility drops. And you get married and now, “Can we even have kids?” So I think it’s just about priorities.

Molly makes an important point. Financial stability is a vital goal shared by each of the study participants; however, the normative expectation that women achieve such a

high standard of financial stability can conflict directly with their family planning desires.

The American Dream, and by extension, the American family, is predicated on the notion that with hard work and perseverance, all Americans can aspire to and achieve these middle-class standards. However, as countless scholars argue, upward mobility is not the norm (Pew Research Center, 2015). Therefore, family planning standards of “normative readiness” that expect women to achieve a middle-class lifestyle prior to pregnancy effectively limit who should reproduce. Scholar-advocates argue that these expectations serve to control the population growth of marginalized people (Luna & Luker, 2013; Roberts, 1997; Ross, 2006; Ross & Solinger, 2017; Solinger, 2005). Latoya, a woman of low SES, sees this problem clearly. She remarks:

I feel like you'll never be ready honestly because it's so much that you have to do and prepare yourself for...My boyfriend would tell my uncle, "I don't know. I'm not ready." Like to be financially stable. But my uncle was telling him, "You can't—you're never going to be financially stable if that's what you're waiting for. You're always going to want more money...and want more stability...You have a baby and just work toward it." So yeah...there's never a perfect time.

Latoya's uncle describes stability as something you strive for but do not achieve prior to childbearing. His comment parallels the findings of family scholars Edin & Kefalas (2005) who conclude that marriage, for women of low SES, is an end goal, not a family starting point. Crucially, they add that delaying marriage demonstrates women's great respect for the institution of marriage and the family values underlying

it. However, common portrayals of women failing to marry and failing to be financially stable tend to argue the opposite (Edin & Kefalas, 2005). In fact, Latoya and her boyfriend intentionally time and space their first pregnancy and hope to do so with their second child. Latoya understands that she is not wealthy and “can’t provide like the fancy extras” for her young daughter. But Latoya does “work hard at two jobs and we make ends meet. I don’t want to sometimes but I do it for my daughter.” Latoya’s narrative adds a layer of complexity to the argument that timing and spacing pregnancies reduces poverty. Latoya struggles financially not because she fails to plan her family, but because of structural inequalities that position family planning considerations at odds with family planning metrics (Geronimus, 2003; Pew Research Center, 2015).

Affording children is central to realizing family planning ideals. Indeed, each of the women balance such preferences against the backdrop of widespread economic inequality and the expectation that they achieve middle-class markers of normative readiness prior to starting their families. Popular news outlets even offer advice on “How to have a baby, even if you’re worried you can’t afford it” and “Balancing the cost of raising a child in the U.S.” The U.S. is an outlier in its family policy foci. Policymakers draft legislation concentrating on shoring up families by promoting marriage even though research clearly indicates that financial stress drives family decline (Cherlin, 2003). In contrast, other industrialized countries prioritize family policies to reduce the cost of having children. Some examples include nationalized healthcare systems, subsidized childcare, and generous child tax credits (Cherlin &

Seltzer, 2014; Miller, 2021). Without these supports, financial (in)stability affects many facets of women's family planning, one of which I discuss below—marriage and relationship stability.

“Please don't have any children before you're married.” Marriage as a family planning norm

Women's reflections on marriage as family planning further illuminate the centrality of family, rather than pregnancy, in women's family planning considerations. Paradoxically, family planning scholarship largely marginalizes the role of marriage in these deliberations. This is likely a symptom of the concept's medicalization in that the pregnancy focus encourages research that subsequently explores efforts to time and space pregnancies in collaboration with a partner vis-à-vis contraception. Consequently, researchers who do study the influence of relationships in family planning largely limit their work to the impact of partner coercion, partner contraceptive preferences, and the duration of relationships on contraceptive use (Borrero et al., 2015; Fennell, 2011; Higgins, Popkin, & Santelli, 2012). Conversely, women routinely discuss the role of partners, particularly marriage, in their depiction of family planning considerations which are distinct from pregnancy planning by virtue of the underlying social objectives they seek around family of which pregnancy is but one part. Indeed, marriage and family are inextricably linked (Cherlin, 2003). In fact, it is a key process of family formation (Manning, 2015); and unsurprisingly, each of the participants acknowledge it as such.

When asked to discuss her family planning considerations, Dorinda neither raises the issue of contraceptive use nor her partner's preferences for it. Rather, she prioritizes the function of that partnership in starting a family and raising a child, not simply whether to become pregnant or not. Where pregnancy planning captures measures like timing and spacing, Dorinda's desire to "start a family" is reflective of more complex considerations related to partnership and connectedness. In this way, she associates family planning first and foremost with family. For Dorinda, marriage is not just "helpful to me...I think it's best for the child. But I also don't think it's like a necessity. I can parent on my own. I just prefer not to...I want to be in love and to be loved...All that lovey dovey stuff that is why we live in this world." Dorinda acknowledges what many policymakers, researchers, and pundits claim, that a two-parent household may be ideal for children, although there is much debate on whether and how this affects children long-term (Cherlin et al., 2008; McLanahan, 2004). Like with age, marriage comes with a proverbial asterisk for the women. While it may be a family planning ideal, Dorinda explains that there are caveats to that rule because "it depends on the relationship...if you have a horrible relationship, there's no point in getting married or trying to raise a child together. No quality in that. Sometimes it's better for people to split and for a family to be just the mom and child." In other words, although marriage is an ideal, it is not always ideal.

Dorinda accepts that being a single mother is preferable to marriage in some circumstances, although not "my dream come true." She is a woman of low SES and her attitude toward marriage mirrors that of other participants who have yet to marry

and/ or are of low SES. Collectively, most aspire to marriage and expect to marry someday, but they do not necessarily regard childbearing and marriage as life events that go hand-in-hand (Edin & Kefalas, 2005). Rather, Dorinda prioritizes the outcomes of her children over marriage. This is consistent with prior research that finds that women of low SES ascribe a higher value to children than do those of middle-class mothers (Edin & Kefalas, 2005). Similarly, women with lower education levels are more likely than higher educated women to agree that motherhood is one of life's most fulfilling roles (Sayer, Wright, & Edin, 2003). As such, Dorinda's sense that her children come before marriage is indicative of the value she places on motherhood and making the best of her single-parent family. Although she idealizes the achievement of marriage in the future, she recognizes the need to "keep my focus on being a good mom today."

Experts routinely claim that family planning can reverse family decline by decreasing the occurrence of single-parent households (Cherlin, 2003). Indeed, they see single mothers as a potential outcome of failed family planning because of the added stress such a pregnancy can place on a relationship (Sawhill, 2014). However, through Dorinda's eyes, single motherhood is anything but. Instead, to ensure her child has the best chance at success, Dorinda opts to separate from her long-term partner saying "we can be a family just fine without him. Actually, we're probably better off."

Although the practical significance of marriage has diminished, as evinced above, its symbolic significance in its connection to family values has grown (Cherlin,

1988; Cherlin 2016). Many of the women indicate somewhat flexible views on marriage, with most feeling it is ideal according to their personal family planning preferences but not required of other women. Molly remarks, “I think that’s ideal, definitely for me, I’m married. But I see that that’s not the way that it has to be. You can be single and okay and marriage is not a guarantee.” Molly’s statement reflects a broader societal shift in U.S. marriage norms in that social respectability and access to financial resources no longer require marriage, but it continues to be something many strive for (Cherlin, 2016). As Cherlin (2003) writes, “although most Americans still value marriage, they hesitate to impose their preferences on others” (p. 27). Similar shifts have occurred around premarital sex so long as it does not result in an unplanned pregnancy. Lindsey explains,

Marriage is just something that was instilled in me by my family because I was raised Catholic. And so it’s like you get married—my mom says she’ll always give in about the premarital sex thing but, “Please don’t have any children before you’re married.”

Similarly for Analise, “It just feels like it’s a sin...having a baby out of wedlock is definitely a sin.” In this way, all three women reflect shifting thresholds in family planning ideals that capture popular rhetoric linking, both implicitly and explicitly, out-of-wedlock and unplanned pregnancies with the family values. These examples illuminate the extent to which medical guidelines can be constructive of and constructed by social and cultural norms. For example, public health recommendations that promote specific ages of childbearing (18+ for the WHO and over 20+ for the Brookings Institute) both reflect and reinforce social norms around pregnancy timing

and spacing (Haskins, 2013). By attaching this timing to family values about marriage and childbearing, family planning norms reflect both public health guidelines and family formation norms.

Indeed, in mid-20th Century America, marriage was the only acceptable context for having a sexual relationship and for bearing and raising children. According to Cherlin (2003), in 1950, just 4 percent of children were born to unmarried women. Fifty years later, the figure was 33 percent. Previously, most women, and many men, abstained from sexual intercourse until they were engaged to be married. When an unmarried woman became pregnant, relatives required a “shotgun wedding.” Consequently, most families had two parents (Cherlin, 2003; 2019). Sex and childbirth prior to marriage is antithetical to many Christian faiths that see marriage as an essential part of, as Analise explains, “God’s plan.” Certainly, religious values frequently emerge as integral to the value systems women prioritize in their family planning. Conservative commentators, policymakers, and pundits argue that marriage cultivates a morality of commitment, constancy, fidelity, and monogamy (Cherlin, 2003). Moreover, children learn these values by being raised in these morally righteous homes. Ellie offers some insight into how such values are passed on and applied:

My dad is kind of conservative...[H]e is more open-minded than a lot of people, but he is definitely “no sex until marriage” and “It’ll ruin your life” kind of thing... So one time I was about to go on a beach trip with my best friend, who was a girl, and then two of her guy friends, and we were going to stay overnight in a hotel and my dad comes into my room before he left and he said, “Just be responsible and I know

people who got pregnant and it ruined their life.” So, no. I absolutely do not want to become pregnant unless I’m married. That would be awful.

It is common for the women to describe a version of this conversation or a general sense that the failing to achieve the family value of marriage before pregnancy has tremendous consequences and is thus, impactful to their the order in which they form their families—marriage first, children second. For Ellie, abstaining from sex is the responsible (and necessary) action which informs her subsequent family planning ideals. Indeed, it is possible that women prioritize sociocultural values like marriage before children, not because medical guidelines are completely irrelevant to them, but because the moral codes handed down from parents are simply more poignant.

Hannah’s narrative suggests that these moral codes are culturally rather than medically relevant. She explains,

If anyone at our high school got pregnant, they’d totally be ostracized by the kids, the teachers, parents...everyone...I don’t think we have that many pregnant kids, especially because a lot of them tend to be upper or middle class like White kids [in our school]. So I think generally if you found out you were pregnant, you have an abortion...[C]ulturally it’s you don’t get pregnant. Like you don’t stay pregnant if you get pregnant. Culturally too, their parents would totally freak out if their perfect little like angels got pregnant. Like they don’t want them to do that. And especially because so many of my friends are more religious or they’re not religious, but their parents are... I feel like a lot of my friends’ parents would freak out like totally...So they’re clearly you oughtn’t be doing stuff that’s illegal. Well okay, that’s quite the slip of the tongue. Obviously, teens having kids isn’t illegal but it sure feels like it. Like...it’s just a moral thing...Like it’s not accepted in most families...So personally, I mean I wouldn’t necessarily recommend having a kid if you were younger than 30 because of all that. It’s just...the culture where I’m from.

Beyond relevance, medical constructions of unplanned pregnancy and its many negative outcomes may serve to legitimate and even necessitate these moral codes (Conrad & Schneider, 1992). While teens may not, in fact, be literally ostracized for becoming pregnant, the belief that they might influences Hannah's family planning preferences. She goes so far as to associate teen pregnancy with illicit activity which reflects popular portrayals of such pregnancies as deviant (Furstenberg, 2008b). Strong perceptions of stigma toward teen pregnancy often have their origins in family values that are enforced through the narrative of "negative outcomes" for pregnant teens. Stigma can create harmful isolation from their social networks and even prevent teens and their families from disclosing the pregnancy, opting instead to conceal it or end the pregnancy, for fear of judgment or negative reactions (Moseson, et al., 2019). In other words, women's family planning considerations often hinge on the perceived acceptability of their decisions.

While women may no longer need marriage for upward mobility, the cultural and social values of feminine respectability like those Ellie expresses above emerge consistently across the participants. For many, respectability is based on marriage status and thus features often in their family planning considerations. In this way, the women connect family planning and marriage not just based on the utility of a partnership, but also to the social and cultural values it represents. Tae reflects, "My mom wasn't married, so that never was like the thing to me like, 'Oh, you have to be married to have a baby.'" However, while marriage in the literal sense is not part of her family value system, a stable partnership is. She explains,

But if it could have went down like that, yeah, I would have had three kids by the same guy because that was always my intent...to stay together, to have kids. Raise them as a family unit with him. I mean no one goes into life like, 'I hope I have three baby daddies.' None of us say that. And no one say that okay neither.

Family planning research often portrays women like Tae as being at greater risk for unplanned pregnancy, in part because she was raised to a single mother (Sawhill, 2014). For Tae, she does not see herself as “at risk” for an unplanned pregnancy, rather she navigates the preferred family dynamic in her home which may or may not include marriage. Certainly, she indicates that having “three baby daddies” is “no one’s” preference, but it is not reflective of family decline but instead, family formation (Edin & Kefalas, 2005).

Women routinely discuss the sociocultural values inherent in marriage, children, and family and, how they reflect the promise of stability that accompanies the traditional American family. While not all aspects of this family form resonate with the women and their own considerations, the hegemony of such norms is evident in how they portray their families. For instance, a common occurrence for our interview team is for women to initially represent themselves as either married or engaged, especially if they have children together, are pregnant, or desire pregnancy with their partner. As Jeannie discusses her desire for children and family planning preferences, she states,

My husband and I—well, okay, I fibbed. Actually, he’s only my fiancé...Well not really even that. But we want to tie the knot. Go to the courthouse. We just haven’t...[W]e’ve talked about it...we want to if we were ever having kids together that’s for sure...A nice stable

family with lots of kids. It's what I always wanted. Like what I had...but I'm not gonna lie. It's been a struggle.

For women like Jeannie who has experienced incarceration, child welfare investigation, the termination of her parental rights, and coerced sterilization (that she hopes is reversible), the image of stability is likely something she feels compelled to portray. Indeed, she goes on to explain that she has tried to convince her father, who has custody of her two daughters, that she is “capable of caring for them” and one way she feels she can do so is to get married. In this way, marriage is symbolic of family formation, but also of family stability and motherhood.

Veronica has also portrayed herself as married to boost her social standing and subsequently improve her treatment in public spaces. At an Ob/GYN appointment while pregnant two years ago, she told the nursing staff:

‘I’m married.’ And they be like, ‘Oh, bless your heart. How many years?’ And it’s just like it’s a total turn socially...I got tired of the looks, the snickering, the ‘22 with three kids’ or ‘21 with three kids’ judgements. And you just kind of—it gets to you after a while. And then I got to a point where I would just lie. You can try to say that, ‘Well, people say marriage doesn’t matter,’ but it really does. Even if it’s not my number one priority. We have been brought up in a society where anything that anyone thinks of you matters. And you have to lie about being married to try and change their...opinion.

Since this appointment, Veronica reports marrying her long-time finance and feels “like in general that is a big factor that I’m married now and the doctors and anybody may or may not know that my kids are his and they don’t get into that line of questioning once they see the wedding ring.” She reports it has been a “nice change

for us socially, to not have to worry about people judging us or the kids and thinking ‘oh he just a baby daddy’ because he's not. We are a family.” Indeed, single motherhood is a fixture in debates about family decline. Thus, for the women, it is important to manage their image so as not to be immediately labeled a single mother. Women who are without husbands to support them and their children are viewed as suspect and potentially undeserving (Gordon, 1994; Seccombe, James, & Walters, 1998). They are "manless women," a stigmatized group that is "reduced in our minds from a whole and usual person to a tainted, discounted one" (Goffman, 1963, pp. 3-4).

This inclination to represent oneself as married or engaged demonstrates just how impactful sociocultural norms and related stereotypes are in forming women’s family planning ideals, but also in the impacts of family planning guidelines in shaping women’s family planning experiences. Indeed, scholar-advocates frequently raise concerns about family planning, particularly the construction of unplanned pregnancies as deviant. Just as Veronica experiences, such expectations contribute to bias, stereotyping, and even the exacerbation of and justification for inequality—the effects of which I discuss in the following chapter (Dehlendorf et al., 2018; Higgins, 2014; Manzer & Bell, 2021; 2022).

Conclusions

As Lauren asserts, family planning is not merely a medical exercise for women. Instead, it is an exercise in family formation in which women balance numerous “family factors” that are composed of many, sometimes competing,

sociocultural norms around family and motherhood but that share a common thread—stability. Medical and governmental organizations have set out to change this culture around reproduction. In doing so, they advocate that women adopt a myriad of family planning guidelines from the intentional timing and spacing of pregnancies to the age in which one conceives. As I demonstrate, such a shift in norms is possible and to some extent impactful, but these family planning guidelines compete with the many other sociocultural norms women value.

Indeed, family planning scholarship routinely compares women's family planning decisions against family planning guidelines, labeling failures to comply as an indication of women's flawed decision-making rather than considering the potential for flaws in the medical construction of family planning. One of the biggest takeaways from the women's narratives is that the universal metrics used to evaluate women's family planning decisions simply neglect women's *family* planning considerations. Family structures and the process of family formation are inherently heterogenous and varied, not a dichotomous either/ or (planned or unplanned). It should follow logically, then, that women's family planning considerations will be similarly varied. Not only does the current family planning paradigm neglect the centrality of family norms, values, and processes in women's family planning considerations, but it sets women's decisions up to be in or out of compliance with such guidelines. The negative effects of which I discuss in Chapter 5.

In sum, comparing women's *family* planning considerations against family planning guidelines demonstrates the complexity and sociocultural values women

weigh. Doing so problematizes the medicalized guidelines widely accepted as ideal measures of women's family planning decisions. Recognizing and challenging this construction of family planning brings us one step closer to supporting women's family goals, reducing inequalities, and informing health and social policies.

Chapter 5

“ONE OF THOSE PEOPLE...”: BAD PLANNERS AS BAD MOTHERS; GOOD PLANNERS AS GOOD MOTHERS

Introduction

I am with Molly and her newborn son in a public library study room. Our interview moves onto her future desires for her family. Suddenly, she breaks down into tears and puts her head into her hands. I immediately apologize for bringing up the subject given her recent divorce, the difficult custody battle over her five children, and that her newborn was an unplanned pregnancy. She looks up, smiling with her face streaked in tears while laughing and says,

Oh! I'm not crying because I'm sad! I'm crying because I'm happy!
You'd think I'd be devastated, but this baby symbolizes the rebirth of
my family after losing my husband. I get to be a mother yet again.
That's always a blessing even if it was a total surprise.

Molly goes on to discuss her dreams for her children. She recognizes that “as a mother...a single mother at that...I am the center of my family's universe” so as “difficult as things are for us right now, I am making it work and I can't help but be happy.” The overwhelming challenges Molly faces are trumped by the value she places on motherhood. Yet, in the public discourse, Molly is a “problem.” She is part of an “epidemic” of unplanned pregnancies especially given her need for government assistance, her lack of employment, and her status as a single mother. She begrudgingly applies for supplemental social support, recognizing that “I'm a living, walking stereotype. I'm not proud of it, but I am proud of being a mother to these

kids.” Molly is living a paradox—she can mother, but to mother “well” requires social support. However, although receiving social support may help her better care for her children, doing so fulfills the stereotype that she is a “bad mom.”

Indeed, this paradox emerges in part through the “motherhood mandate” and all that is implied within it. It is well-established that women are expected to become mothers (Russo, 1976). This motherhood mandate implies women are incomplete unless they mother. However, one must also mother well (Thurer, 1994). In a culture of monitoring and reprimanding women for “bad mothering” (Malacrida & Boulton, 2012), the well-being of babies and children is conceptualized ecologically, wherein everything about an individual’s life is potentially risky to one’s health (Stevens, 2016). Women are expected to begin this form of idealized mothering during pregnancy (Copelton, 2007; Waggoner, 2013; 2017), or even before conception via preconception care, and as I argue, through family planning (Waggoner 2013; 2017). Women who fail to do so are often met with stigma and an internalized sense of failure (Becker, 2020; Moseson et al., 2019). However, despite the centrality of motherhood in women’s lives and the significance of family planning as part of achieving that goal, little is known about how women make sense of family planning expectations in relation to their mothering ideals and desires, and in particular, how they manage negative feelings about their outcomes.

Given these expectations, it is unsurprising that when asked, every woman in the study links family planning to their role, past, present, and/or future, as mothers. Often, they elaborate on the ideals of good motherhood, such as selflessness, like

Molly does when she says that “I would do anything for my children...I know...that means a lot of sacrifice.” Indeed, discourses about what it means to be a “good mother” often 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, 2005). They follow expert biomedical advice on reproduction (Rapp, 1999) and childrearing (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. By this construction, Molly and the fifty percent of women who fail to plan their pregnancies cannot be good mothers, and this status is determined before they have even given birth.

In this way, the construction of family planning as a social problem reflects social norms and expectations regarding how women should organize their reproductive lives in relation to their social and economic position in U.S. society, often to the exclusion of what individual women may desire for themselves, their families, and their communities (e.g., their desires for and visions of motherhood) (Aiken et al., 2016; Barcelos, 2020; Borrero et al., 2015; Geronimus, 2003; Littlejohn, 2021; Mann & Grzanka, 2018; Stevens, 2015). By this standard, Molly should not have any additional children despite her desire to mother and mother well simply because the definition of good motherhood obligated by family planning conflicts with Molly's experience.

In challenging the paradigm of family planning, the question becomes, is the paradox Molly faces—to be a “good” mother off welfare (but not providing enough for her children) or a “bad” mother on welfare (but providing adequately for her children)—the result of her failure to plan her pregnancy or is this a consequence of social structures and norms that fail mothers? Such a question is often lost in rhetoric about health decision-making, individual responsibility, and risk, especially within the context of women and reproduction. Today, women who can be potentially pregnant are lifetime mothers—expected to manage all pregnancy risks well before conception (Waggoner, 2017).

Accordingly, the family planning paradigm’s persistent focus on pregnancy planning not only neglects the family considerations women make, but also their roles as mothers. In doing so, the family planning paradigm establishes criteria that designate for whom mothering is socially acceptable. Through the lived experiences of women like Molly, this chapter demonstrates such effects on women’s lives as they contemplate and navigate the assertion that bad (or lack of) planning is bad mothering. Revealing this stigma is essential because it has tangible consequences for women, children, and their families (Aiken et al., 2016; Moseson et al., 2019).

“A baby having babies”: The face of failed family planning

A pattern emerges when you ask women “who is least likely to plan.” Where women associate family with stability in the previous chapter, they associate those least likely to plan with instability—less stable in relationships, in finances, in housing

and so on. In other words, women who fail to plan are less likely to achieve their dreams around “family”, not just their preferred pregnancy outcomes. Like Theresa, each of the women also associate that “there is more of a negative connotation with an unwanted or surprise pregnancy when you don’t plan or aren’t ready for a family in all the right ways.” Indeed, there is a strong sense among the participants that there is a “right” and a “wrong” way to become a mother, but just as importantly, your status as a mother, and the quality of your family, is connoted by the planning status of your pregnancy. Theresa adds,

I feel like if it’s more often happening to folks who are unstable...[a]ren’t married or in unstable relationships and have premarital sex...I feel like married couples more often would plan if they’re going to try for a baby or if they’re going to try to prevent a pregnancy from happening because they are just so stable. I’m not saying that one pregnancy is more right than the other, it’s just that people see the unplanned or unwanted ones as bad...or worse. You know?...It’s just that...[t]heir ability to be a mom is kind of called into question because of their circumstances if you know what I mean...[A]nd then your family is all messed up when you aren’t together with the dad anymore...

Theresa reflects that the classification of one’s pregnancy as planned or unplanned is a quality-control measure of one’s mothering and family—bad or good, stable, or unstable.

“Readiness” to mother is implicit in notions of stability because social norms about readiness are inflected with White middle-class values, which presuppose that childbearing is only socially acceptable when one is a financially secure adult in a committed, long-term relationship (i.e., stable) (Geronimus, 2003; Stevens, 2015).

This logic, while allowing for “happy accidents” or “surprises” among privileged social groups, stigmatizes people who become pregnant and have children when they are assumed not to be ready—young, low-income, racially marginalized, and/or unpartnered because such pregnancies either create or exacerbate high levels of instability (Stevens, 2015). It is likely that the women’s consistent association of unplanned pregnancies with instability is a result of knowledge produced around family planning. That is, although a notable percentage of unplanned pregnancies occur among married women and women of high SES, their pregnancies are rarely, if ever, the subject of scholarly research or public health discourse that contributes to rhetoric around family planning risks (Finer & Zolna, 2016).

One participant, Nery, illuminates the pressure she feels to uphold these family planning expectations. She depicts fretting for nearly a decade about “getting pregnant before I was stable. I really wanted to be remarried or engaged and have a solid career before starting a family. I knew I was having sex with quite a few men after my divorce and all I did was worry because it would have messed up my career, affected my daughter, and made us look bad as a family.” She lives in a small town which she describes as “conservative” so “these types of things are more than frowned upon.” To follow-up, Nery explains that “surprises” are okay in her community for some women, “especially if they can mother the child on their own without needing the state’s support but, you see? I would have needed help.” In other words, it is not simply the status of the pregnancy that justifies judgement or intervention for women, rather it is

the combination of status and stability that people like Nery acknowledge but also work to attain.

Her anxiety about planning and the repercussions of not doing so makes sense when she elaborates further on the types of women she feels fail to plan. She explains:

[H]ow do I say it in a nice way? I think poverty plays a big role in pregnancy risk...and its always people from bad families...It's just a cycle...[A]nd even for me, I'm not buying that as an excuse. I was poor and I didn't get pregnant. Because anybody can go into a clinic and get birth control or get condoms. No need to be risky with that. It's their choice not to use a condom. A bad one at that. In general, just poor education. People who have—I don't want to say a better education because again, we're all afforded the same education. But I think it's just whoever chooses to use what they have at their disposal...

Nery's lengthy response reveals many of the stereotypes associated with "non-planners," and in particular, the relationship between risk, responsibility, and decision-making. Nery acknowledges several structural limitations associated with pregnancy outcomes, namely poverty and education (Geronimus, 2003). But she quickly adopts traditional "American ideals" rhetoric around individualism and opportunity to dismiss such barriers as anything but poor choices about birth control use and a difference in "lifestyle". As Lupton (1993) points out, the dominant theme of lifestyle risk discourse is "the responsibility of the individual to avoid health risks for the sake of his or her own health as well as the greater good of society" (p. 429). In this way, all structural causes of health outcomes are repackaged as evidence that a woman has failed to comply with the directives to reduce her risk of an unplanned pregnancy and therefore, is to be blamed for her predicament (Conrad & Schneider, 1992; Lupton, 1993; Zolna,

1976). The dominance of the risky behavior frame of family planning is buttressed by a more general dominance of lifestyle theory in U.S. health promotion policy. As Nery's statement reflects, one reason the risky behavior framing is so popular is that it is consistent with core American values of individualism, upward mobility, and family stability. In fact, Nery assumes that non-planners come from bad families. In this way, the cycle she refers to is one in which "bad families" produce "bad mothers" who then go on to produce "bad families."

Nery also reflects another cornerstone of the American Dream value system—opportunity. As her narrative suggests, stereotypes about "non-planners" and bad mothering/family cycles parallel those of welfare recipients (Seccombe, James, & Walters, 1998). Nery echoes the deeply held American disdain for welfare recipients. In Nery's mind, everyone has equal opportunity to acquire the skills, traits, and human capital needed for upward mobility, and in this specific case, to access contraception. Consequently, for those who struggle, the blame falls on themselves—especially when it is assumed they will contribute to extending the cycle of "bad mothering/ families." In this almost social Darwinian view, welfare recipients, especially those who have unplanned pregnancies, are a particularly blatant example of those who have failed to "make it." Indeed, it flies in the face of what "real Americans" aspire to (Furstenberg, 2008b).

Anti-welfare attitudes are one of the most persistent facets of American public opinion (McLaughlin & Lichter, 1997). The construction of welfare mothers as "non-planners" contributes to stereotypes and the attribution of poverty. Aligning welfare

mothers and “non-planners” is intuitive given how both are often constructed as the source of many American social problems. Below, Nery offers classist stereotypes and attributions for not only others’ poverty, but the source of her own struggles as well.

She explains:

I think people in the ghetto are less likely to do planning and I think part of it, too, is because from my work in social services, I see *those people*...their rent is paid, they get their food stamps, their medical is paid. And this comes out of my taxes! Things are tight as it is. You don’t see anyone helping me and my family even though we could use it. So these moms, they never have to worry about, “How am I going to pay this bill?” If their child is sick, they don’t have to call out of work. They walk into the offices and demand that they get these free services, where the working class, we worry about, “If I call out of work today, how am I going to explain this to my boss?” Or the stressors of, “Oh, my gosh, if my kid is sick five times this month, then that’s five copays that I have to come up with.” And daycare. And so Yes. Where when you’re from the different lifestyle, you don’t choose to plan.

It is common for welfare recipients (and non-planners) to be blamed for other people’s struggles. Pundits routinely pit the working class against the impoverished which erodes public support for welfare spending and recipients. Time and time again, scholars find that even women utilizing welfare attribute welfare use to the laziness and personal shortcomings of other women (Bullock, 1999; McLaughlin & Lichter, 1997; Seccombe, James, & Walters, 1998). Maria, who herself had an unplanned pregnancy at 15 years old, does so when she says:

I was 15 years old, you know? When I had my child. It’s kind of—it’s having a baby! And that’s what it’s right now on the streets here in the city: baby having babies. Because they just have sex. With whoever!...[A]nd you know what? A lot of people having kids just to get more benefits like section 8 [subsidized housing], more and more so

they can say, “I’m home. I’m doing nothing.” Not because they actually care about their kids. Lazy people. I on the other hand, take care of my business. I do my work. I take care of my kid.

Maria reflects numerous tropes traditionally associated with “bad mothers” such as laziness, lack of planning, and welfare usage to distance herself from these women and related judgements. To do so, she employs a strategy of “comparative mothering” where she compares her mothering practices to others, effectively distancing herself from the identity of bad mother (Bell, 2014).

Paradoxically, these women Maria describes share many similarities with her. They have unplanned pregnancies, they are poor, they are often women of color, and they are younger. However, for Maria, *her* planning status does not inherently mean *she* is a bad mom or that the family she formed is somehow tainted. Rather, she redefines broader constructions of bad mothering by explaining that she is not lazy, takes care of her children, and does not utilize welfare benefits. As Bell (2014) explains, women may use this “comparative mothering” to construct a personal identity more consistent with their self-concept as mothers. Maria’s efforts to do so demonstrates that women do, indeed, link planning status with motherhood and for the many women who experience unplanned pregnancies, this linkage results in a conflict between how they see themselves as mothers relative to how society does.

Maria’s example also reflects ways motherhood is venerated when the mothers are middle and upper class, married, White, and as I add, their pregnancies are planned; the mothering done by poor, nonwhite women, whose pregnancies are not planned however, is systematically devalued (Colen, 1986). Indeed, Ellie reflects this

“stratified reproduction” when she says, “the only time you should get pregnant is if you are trying to just because there are so many kids who like were born unplanned and they don’t get the love or care that they need and that’s really hard to think about.” In other words, it is assumed that children who are unplanned are unloved and uncared for. While that is a conceptual leap, most participants make similar claims, particularly about the link between these pregnancy types and its effect on families and society.

Ellie goes on to say:

[U]nplanned pregnancies aren’t good for families...Like you see it on the news or on TV all the time. People and no awareness...ignorant...abusing their kids...low-income people...the ones with the accidental pregnancies or like the “oops” pregnancies, which is really bad...It’s just poor people don’t know or they don’t consider all of the ramifications of it...And it’s like as a society or in school we need to teach people or like if people don’t know that there are other things in life possible for them, then they might not like think as much like, “Oh, what if I get pregnant?” kind of thing. Like that they are okay with getting pregnant. Like it’s their culture or something. Those people who think that pregnancy is a good way to stay in a relationship... but they don’t realize their pregnancies and children affect everyone around them...I mean they cost us money. I don’t know about my financial situation in the future but emotionally, I feel like comparatively I would be able to provide a good home for someone who needs it because I would love my child unconditionally no matter my finances or the quality of my relationship. I know I would be a good mother.

Once again, women like Maria and Ellie employ comparative motherhood strategies to compare themselves to other mothers and to set themselves apart. Here, Ellie compares herself as a hypothetical mother to sensationalized constructions of bad mothers—those who abuse their children, do not love them, are ignorant of the consequences of pregnancy, use children to repair relationships, and so on. Where

Maria uses comparative mothering to distance herself from her own impoverished identity, Ellie employs it to align herself with the dominant social identity she holds as a middle-class, college-educated, White woman (Bell, 2014).

Popular stereotypes of women with unplanned pregnancies are pervasive as evinced by the women's narratives above. Yet, many women will experience a "pregnancy scare" in their lifetime and half of childbearing women will experience an unplanned pregnancy (Finer & Zolna, 2016). Indeed, Sarah recognizes that an unplanned pregnancy "could happen to anyone" and that "almost every single one of my friends...even though they come from good families" in her high-income neighborhood "have at one point thought they were pregnant. But I guess they do something right because they never are." Despite the probability that she or her sexually active teenage friends could become pregnant (Finer & Zolna, 2016), Sarah retains an alternative image of which teens actually become pregnant. She explains that two girls in her high school class recently became pregnant,

[a]nd they were two girls who I would guess were like lower socio-economic status...from tough families...you know...[b]ased on appearance...Clothes type of thing...But so I think it kind of went along with the stereotypical high school pregnancy girl like what you would think for them to be...

Despite she, herself, and her friends being "high risk" for teen pregnancies, Sarah actively manages to distinguish herself, her friends, and their "good families" from "the stereotypical high school pregnancy girl from tough families" by leveraging their social class as evidence that despite so many pregnancy scares themselves and their

status as teenagers, they are somehow less at risk of experiencing such a pregnancy. This comparative work allows Sarah to assign blame and judgement to her pregnant (lower SES) classmates without having to accept it for herself and her friends or let it reflect poorly on her family.

Sarah also indicates something important about how privilege operates in the case of family planning. Not only does privilege grant you access to resources and support if you do become pregnant, but it also offers the privilege of not “becoming pregnant” in the public eye. Hannah, another high schooler who also attends a privileged high school says:

I don't think we have that many pregnant kids, especially because a lot of them tend to be upper or middle class like White kids [in our school]. So I think generally if you found out you were pregnant, you have an abortion...[C]ulturally it's you don't get pregnant. Like you don't stay pregnant if you get pregnant.

Hannah's narrative reflects the privilege to not “become pregnant” and implicitly speaks to abortion access. For many reasons, abortion access is stratified and therefore, decisions about whether and in what circumstances women mother are beyond their control (Kimport, 2022). In some cases, abortions are unaffordable, especially for low SES women who would rely on federal funding to access such procedures. In other instances, anti-abortion cultural narratives make abortion socially impossible to choose, and for many marginalized women, negative experiences with health care preclude abortion as an option (Kimport, 2022).

As evidenced in the narratives above, there is a clear “face” of failed family planning and the women actively work to distance themselves and their families from these stereotypes, particularly as they differentiate themselves from bad planners and bad mothers and stable families or unstable families. Public health rhetoric and popular stereotypes support and perpetuate this the image of bad planners and bad mothers as marginalized women and “welfare moms”. Meanwhile good planners and good mothers are White, middle-class, and meet all stability criteria like the house, the career, and the marriage. In this way, medicalizing family planning positions its solutions within the public health arena and exposes women to surveillance, public scrutiny, and risk rhetoric that attributes blame, judgement, and responsibility to individual women and by extension, the families they form. Taken together, the construction of family planning not only offers a solution to unplanned pregnancies, but it also constructs those who experience them as the problem. In the following section, I examine how women balance family planning expectations and the social norms around gender, race, and class embedded within them.

“It was my fault”: Personal attribution of family planning norms

In re-reading women’s transcripts, one word continuously rose to the surface—mistake. I began keeping track of how often it was used and in what contexts; it became clear that women feel that decisions or outcomes not aligned with family planning norms are in fact mistakes or “almost a mistake.” For instance, Maria reflects on her unplanned pregnancy, saying:

I am the type learn from my mistakes so you can see how my pregnancy when I was a little girl changed me. I was in the wrong to have gotten pregnant. What I know now, I learned it the hard way. Don't get pregnant young. It was all my fault. But I have made the most of this mistake by not getting pregnant again and contrary to popular belief, I became a good mom to [my daughter]... We have a good little family.

Maria terms her pregnancy a “mistake” and one she has had to learn from. But by emphasizing her role as a good mother and that she has a “good” little family despite her failure to plan, Maria demonstrates how women value family planning and pregnancy differently than they value motherhood and family formation. In fact, Maria rejects her mother’s assumption that she is “a horribly irresponsible person and mother...promiscuous and slutty” because she is young when she became pregnant. In this way, stigma about family planning outcomes occurs in tandem with normative motherhood ideals (e.g., Hays, 1996; Lareau, 2003). These cultural ideals of motherhood reflect a set of rules women must adhere to in order to be considered good mothers and form “good little families.” Implicitly, the way society communicates these goals assumes women’s decisions should be motivated by motherhood—that mothering traits, like having a stable, planned family, are incorporated into women’s sense of self or identity (Risman, 1998).

Like in other areas of medicalized reproduction, these gendered and cultural expectations of motherhood have particular bearing on the health practices of women, ranging from nutrition, childbirth, reproductive technologies, and beyond (e.g., Malacrida & Boulton, 2012; Markens, 2007; Wolf, 2011), particularly how these health choices might impact their children. As Maria emphasizes, she shares these

concerns. Yet, despite her mother's judgements and her own apprehension, she did in fact become a good mother to a "perfectly healthy daughter" and feels that their "good little family" is "you know...we don't have much but we've got what we need" (i.e., they have a modicum of stability). For Maria, becoming a good mother to a healthy daughter negates stereotypes that would suggest otherwise. Many of the women overcome any negative personal feelings or self-judgements about their pregnancies by focusing on the subsequent quality of their mothering practices and by depicting their families, although often non-traditional, in a positive light. In this way, family planning goes beyond conceptions of pregnancy to those of motherhood and family.

Consistent with public health rhetoric that utilizes individualist explanations for outcomes such as poverty and poor health, most of the women employ judgmental phrases and/ or blame and criticize themselves for unplanned pregnancies or "risky" behaviors that could have resulted in a pregnancy. For instance, Shauny is relieved she did not have any negative outcomes after having unprotected sex. Her statement reveals the extent to which most of the women see unintended pregnancies as "bad" and behaviors that could lead to such outcomes as "embarrassing." She recalls:

I was using nothing. I was a very stupid teenager...I don't want my daughter to make the same mistakes I did...thank God I didn't get pregnant and nothing bad happened...embarrassing mistakes. Embarrassing and downright risky behavior...I would have taken good care of the baby, it's just...what would my family think of me?

Like, Maria, Shauny holds many negative feelings about her past behaviors, not necessarily because she feels pregnancy would be the worst outcome for her

personally, but because of how others, especially her family, would perceive her and her pregnancies. As Aiken and colleagues (2016) argue, women's sense of self and their pregnancies are strongly affected by stigma around family and motherhood. In their study, women who feel their pregnancies are not socially acceptable face greater rates of anxiety, depression, and postpartum depression. They are also less likely to receive support from their families. Meanwhile, despite being unplanned, women who hold less concern about the social perception of their pregnancies fare better. In this way, the call to adopt family planning as a new cultural norm (IOM, 1995) may in fact do more harm than good for some mothers and their children. Indeed, words like mistake, stupid, and embarrassing are emotionally toxic. Critical inner dialogue about actions have been linked to depression, feelings of helplessness, flagging motivation, and a number of other worrying symptoms. Paradoxically, family planning is often justified by healthcare providers as a remedy for many of these problems among new moms (Mark & Cowan, 2022).

Many women find ways to navigate the negative social perceptions surrounding their family planning decisions and outcomes. Shelby became pregnant as a teenager and has since had two other pregnancies, all with three different men. She recognizes that “this ain't a good look for me an my family. Shoot. I'd judge me too.” However, she adds, “but people don't know. They see I'm a good mom. I'm not the one in the neighborhood out yelling at my kids to get inside wearing my slippers, you know what I'm saying?” To manage the outward perception and to protect her kids from “public ridicule” she “don't tell people I have three kids by three different dads.

That is embarrassing to me.” For years, Shelby has refused to tell anyone “except my close family” and for others she says, ““Oh, yeah, they all have the same dad’ even though they didn’t.” Shelby goes on to discuss the benefits of having one dad, “it just looks better and it feels better too. Makes me feel like we got some semblance of the family I always wanted even though deep down I know we don’t.” By selectively revealing her family and pregnancy status, Shelby demonstrates yet another way women’s mothering is called into question—through the perceptions of stable partnerships. She misrepresents her relationship status to improve her social standing and that of her children. This reveals the presence of pregnancy hierarchies but also family hierarchies. She says “we is stable with or without a man in the house. But things could be easier. I’m not gonna lie.” Such reflections help explain why in the prior chapter women value various forms of stability in their family planning ideals. Not only does this stability reflect family ideals, but mothering ones as well.

Other women cope with such expectations by maintaining rigorous control over their contraceptive use. In other words, women seek to prevent pregnancies not just because they desire to plan their families, but also because they recognize the stigma surrounding such a pregnancy if one was to occur. Taylor remarks:

At the end of the day, you’re the one—if you are to get pregnant, you’re going to be the one stuck with the child. You [points to female interviewer] or me. Not him. Not “them” or society. Unless you become one of those moms who abandon the kids and leave them with the dad. Which is just terrible. But to me, dads always have that freedom to come and go as they please, whereas us moms, we’re stuck with the child no matter what. We are the mothers so you have to be the one to deal with that kid and everything that’s going on. If you become

pregnant. It's your fault. If something is up with the child, you the only one to fix it. To be responsible for it. So I would say if you don't want to get pregnant, it's probably on you—you need to prevent it. That's why I'm so damn careful.

Taylor rigorously manages her contraceptive use and is careful when choosing sex partners. These actions reflect ways family planning expectations, like other household and family responsibilities, are organized along normative expectations about men's and women's disparate gender roles (Fennell, 2011; Hochschild, 1989; Kimport, 2017; Lorber, 1994; Terry & Braun, 2011; Wigginton et al., 2015). Indeed, family planning policies, public discourse, and interventions reinforce a narrative that women are normatively more responsible for pregnancy and childbirth than men. These depictions simply add family planning to a long list of ways women are already responsible for family and reproduction (Hochschild, 1989). Consequently, women may also be penalized for any problems encountered with a pregnancy or failing to meet related expectations around family and family planning (Armstrong, 2003; Flavin, 2009; Luker, 1984; Waggoner, 2017). As Taylor, herself notes, not only are you blamed for the outcomes of your decisions, but responsible for fixing them through mothering as well.

Mel's narrative reveals the gendered *and* racialized norms implicit in associating family planning with motherhood ideals. Mel navigates both sets of norms and the potential for stigma. Like Nery, Mel frets about becoming pregnant. However, Mel must do so not just because she would be seen as an unfit mother, but because she would be seen as a Black, unfit mother. She explains:

I was really afraid about having an unintentional [pregnancy] and just not wanting that to be me—a young, unwed mother, like that teen mom...particularly being black...Like the Reagan welfare queen...Like huge stigma and also not wanting to devastate my parents and just you know, be another pregnant Black girl from my community...so it was definitely like, “No, this would be a bad thing—and that was a strong message. Like, “This would ruin your life socially, emotionally, your future plans, how people see you and so I knew, “Okay, if I am going to have sex, I have to be in charge of this and not f[***] it up.”

Like Taylor, Mel manages the “life ruining” consequences of an unplanned pregnancy by being diligent with her birth control. In doing so, she internalizes the message that her contraceptive missteps carry a lifetime of consequences. Like all participants, Mel receives regular messages that unplanned or mistimed pregnancies are universally negative and something to be avoided. Here, her reasoning around taking responsibility for contraception also reveals the stigma and shame associated with such pregnancies and the power parental judgments, perceived or real, can have on feelings of responsibility, use, and decision-making.

Mel’s reference to a Reagan welfare queen is a poignant one—although dawned as a part of Reagan’s anti-government and anti-poor sentiment in the 1970s and 1980s—the welfare queen trope has made a comeback, used in the campaign of former President Trump, for example, to justify spending cuts to welfare programs (Lucks, 2020; Seccombe, James, & Walters, 1998). The welfare queen image is important in the construction of mothers who fail to plan. As with welfare recipients, the face of “non-planners” is often that of an African American woman, and as Nery’s quote from earlier demonstrates, there is a strong stereotype that African American

people receive welfare while White taxpayers subsidize their lifestyles. The welfare queen is also promiscuous, having as many children as possible to increase her benefit totals. Although the Reagan welfare queen has always been a myth, it remains a potent stereotype that many African American women in our study must manage both through their diligent contraceptive use and in their efforts to be ideal mothers (James & Rashid, 2013). Indeed, as Mel concludes, “it’s just a balancing act. I know I’m an amazing mother, but I also carry a lot of baggage around from messages I received about, do anything but be an unwed, young, black mother.” She adds:

Like that was kind of the culture and the idea...all of those stereotype messages, telling me I can never be mother enough just because I conceived my daughter a few months earlier than I planned...I don’t believe it...[b]ut I kind of do.

“Stupid, Stupid, Stupid!”: Attributing family planning responsibility

Women navigate the social expectations and stereotypes around family planning by managing how others perceive them, e.g., telling others their children have one father, telling others they are married or engaged, obtaining an abortion, managing contraceptive use, as well as in how they construe the failures of others. Consistent with research about other health conditions like obesity, HIV, and substance use disorders, those affected often set themselves apart by comparing their behavior to others, particularly those perceived to have a lower status than themselves (Saguy & Gruys, 2010). In doing so, the participants deflected blame and negative stereotypes by attributing it to others. Sophia employs this strategy saying:

[My cousin] had a [pregnancy] scare because her boyfriend was moving away...and they didn't use a condom. And I was like, "Are you stupid?" I was like, "You took the same health class I did. You should know this." And she was like, "We didn't have any, but I wanted to do it." And I was like, "You're stupid. Stupid, stupid, stupid." So she was worried for like two months that she was going to have an unplanned pregnancy with some guy she wasn't even dating anymore...But I was like, "Well, couldn't you just keep it in your pants? That's what you get for being stupid. You get scared and any and all consequences headed your way" ...It just reinforces my opinion: use contraception every time or get the blame.

Dominant discourse treats unplanned pregnancy as the result of bad individual behavior. Interestingly, Sophia's cousin's experience merely reinforces the individualization of family planning—one must use contraception every time unless you are "ready" or else you are "stupid" and deserve the consequences. Here, rather than sympathize with her cousin, Sophia attributes the cousin's distressing outcome to her personal shortcomings and irresponsible behavior. Perhaps in an effort to further assert her moral superiority, Sophia announces that she uses contraception every time.

Sophia also employs numerous stereotypes related to sexuality and "corrupt" behavior associated with teenagers who become pregnant (Sawhill, 2014). Indeed, by telling her cousin to "keep it in her pants" or you "get what you deserve", Sophia constructs this behavior as a lack of self-regulation. Teenage sexuality is frequently cited by pundits and medical professionals as justifications for intervention (Higgins, 2014). However, less apparent in Sophia's narrative is her careful deployment of dominant family planning discourse. By adopting its values and aligning herself with those standards, such as using contraception every time she has sex, Sophia avoids any

association with such behaviors, even though she, herself, acknowledges “not always being as careful as I should be.”

Women also frequently employ comparative mothering to distance themselves from perceptions of bad motherhood that are commonly associated with failures to plan (Bell, 2014). In particular, the participants are cognizant of women they feel cannot provide for their children and frequently compare their parenting qualities to these women as a way to differentiate their own mothering. Jeanie, who has lost custody of both daughters and receives welfare benefits, is gobsmacked by women who have unplanned pregnancies. She explains that even though she has had challenges, her daughters are both “wanted” and “loved.” Conversely, she reflects:

Just like, what? Women having babies that can't take care of them. It's just—it just seems like some people just get pregnant just to be—I think you shouldn't have children until you're ready...Have financial stability, have a stable relationship. Actually want to be a mom. Because that's like—I mean and you've got to be willing to give a lot of love. And I know you have to love yourself before you can love anyone else, but you also have to put a lot of things on the back burner to be able to take care of your kids properly—you can't go get your hair done, and go get your nails done, and not have diapers like a lotta welfare moms do. And they get to keep their kids! I never spent my check on anything but my kids.

Clearly this is an emotional conversation for Jeanie. Several times throughout the interview she needs to pause and sit quietly with her thoughts. Jeanie is aware she no longer has custody of her daughters, but she maintains that she is a good mother by making the claim that her pregnancies are socially sanctioned because of her simple desire to care for her children. As other researchers have found, Jeanie also

distinguishes herself from other welfare recipients by contrasting fraudulent and/ or “irresponsible” spending with her more thoughtful use of welfare funds. Despite its rarity, women routinely rely on stereotypes related to issues like welfare fraud, as a means to improve their social standing despite also receiving government support (Seccombe, James, & Walters, 1998). Indeed, Jeanie also holds a common and deep-seated cultural belief in self-reliance; a belief that makes unplanned pregnancy—like wealth—something regarded as under personal control and as reflecting one’s moral fortitude and mothering capacity.

Family planning is imbued with numerous social and cultural norms around morality. Perhaps, none more so than the issue of abortion. As Andrea Becker (2020) posits, abortion and good motherhood are often constructed as diametrically opposed, but in fact, seeking an abortion can itself, be good mothering. Some participants use women’s abortion decisions to distinguish themselves from others. For instance, while actively judging the decisions of her friend, Lee cuts her friend “some slack” because while she had an unplanned pregnancy, at least she did not choose abortion. She explains:

Most of my friends were sexually active. I was the last one to start...And all of them use the pull out method...And one of them is having a kid soon. So I wasn’t like, “I told you so!” She wasn’t planning to have a baby. But I mean I have respect for her for not like aborting the baby or anything, but still. A mistake...And there were rumors—not even rumors, but people kind of just like make fun her or a girl pregnant in high school and I guess [the girls] just don’t think about the risk.

Indeed, Lee sees decisions about family planning as “good” or “bad.” So much so, she tells her parents about her sexual activity to limit the likelihood that she will make a “bad choice.” So ‘when I wanted to have sex I told my mom, “I would like to be on birth control. I don’t want to make a bad decision and you guys not know about it.”’ This judgement of self and others for having made “bad” individual decisions reflects the numerous social and cultural values embedded within the practice of family planning and the great strides women go-to to navigate and ultimately resist constructions of family planning that position not only women’s decisions, but the women themselves as either “good” or “bad”.

Conclusions

Regardless of their social standing, all the women grappled with their social circumstances and ideological notions around family planning as they made sense of their own experiences and family values. Their perspectives and their perceptions of others were shaped by broader cultural beliefs and ideologies relating to sex, pregnancy, marriage, self-reliance, family, and motherhood. Consistent across all participants was the belief that family planning, like family, signifies stability. Stable mothers have stable families. Unstable mothers, have unplanned pregnancies, which result in the unstable families they are thought to cause.

Although most family planning research emphasizes pregnancy and pregnancy prevention, the sociocultural norms embedded within family planning behaviors give value to whether a pregnancy is planned or not. Doing so serves to further stratify

pregnancies and the women who have them. Consequently, women must navigate the expectations to plan but also reconcile their own self-concepts with such norms—often at the detriment of other women. In other words, the family planning paradigm serves to label some planning behaviors, and by extension pregnancies and families, as socially acceptable and others not.

Chapter 6

“YOUR ONLY OPTION IS TO PLAN”: THE UNEVEN BURDENS OF FAMILY PLANNING

Introduction

Although family planning is a cornerstone of American reproductive health policy and now a dominant reproductive norm, debates persist about whether family planning actually *causes* the improved social and economic outcomes it promises (Geronimus, 2003; 2004; Geronimus & Korenman, 1992; Kavanaugh, 2008; Mark & Cowan, 2022). Indeed, the social and medical benefits of family planning are widely taken for granted despite considerable research demonstrating the association is weak (if correlated at all) across numerous measures like maternal mental health and social mobility (e.g., Geronimus, 2003; Geronimus & Korenman, 1992; Mark & Cowan, 2022). Consequently, more and more researchers have begun to investigate the effects of structural level factors such as economic and educational opportunities on such outcomes (see, Furstenberg, 2008b; Geronimus, 2003; Gomez, Arteaga, & Freihart, 2021; Kavanaugh, 2008). As I demonstrate in this chapter, women’s positive outcomes are achievable not because of family planning but *despite* it. And, in fact, family planning, as currently conceived, may contribute to poorer outcomes because it detracts from other policy solutions that may have greater positive impacts on women and children (Thomson-DeVeaux, 2022).

Such inquiries are imperative because they can inspire movement away from the standard health behavior model of family planning that currently emphasizes

individual choice and responsibility to one that recognizes the contextual factors impeding or facilitating individuals' ability to achieve their family planning ideals. Indeed, as evidenced in Chapter 5, the focus on individual responsibility imparts the message that there are morally tinged “right” and “wrong” ways of controlling one's fertility and blames the woman who is unable to conform to societal fertility rules as being irresponsible or “morally lacking”. This construction deflects professional and governmental attention away from structural and collective determinants of family outcomes as well as reproductive health outcomes more broadly (Kavanaugh, 2008; Kelly, 2014).

To date, most of the work that captures the effects of structural inequality on women's family planning experiences focuses primarily on ways external factors, like economic standing and culture, make family planning irrelevant or less relevant in their lives (Geronimus, 2003; Gomez, Arteaga, & Freihart, 2021; Kavanaugh, 2008). Indeed, ample research finds that many groups, including people of color and of low SES, do not relate to conventional notions of family planning including achieving educational and career goals and marrying before having children (Arteaga et al., 2020; Edin & Kefalas, 2005; Jones, Frohwirth, & Blades, 2016; Kendall et al., 2005). Yet these normative expectations are embedded in family planning interventions (Callegari et al., 2016; Stevens, 2015). So much so, the Brookings Institute released a “Success Sequence” where they recommend accomplishing three steps to help people avoid poverty and enjoy greater economic (and familial) success in life—graduate from high school, be gainfully employed, have children while married, and be 21 or

older before childbearing (Haskins, 2013). However, researchers who tested this “sequence” found results differed by race with Black individuals still facing fewer economic prospects compared to their White counterparts even if they delayed starting a family (Reeves, Rodriguez, & Gold, 2015). In other words, individual-level health promotion efforts like “Success Sequences” that encourage pregnancy timing neglect social factors, like the well-documented effects of structural racism, on limiting the economic and social mobility of marginalized groups (Geronimus, 2003, Reeves, Rodriguez, & Gold, 2015)

Additionally, researchers like Gomez and colleagues (2021) find that structural inequalities constrain reproductive self-determination and create gaps between desired and actual childbearing. Indeed, as I found in Chapter 5, women feel compelled to postpone childbearing or limit childbearing altogether because they lack sufficient resources to care for their children. Kavanaugh (2008) similarly finds that contextual factors like poor schools and limited job opportunities create barriers to women achieving their desired family outcomes. To build on this research, I concretely articulate some of the ways women’s resources are translated into health advantages whether they plan their pregnancies or not and that women’s lack of resources can create disadvantages. In doing so, I demonstrate several *mechanisms* of inequality and their effects on women’s family planning desires and decisions—namely unequal institutions and income inequality. By taking this approach, I explicate some of the external factors that contribute to marginalized women’s worse outcomes when their pregnancies are unplanned and offer alternative policy approaches. Along the way, I

also challenge many of the assumptions raised in Chapter 5 that blame women for their difficult circumstances, particularly those that stereotype non-planners as irresponsible, lazy, ignorant, and casual about their family planning decisions.

To do so, I first demonstrate the “(f)utility” of family planning among women from different socioeconomic backgrounds. Most women, though they value the ideal of family planning, find it futile in their own lives because such decisions and outcomes do not operate in a vacuum. That is, their outcomes are the result of many factors that ultimately negate the effects of whether one plans or not. I then demonstrate the ways social institutions like education, welfare, and housing inequality obligate women to attempt planning, not because they necessarily value its benefits for their families, but because U.S. policies around work and welfare fail to give women an alternative to planning. Lastly, in contrast to most family planning research and policies that connect unplanned pregnancy to negative social and life outcomes, I illustrate structural level factors, not solely unplanned pregnancies, create such effects. In this way, I further demonstrate the contextual and complex dimensions of family planning and how, as a process, it extends beyond merely individual pregnancy decisions and outcomes.

“... it is a fantasy world...”: Exposing the (f)utility of family planning

Researchers, pundits, and policymakers routinely link family planning to poverty reduction (Markell, 2016; Monea & Thomas, 2011; Thomas & Monea, 2011), arguing that intentionally timing and spacing pregnancies allows parents to save up

funds to allocate to the expenses associated with childbearing as well as provide for their children in the long-term. As Kathy's narrative illustrates, this logic obligates and assumes that women possess the financial resources and opportunities not only to save funds in advance of a pregnancy but to estimate they can also care financially for their children for years to come prior to that pregnancy. Not only are such logics stratifying by suggesting you should only parent when you can afford to, but they also demonstrate how notions of family planning extend well beyond pregnancy planning. Kathy, who has struggled to maintain stable employment and health insurance over the years, may never meet these standards. She explains their futility saying:

I know some people actually plan for their kids...they like save up money, and stock up on Pampers, and they have their little baby rooms all settled up..., but that's not people from where I'm from. Everything is so expensive. I don't think I would ever be able to do it. Same goes for everybody where I grew up at...we want to do good by our kids. We just can't. We can barely afford the day-to-day needs, let alone plan ahead...[N]ot to mention, any job I've ever had doesn't provide health insurance and it's hard to keep up with my Medicaid paper[work].

As Kathy demonstrates, achieving family planning standards (e.g., financial stability) is itself resource intensive. For instance, achieving the numerous family planning guidelines like preconception care, good health, and stable employment come at a cost. Additionally, the added recommendation to save enough to afford expenses after the child is born comes at an extraordinary cost. For example, the average annual expenditure per child per year for U.S. parents is between \$12,000-\$14,000 with the state providing minimal social support and subsidies to offset these costs (Lino, 2020). Notably, this cost per child amount is more than Kathy makes in a full year. In other

words, given the resource-intensive nature of family planning, especially if its conceptualization is extended to preparing for long-term costs, it is only a “solution” (option) for those not already impoverished; put simply, family planning is not a route to upward mobility unless you are already upwardly mobile. Consequently, it feels like a futile exercise for women like Kathy—not simply because their personal or cultural values do not align as prior scholars have noted (see, Geronimus, 1992; 2003; Kavanaugh, 2008) but because the exercise of planning itself requires resources many in poverty simply lack.

Jennifer reveals that “doing everything right” in terms of family planning does not guarantee the results it promises. So much so, Jen calls this assumption “a fantasy world.” She reflects:

I guess it is a fantasy world I was living in thinking I could have all that. The kids, the house, the happy marriage, the career...[t]hat “Leave it to Beaver” family. Even though I did the right thing and got married and planned my last two kids.

Jen comes from difficult circumstances. She has been sexually assaulted, in a violent relationship, and grew up occasionally homeless. For Jen, the promise of family planning is closely tied to “finally getting what I want, that American Dream” so prevalent in women’s construction of their ideal family from Chapter 4. She remarks that “even though I haven’t been perfect and made some mistakes, I checked all the boxes but those boxes don’t pay me enough, don’t help me with childcare for my autistic son, pay for my housing after our apartment burned, or help my husband who needs mental health counseling.”

Jen's story reveals the limitations of "check(ed) boxes" to success, or as the Brookings Institute calls it, the "success sequence." She finishes high school, maintains full-time, albeit low-paying, employment, is married to a man who largely has been employed, and surpasses the age recommendation for of her pregnancies. "If you do the math, I should be good!" Jen exclaims. However, Jen is not good. She is living in a motel with her children, does not have enough food to eat, and is trying to keep her husband's mental health in check without being able to afford his prescribed medications "whose prescription has probly expired by now." For Jen, institutional and structural factors make the success sequence she attempts to follow ineffective. Jen expresses a need for numerous resources to achieve her family dreams; yet these are notoriously difficult to access for women of low SES in the U.S. For instance, healthcare is tied to employment, but often difficult to receive or afford for underemployed people (Lino, 2020). Mental health services are often not covered by insurance even if one has employer-sponsored care (Mark & Cowan, 2021). Among Medicaid recipients, subsidized childcare and mental health services are often unavailable, lower quality, and/ or resource-intensive to utilize (Lino, 2020). In this way, "success sequences" and family planning may be futile for everyone but those already on the road to or having achieved "success."

Similarly, meeting family planning standards does not guarantee perfect outcomes for one's subsequent pregnancy. Nery, who has significantly more financial resources and stability in her life than Kathy or Jen, experiences postpartum depression despite meticulously planning her pregnancy, being married, living in a

brand-new home, having a career, and following all her doctor's orders (even starting vitamins she dislikes and foregoing her much beloved caffeine). However, despite her adherence to the family planning regime and ticking off the success sequence boxes, she experiences severe post-partum depression, struggles to breastfeed, almost loses her job, is not always emotionally available for her daughter and newborn, and feels significant strain on her marriage. All of which are supposed to be minimized or eliminated by family planning (see, e.g., Monea & Thomas, 2011; Sawhill, 2014; Thomas & Monea, 2011). Two years after her first interview, Nery now runs her hands through her greying long black hair, saying:

I guess I just don't know any more if anyone is ever ready. I now *hate* it when people say, "We're waiting because we just want to be ready." But as I recently found out, you're never actually ready. I was a real apostle for planning when we talked last time. I even remember calling out women for not planning...[W]e had it all planned out.[to] have this pregnancy and then baby right after because we are both getting older and wanted to avoid a geriatric pregnancy. But then when my postpartum depression happened, we just had to put it off...we were going to have two babies perfectly spaced and then [my husband] was going to have a vasectomy and then we would be done... We even started a college fund for the second baby. So I plan a lot of things...but things never go the way you want them to go.

Nery describes herself as "a real planner" even an "apostle." However, as her narrative suggests, family formation does not occur in isolation. Rather, numerous factors shape outcomes. Consequently, Nery is not sure she and her husband will have a second child together, setting aside their dream of having siblings to "play together" in their recently fenced-in backyard. Naturally, nothing is a guarantee, even family planning.

However, Nery now feels “like a complete failure” and wonders throughout her interview “if I could have done something differently, would I have my second baby?” In this way, Nery accepts that family planning may be futile, but still assumes personal responsibility for her less-than-ideal pregnancy outcomes. Nery’s story reveals the consequences of the standard health behavior model of family planning that emphasizes individual choice and responsibility. Family planning guidelines and “sequences of success” do not capture the precarity of reproduction nor do they account for the added burden women take on. Indeed, like most gendered areas of reproduction and the family, women are positioned as primarily responsible for the outcomes (Bertotti, 2013).

Mel’s family planning efforts reflect the significance of this burden. She details the struggle her mother and father experience because of not planning for their children and the effects it has on her own ideas of planning:

My mom in particular was so stressed like through all her unintentional pregnancies she had. And money was the main reason. I don’t think she would have felt so awful if they had money to provide everything we needed. She loved us and was happy to have us. But she was also afraid she couldn’t afford to take care of us...[I]t’s unthinkable that in a country with so many resources mothers, Black mothers in particular, have to feel this way.

Mel’s mother suffers from depression and anxiety because of her worries. “Like I think if my parents hadn’t been living hand-mouth she wouldn’t have been so anxious or depressed. Like she was just so terrified of being through back into poverty...”

Mel’s mother speaks to her often of “those days and just not wanting her children to

have to go through that.” Mel recognizes that “it made my mom feel like she was failing us if she couldn’t give us what we wanted. But if she had postponed being a parent until she “made it” my brother and I wouldn’t be here.” Mel raises an important issue that emerges for women as they contemplate their preparedness to parent. Does being poor mean you should not have a child? Researchers’ (Monea & Thomas, 2011) response to this question is that anyone who completes the “success sequence” should be able to take on the obligations of parenting. However, as prior findings reveal, these check box approaches only really work for people with enough resources to achieve them.

The dominant construction of family planning, where financial stability is a central tenet, creates a dilemma for Mel and her husband as they debate whether to become pregnant. Mel feels like she is “walking a tightrope” as she and her husband debate whether and when to have a child. This active and intentional planning process reflects the potential conflict women encounter as they weigh their financial resources against their desire to mother. Mel says:

And so [my mother’s] experience really influenced me. That was a huge thing where it was like, “Okay, we’ve got to have enough money.” But now I’m not so sure because I don’t want to live in a world where only people who are middle class have babies...that’s some eugenics classist stuff. And I have to face that for myself at a certain point when we had decided to have a baby and we didn’t have enough money. And I was in my early 30s or late 20s when we’re like, “Yeah, I think we want to do this,” but we’re like, “We don’t have to do this now. We don’t feel we’re ready.” And money was one of the things, but I remember at a certain point just working through it and being, “Listen, I think 34, even if we don’t have the money, if we want to still do this, let’s just do it.” Because again, I don’t want to live in

that world and I don't want to limit myself in that way just because—yes, it's going to be harder, but maybe we can try...But I also need to be a healthy age to have a child. So what do you do? Which matters more? Being your healthiest or your wealthiest?

Mel reveals a central justification for questioning the paradigm of family planning and challenging if its promises are sound. Feminist scholars have long noted the dual potential of family planning guidelines, policies, and related initiatives (Luna & Luker, 2013; Solinger, 2005). These programs are tools to support women's efforts to control their own fertility, reduce the risk of maternal mortality, and improve other important outcomes (Lupton, 2012). However, policymakers have historically treated women's reproductive bodies as vehicles to address larger social problems, like population growth and poverty (see, e.g., Higgins, 2014). Thus, family planning guidelines have multiple objectives—support individual women and families but ensure social and political objectives as well. When women require social support to care for their families, women's desires to mother are put into direct conflict with the secondary goals of family planning—to reduce costs and control population growth (Markell, 2016; Sawhill, 2014; Secura et al., 2010; Thomas & Monea, 2011).

In this way, family planning guidelines reflect social norms and political objectives about when and in what context women's pregnancies are socially sanctioned. As a result, family planning reinforces stratified reproduction by providing and justifying the parameters in which some pregnancies and by extension, some families (from marginalized groups), are systematically devalued while

simultaneously (over)valuing the dominant groups' reproduction (Barcelos & Gubrium, 2014; Colen, 1986; McCormack, 2005).

Often women who fail to plan are portrayed as ignorant or not valuing the fundamental “values” implicit in family planning (Furstenberg, 2008b; Sawhill, 2014). These stereotypes help foster public attitudes toward mothers as “good” or “bad.” This is not to say all women prioritize family planning or are even fully aware of its guidelines (Geronimus, 2003; Moseson et al., 2019). However, all of the participants in this study value providing for their children and being good mothers. If and when they “defy” family planning guidelines it is often because following them forces an impossible choice—achieve all levels of stability required by family planning or forgo mothering altogether. Indeed, in many cases, women juggle two, often opposing, social norms--the mandate to mother and the mandate to mother well (Thurer, 1994; Russo, 1976).

Latoya grapples with this very conflict, and as described in Chapter 5, her uncle must persuade her to pursue motherhood. He does so by adapting the family planning paradigm to fit Latoya's current circumstances. As she recounts, “[M]y uncle was telling us, “You can't—you're never going to be financially stable if that's what you're waiting for. You're always going to want more money...and want more stability...You have a baby and just work toward it.”” For Latoya's uncle and ultimately Latoya, readiness is not easily achieved and the resources one needs to be ready (financial, housing, relationship stability) are not equally distributed. Rather,

women's outcomes are often products of inequality, rather than flaws in individual decision-making, which I explore in more depth below.

“I can't afford the family I want”: Family planning as an arbiter of inequality

As alluded to above, when focusing on family planning metrics like age, relationship stability, housing, and other timing and spacing considerations, it is easy to take for granted the broad and ubiquitous range of resources needed to achieve one's desired family. This need for resources goes largely unnoticed, allowing well-resourced people to see themselves as self-sufficient, and to be unaware of the energy and strategies required of others to secure family well-being in the absence of the same range of resources (Geronimus, 2003; Link & Phelan, 1995). Consequently, stereotypes and judgements about those who fail to meet family planning guidelines readily persist, and policies continue to target individual behavior change.

It is helpful, then, to view the women's struggles, not from a standard health behavior model that remains focused on individual decisions, but rather from a social determinants of health (SDH) perspective. Doing so shifts analysis away from individually focused, lifestyle theories about women's family planning behavior that attempt to identify issues like contraceptive decision-making and personal contraceptive knowledge, to that which captures the economic, political, and/ or structural facilitators or barriers impacting women's family planning outcomes. A dominant assumption of the SDH framework is that health inequalities across groups of individuals are due to the impact of these structural factors. Because this is not an

exhaustive study of all factors, I use Link and Phelan's (1995) theory of fundamental causes broadly to contextualize why inequalities exist across women despite their family planning status. Indeed, the women consistently describe the role finances play in their stability and family planning considerations. According to Link & Phelan (1995), this focus makes sense because SES embodies a range of resources like money, knowledge, power, prestige, and helpful social connections that protect health over time regardless of intervening mechanisms like family planning programs that offer contraceptive education and access (Link & Phelan, 1995). In this section, then, I explore the range of resources (or lack thereof) that either support or impede women's family planning efforts.

Maren's description of her family planning ideals relative to what she feels she can achieve captures nearly a dozen ways resources impede upon her family planning goals. Her narrative is reflective of many women. Maren is energetic. She shows me her to-do list for the day and the calculations she has made in preparation for our interview about whether she can afford a second child. Her newborn is sleeping in the car seat next to us as we conclude her interview by talking about her reproductive life goals and desires for family. She explains that she "would be *so* happy if I had another child because it's like that experience is so beautiful and I would be so happy." But she also knows that "it would be a struggle. A hard struggle to have a second child even though I'm desperate to have a sibling for my son." The problem is, she "doesn't have the money for a down payment on my own place and my credit score is still bad

from identity theft so renting is hard...and them projects [subsidized housing] in the city is scary...I grew up there.” As a result, she describes:

I moved back in with my mom and stepdad and if my stepdad found out I was pregnant he'd be just kick me out. He doesn't believe in babies before marriage, and he forgave the first one on account I was still with his father at the time, but he won't forgive the second one. And space is tight in the house.

Maren goes on to discuss why she is “stuck” in a low-paying job for the moment. It is in her desired field, social work, but it is an entry-level position paying just over minimum wage with a mandatory 90-day probationary period for both health insurance and paid time off accrual. Ironically, Maren became pregnant because her employer has a religious exemption that does not require that they pay for contraception, and Maren's preferred method, the Nuvaring, is cost prohibitive without insurance. “So for now, if my son gets sick, I just gotta take my time unpaid and pay out of pocket for the doctor,” which further exacerbates her already strained financial circumstances. She explains that she is in the process of taking classes to finish her bachelor's degree so she can be qualified for a higher-level position at her current place of employment but there are barriers. She elaborates saying:

The paperwork is almost impossible. Not to mention, who has time for all that? They keep saying, “Oh, you've got to prove that that's your baby and that you're taking care of him.” And I'm like, “Well, I just had him, he's six weeks old, and the semester is starting. I need you to help me out.” But they're like, “Oh, we're not giving any financial aid for late registrants.” So it's like, “What am I supposed to do? Because I'm out on “maternity leave” from school and my job doesn't pay for maternity leave because it's part-time. So it's like now I'm not working, and then it's like, “Okay, I've got to get him in daycare while

I go back to school or go back to work.” The daycare’s like, “You have to work to get childcare assistance.” So now I’m in a bind where he might not even have daycare because I’m not back to work yet and it’s like I can’t go to school in my time to better myself and get another career. So even though I really want another child and want a sibling for my son, if I had another child, it would kind of be hard where I kind of feel like I may be stuck on Section 8 [subsidized housing] or even if I could get Section 8, or welfare, I would be fucked until maybe my kids can get grown, and then that’s when it’s, “Oh, I’m going back to college.” But I feel like I would be stuck here in the inner city in like poverty with two kids. No one wants that. I don’t want that. I don’t want that for my kids. No one dreams of this life. But I would be definitely homeless for the beginning of the pregnancy because my family would kick me out and maybe an organization out here might help me get into like transitional housing or someplace. That would be a struggle, but I think in the struggle, I would love my babies, but I would feel very sad that—I feel like my kids, it’s any kid, any family, if we all could have the world or a piece of the world, a home, and the nice environment and not in the city with crime and living in poverty and on welfare, that’s not really something I would want for my child. I would want them to like live nice, but I couldn’t give that, so it would be hard and it would be a struggle to see my kids even though I would be happy that they’re here. So the fact of the matter is, I can’t afford the family I want. It makes me sad that I can’t choose my own dream.

One of the most prevalent assumptions the women in our study make is that poor women are lazy, choose welfare, and have many children to make staying home more comfortable. Participants and much of America feels this way (Pew Research Center, 2015) even though Maren’s story of hard work undone by barriers is much more common (Kavanaugh, 2008; Lindo, 2020). Believing stereotypes, however, fits the American Dream narrative and makes federal welfare budget cuts and “return to work” programs acceptable to voters (Cherlin, 2003; Cherlin & Seltzer, 2014; Furstenberg, 2008a).

It is difficult to quantify the numerous barriers Maren faces to achieve her desired family of two children, a college degree, a husband, and a home of her own—ultimately the image of stability and family so prevalent in Chapter 4. Perhaps most notable, is the way in which the very mechanisms designed to lift people out of poverty create more barriers to Maren’s upward mobility. Education, for instance, under federal programs that provide financial aid to low-income people, is an excellent resource, but bureaucratic obstacles like those Maren describes make accessing these valuable programs challenging. Meanwhile, many family policies like childcare, parental leave, and subsidized housing not only fail to meet Maren’s needs, but they may also conflict with some of her family goals like a safe environment and quality time with her son during these key developmental stages.

In addition to poverty alleviation, family planning promises increased stability and better maternal outcomes by supporting educational attainment. However, a combination of school policies, limited family policies, and social stigma around teen pregnancies affect educational attainment, rather than one’s failure to adequately plan a family. Candace reflects on a memory she has from middle school, saying:

I think the first time I heard teachers talking about [teen pregnancy], I was like 12. And there was a girl who was leaving school because she was like 13 and pregnant and her parents wouldn’t let her go to school and the school said she couldn’t bring the baby into the classroom—too disruptive maybe? I don’t know. So that’s when like they started talking about it at school and all the kids were talking bad about her. I don’t know if she even graduated just like most pregnant girls in my school.

Indeed, this young person's teen pregnancy certainly creates challenges for her to complete high school. However, emphasizing her individual choices that resulted in the pregnancy situates blame for all her poor outcomes, such as her potential dropout status on failing to plan. As Candace points out, the student's parents removed her from school, and the school had no plan in place to support students with childcare. Research indicates that lacking access to affordable childcare is a significant barrier for students from fulfilling educational requirements, regardless of age and regardless of family planning (Lino, 2020; Pew Research Center, 2015). Increasingly, childcare is a burdensome expense for many families, even well-resourced families and yet, the U.S. spends the least of any Organization for Economic Cooperation and Development (OECD) member country on alleviating some of this cost burden for families (Lino, 2020).

Jen has a similar story with a common narrative. She becomes pregnant as a teen, somewhat, but not entirely, unexpectedly. In lieu of an abortion, she and her family feel she can take the summer off and return to high school in the fall. She recounts:

I made mistakes. A big mistake. I was really too young to have a baby [at 14]...I had him in June, I went back to school again in September with everybody else. The pressures of school and the baby, they were too much. It was too much and But I just I wasn't getting help from his dad, so I ended up having to drop out of school. Try to get a job. It sucks...I was in 11th grade...I hate it...Every time I think about it, I'm like, "If I would have just went for that one more year, I could have made it to be a senior and then I could have did the co-op thing and been able to find it to where I had daycare for my son, to work in the morning, or however and been done with it and graduated." But I took

the easy way out and then stayed with him, I just didn't have daycare or help for my son...I think that's why I'm so stuck on my kids now. Like my kids know in my house, it's mandatory... all my kids have to go to college. It's not up for discussion. I took the easy way out but I'm not going to fail my kids.

For Jen, she feels she “took the easy way out” by staying home with her son and dropping out of school. However, as Katrina Kimport (2022) suggests in her study on mothering and reproductive decision-making around abortion, some choices are simply “unchoosable.” Indeed, Jen lacks a true choice due to her social conditions. Likewise, Frank Furstenberg (2008a; 2008b) writes about the largely false narrative of young promiscuous teens who are irresponsible or do not want to take responsibility for their actions. By understanding more than the statistical breakdown of Jen's life—a high school dropout, a single mother (at the time), poor, from an “urban neighborhood”—it becomes clear that the structural conditions in her life did not support an alternative outcome. Therefore, it is the social conditions and unsupportive policies that affect poor outcomes, not simply whether Jen enacts family planning.

In Chapter 5, Nery does not accept the “excuse” that poor outcomes are the result of lack of opportunity. Rather, part of the American mythology is that all citizens are granted the same set of opportunities, and part of living the proverbial dream is making the most of those opportunities through good choices (Johnson, 2015). In many ways, Violet has opportunity, but limited choices. She explains:

[W]hen I got pregnant, I was engaged. I should have graduated from college, and then bought my house, or went to grad school, and my child would come later...but because the negative impact of me having an unplanned pregnancy in college that didn't happen...I was about to

graduate college...was going to be financially secure, living my dream...going to graduate school for psychology. I had great grades...to now, "Okay, you're on welfare, you're working a part-time job, you're a drop out," and this all went from an unplanned pregnancy...I'm not saying I regret my child...but I had to pick up a second job, work even harder...And I do baby-sitting and watching other people's kids to make ends meet. This is not what I had in mind for myself or my child. My life would be so different but I couldn't take care of my child and finish school and work. I didn't have any help. My fiancé left me. My parents largely abandoned me. My professors wouldn't give me incompletes, they wanted me to take my finals while I was waiting to go into labor...and I was raised in a way that says you don't have an abortion...It all felt impossible, but here I am...that welfare mom...I don't know how I got here...[I]t just goes to show your only option is to plan...but then again, how do you plan for all this?

Public health discourse around family planning largely focuses on risk and risk mitigation by designing interventions that target "high risk" populations, such as marginalized groups, and then attempt to modify their behaviors (Lupton, 1993; Secura et al., 2010). However, little family planning research explores what Link and Phelan (1995) call the fundamental causes of disease which they define as the social conditions that put people at risk for poor outcomes in the first place, i.e., "risk of risks." While Violet does not come from a particularly upwardly mobile family, she is in college, doing well, engaged. Violet also benefits from family planning saying that she is a "zealous" birth control pill taker and is shocked she became pregnant. In this way family planning, or her concerted effort to time and space her pregnancy, failed. But so too did her social supports. While Violet has "opportunity" she does not have the same opportunity as everyone else regardless of Nery's assertion to the contrary. Because Violet has few financial resources, she struggles to overcome this lack of

support. For instance, neither her fiancé (who ultimately leaves her) nor her family members are willing or able to care for her child. Worse, she must take failing grades that semester because accommodation decisions are left to the professors and their willingness to grant extensions on her final exams. In addition to financial resources, Violet lacks the social connections and helpful relationships that Link and Phelan (1995) argue can be mobilized to overcome health-related barriers. In this case, Violet describes being unsure who to contact at the time to appeal her professors' decisions and who to ask for help. In this way, Violet lacks the range of resources needed to overcome the multiplicity of social conditions that make mothering such a challenging and ultimately, unequal process.

A consistent theme among the women who struggle most with mothering despite planning status are those who lack financial resources *as well as* social support. Neither Jen nor Violet receive financial or caregiving assistance from their partners which obligates that they both leave school. This lack of support is compounded by a lack of financial resources to pay for what would have otherwise been free support. As Candace recounts, the pregnant student in her school is required to leave not only because school policy did not permit her to bring her child to school, but because the parents demanded she leave. While Maren can temporarily move in with her mother and stepfather rather than become homeless when she and her partner separate, there are conditions on this living arrangement that make it tenuous. These circumstances make Maren's efforts to achieve financial freedom, despite planning her child, even more challenging.

Comparatively, although Hannah is speaking hypothetically in the following quote, she captures the power of social support as a resource for women who become pregnant. She describes:

I would probably be a little bit like disappointed...in myself for letting it happen...Like I wouldn't want to be a statistic of dropping out of high school or not going to college because I had a child. Like I have a supportive family with funds. Not a lot, but extra. And also I have three older brothers and they would help me, too. Like I have had this discussion with my family like, "If anything happened, would you guys be there or would you guys disown me?" They said they would always be there for me. They would think I was dumb but they would love me and my baby, take care of us financially and emotionally which would be a big help so I could stay in school and not have to work or pay for daycare because my mom doesn't work. She's always stayed at home.

Indeed, Hannah's circumstances are substantially different from those of Jen, Violet and the others. Where Maren worries she may be unhoused by a future pregnancy despite desiring to plan for it, Hannah's family states they will offer wraparound support even if her pregnancy is unplanned. In this way, Hannah's (hypothetically) unplanned pregnancy is likely to have a remarkably different conclusion. Such a juxtaposition in potential results demonstrates the power of resources like social supports to improve outcomes for women and their children rather than family planning itself. Such findings illuminate the limitations of family planning as currently conceived and the need to expand its definition to capture these social components.

Minnie is a significant source of social support to her daughter and grandchildren. She loves "my daughter and grandkids with all my heart and I do everything I can for them, even though it's not always enough." Minnie recently "had

an auto accident. So I haven't been employed and I'm not able to go back to work because of this COVID..." Minnie is a caretaker and her doctor will not sign off on her return to work because her breathing is still too impaired by the car accident to justify the risk of contracting COVID at her job. Minnie says:

It just keeps snowballing and I have [my daughter's] newborn at home, I have grandkids, and I can't do it. I just help my daughter out because she has a newborn and she's out of maternity leave time and she has to go back to work. I'm going to pick up the slack and I want her to go back to work...I just want her to just keep succeeding.

In other words, Minnie steps in to be the resource her daughter needs to remain employed, to manage the challenges of COVID and childcare, as well as to fill in the gaps left by her daughter's mere two-week paid maternity leave. Furthermore, because of COVID, Minnie's two grandchildren are required to stay home and learn online. One member of the family, then, must monitor the children while the other works. If Minnie could return to work, the COVID pandemic would still put them in dire economic circumstances because of the lost income from one able-bodied worker. Although she is happy to help, Minnie describes how challenging it can be. She shares,

been so stressed and I hit my lowest point recently because the unemployment insurance stopped paying my wages in October...[this interview was in January]. But I tell myself, "It is what it is and I can't afford no other stress. I'm too old for that." It takes a toll on my appetite and kids and it's not good for us...I'm still trying to hold on and still trying to be here for my grandbabies and (exhales) but it's going to get better. I just have to hope it will.

What is not obvious from this example is that Minnie's daughter meticulously planned her children. She "did all that measuring and temperature taking to make sure she could conceive. She saved her money and waited until she and her boyfriend was ready." Neither Minnie nor her daughter could anticipate that the children's father would leave or that the COVID pandemic would cut their work hours, or certainly that Minnie would be injured in a car accident. Yet, family planning neither kept this family together, nor did it protect it from near economic collapse. Examples like Minnie's, demonstrate the failures of public health measures around family planning that overemphasize point-in-time decision making about contraceptive use and pregnancy timing and thus, the need to expand our understanding of family planning. Indeed, placing government expenditures primarily in preventing pregnancies does not adequately buoy women and families, once the children are born—planned or not.

Megan, by contrast, is middle-class and has a more flexible work schedule than most. She describes that even for her, external factors like unexpected costs, the COVID pandemic, and other family dynamics obligate her to be "extra ready" for children. Yet, having met many of the conditions within the "success sequence," changing social conditions still make meeting the demands of parenting very challenging and resource-intensive for Megan and her spouse. She describes:

Planning a pregnancy is actually less about birth control and more about having childcare set up or even the birth itself can be a big deal. My middle child was a planned pregnancy. My first, who was not planned, was born 16 days after our healthcare policy renewed so I hit two high deductibles with one pregnancy. And it was \$6-7,000 out of pocket...So we had to do some fast math to figure out where that

money was going to come from and that was very stressful. We barely thought to celebrate our baby. So planning a pregnancy to me is preparing for all of that stuff...I don't think unplanned pregnancies are bad necessarily, but I think it's important to plan if you would want a certain daycare, they're all at capacity, especially now with COVID, they can only have so many kids per daycare and so everything is so limited...It's just luckily my husband works from home and he can have them here...And we haven't lost any income due to the pandemic or been furloughed. So yeah, we're very fortunate but not everyone is.

In this case, Megan and her husband enlist their range of resources to respond with agility to challenging conditions related to COVID. For Minnie, who is of low SES and thus with fewer resources, these challenges, despite her grandchildren being planned, create greater instability that affects her health as well as the well-being of her grandchildren.

Conclusions

As evidenced by the findings above, family planning is not a panacea for addressing the multitude of challenges women face as they endeavor to form and care for their families. While planning for a child is undoubtedly helpful, it does not guarantee the benefits promised by many policymakers and experts that promulgate family planning as a “silver bullet” poverty cure and way to greater family stability (Monea & Thomas, 2011; Sawhill, 2014; Thomas & Monea, 2011). Rather, family planning is a resource intensive process that obligates a level of financial means and stability, both of which are unevenly distributed across women. For example, to adequately plan, one must have access to healthcare, contraception, stable and affordable housing, the resources required for marriage, and the finances to procure

extra provisions for newborns that are costly. Recognizing these factors may help explain why about half of U.S. pregnancies are not planned—indeed, the U.S. is one of the most unequal countries in the developed world, therefore, it makes sense that so many individuals would struggle to employ the resources necessary to plan (Johnson, 2015).

The findings also demonstrate the ineffectual nature of “check box” exercises like success sequences and family planning guidelines that aim to educate women about the ideal circumstances in which to have a child. As with many public health efforts, the focus on individual risk factors like age, race/ ethnicity, education level, socioeconomic status and the like fails to capture the “risk of risks” or the social conditions and structural level factors that position women as more susceptible to poor outcomes in the first place (Link & Phelan, 1995). Therefore, shifting away from a standard health behavior model to those that capture social determinants of health like income and educational inequality can support research and policies that bridge economic gaps currently causing many of the poor outcomes women experience.

Simply put, as conceived, family planning efforts do not redistribute resources, and resources are needed to address the economic inequality that causes many of the poor outcomes family planning attempts to resolve. Rather, broad social safety net programs and family friendly policies can do so and have been found to address many of the social problems family planning has yet to remedy in its current narrow conceptualization (Cherlin & Seltzer, 2014). In fact, several recent studies measured the effects of the expanded child tax credit—a policy passed in 2021 that gave parents

several hundred dollars per month per child in their family. They found that it was a success and significantly reduced child poverty by making it easier for families to buy food and pay for housing and utilities. In combination with other COVID-19 relief measures, particularly the three stimulus payments that went out to most Americans, the child tax credit lifted children out of poverty during a time of significant economic upheaval that should have sent more children into poverty (Thomson-DeVeaux, 2022). However, such programs are expensive, not always politically popular, and therefore, may lack political will to implement. As economist Isabel Sawhill is quoted saying “It’s very expensive and very hard to reduce poverty. Reducing unplanned births with contraception is easy and cheap by comparison” (Sanger-Katz, 2018).

In sum, these women’s life experiences provide a palpable example of how social conditions and inequality act as the mechanisms that shape family planning outcomes. Failing to recognize and act upon social factors within our understanding of family planning such as the educational policies that keep women like Jen and Violet from pursuing their education, the limited family leave policies that forced Minnie’s granddaughter back to work, or the lack of access to safe and affordable housing that is preventing Maren from growing her family, create the outcomes that force women to choose the “unchoosable”—to mother well or not at all.

Chapter 7

CONCLUSION

This study set out to understand how women conceive of family planning and enact its tenets (or not) in their lives. Over the course of five years and dozens of interviews with women, it was evident that researchers and policymakers define and measure family planning in significantly different ways than women do. By focusing on timing and spacing pregnancies, family planning definitions such as those purported by the WHO, focus on pregnancy planning and neglect the social, embedded process of family formation. Indeed, family considerations were central to women's conceptualization of family planning whether through the family values they connected to different aspects of stability like the home and marriage or through how they made such considerations through the lens of what it meant to be a mother. Put simply, for the participants, family planning is a social endeavor rather than a medical one.

While much of the research about family planning focuses on why women plan or not, I explored whether and how family planning (as currently conceived) is relevant or beneficial to women. In doing so, I illustrated how women balance numerous "family factors" related to stability within their family planning considerations. More specifically, the women most frequently cited a desire to achieve a suitable age, have a stable home, income, and relationship prior to starting their families. While on the surface, these could be construed as pregnancy planning, the

women connected these considerations to much broader notions of forming families and the sociocultural values and norms embedded within them.

Understanding these more social and familial dimensions is critical because traditional family planning guidelines often competed with the family factors women most valued. For example, women like Latoya and Mel wanted to start a family but both worried that they were not yet financially stable and therefore, could not provide the lives they wanted for their children. Paradoxically, as Latoya and Mel worked to achieve this stability, their age became a concern. As each neared 35-years-old, the risk for complications like miscarriage and high blood pressure increased. Therefore, by waiting so long to meet one goal, financial stability, they risked not achieving another, a healthy pregnancy. As this example highlights, comparing women's *family* planning considerations against family planning guidelines demonstrates the complexity and sociocultural values inherent within such a process as well as the potential conflicts women must navigate.

Like stability, the women consistently discussed the centrality of motherhood, and in particular, the desire to mother well, in their family planning considerations. However, achieving family planning standards promulgated in public health research made women question whether they were in fact good mothers by virtue of whether they met social expectations around family formation prior to mothering. To make sense of these tensions, many women emphasized that their mothering capacities were not impacted by failing to be married, wealthy, or have a certain kind of home prior to childbearing. They also compared themselves to other mothers as a means of

validating their claims of good mothering, often describing themselves in a positive light while depicting other mothers more negatively.

Taken together, many of these findings directly contradict popular discourse that suggests some women do not find value in planning for their families (see, Sawhill, 2014). Rather, the guidelines against which women's "planning" was evaluated simply did not resonate or apply to most of them. Instead, the women simply prioritized different values; universally sought some modicum of stability prior to having their children—whether in terms of their age, their relationship, their housing, and/ or their ability to mother. As was expected, the specifics of what women considered to be "stable" varied based on their personal backgrounds and preferences. For example, Steph wanted to live in a small apartment with her children, dog, and husband while Devyn was impatiently counting down the days to upgrade her town home to a large single-family home that mimicked the one she had growing up.

Rather than not value planning for their families, the women's narratives revealed that achieving these goals obligated a set of resources that are not equally distributed across women—therefore, the level of stability achievable among women inevitably varied. Women with fewer means often struggled to ever feel or become stable. Yet their experiences revealed the ways structural inequality—particularly economic inequality—precluded them from being stable and how existing social safety nets did little to support their efforts or improve their outcomes. Moreover, through the experiences of wealthier, more economically stable women, we see that they achieved and maintained stability whether or not they planned their pregnancy,

simply because they were able to enlist their range of resources to overcome any challenges related to having not planned.

Indeed, numerous women who did plan their pregnancies, like Minnie's granddaughter and Nery, still encountered problems that no amount of planning could prevent. Minnie's granddaughter, when confronted with the added strain of the COVID pandemic, could not provide for her children when COVID relief was reduced. Meanwhile, Nery, who not only planned every detail of her pregnancy, but judged women who did not, still suffered with severe post-partum depression. Indeed, researchers suggest family planning may improve mental health outcomes, yet Nery struggled just the same (Mark & Cowan, 2021). Meanwhile, women like Megan who did not plan each pregnancy had sufficient resources to overcome the risks of not planning, like covering the unexpected insurance deductibles and having her husband help with childcare when the daycares closed early in the COVID pandemic.

Given these findings, it may be useful to explore family planning outcomes through a fundamental cause theory (FCT) lens in which women's "risk of risks," or structural level factors like SES, are understood in relation to their outcomes. As currently constructed, family planning risks are studied at the individual level from a health-promotion perspective where women's sociodemographic backgrounds like age, race/ ethnicity, social class, and even marital status are construed as risk factors rather than the social conditions in which some women are more likely than others to experience poor outcomes. In this way, using an FCT perspective may also improve policies. As of now, family planning policies favor pregnancy-prevention programs

such as contraceptive access initiatives like the one our research team set out to evaluate. Alternatively, I suggest it would be beneficial to evaluate social safety net programs for whether and how they may be strategically implemented to improve the many health and social problems linked to family planning by addressing their root, structural causes.

Toward a new paradigm of family planning

As I have hedged throughout this study, another way forward is to fundamentally shift the way family planning is defined and studied. In its current form, family planning is a public health paradigm and as illustrated through the women's experiences, simply falls short of its claims to be universally beneficial and applicable. Despite the apparent need to reconceive of this construct, I was initially hesitant to do more than critique family planning because as Irving Zola (1976) wisely points out, there are significant risks and limitations associated with simply nuancing or redefining medical conditions and their related terminology, particularly if the problematic assumptions fail to be challenged. Nevertheless, I do believe it is critical that new research based on well-founded epistemological considerations and more inclusive definitions be stimulated from these findings—particularly research that focuses on women's family planning experiences, needs, and desires. Therefore, I propose reconceptualizing **family planning** as an umbrella concept under which family formation considerations are conceived and prepared for.

I propose this broad “definition” for several reasons. The first of which is epistemological. By revising family planning to be an umbrella, family-oriented concept it allows space for research to consider the many family dimensions women highlighted above such as marriage, motherhood, divorce, “home,” and the like. Further, shifting research beyond pregnancy considerations can begin to undo harmful conclusions that perpetuate stereotypes about “at risk” groups of women whose pregnancies, and by extension, families should be monitored at best, and limited at worst. Indeed, capturing greater nuance in women’s decision-making and similarities across groups of women, as I began to do in this study, challenges assumptions that those who plan are in some way lesser than. Such assertions are borne out of the thousands of studies that focus on women like Kathy whose pregnancies were unplanned and circumstances were unstable while completely neglecting the stories of many women of high SES like Stephanie, Devyn, or Megan, who also failed to plan. Studying almost exclusively marginalized communities creates a sort of confirmation bias in which differences between women are created and those who fail to meet family planning standards are devalued.

The second rationale for this shift is theoretical. Conceptualizing family planning as a family formation process extends how family planning is currently theorized about. In its new form, the definition obligates that researchers incorporate the multitude of processes and considerations that go into family formation (e.g., marriage, fertility, cohabitation, family values, norms) rather than simply pregnancy and fertility. Indeed, as I layout in greater detail in Chapter 2, family scholars are

ahead of the family planning discipline in terms of their recognition of diverse family forms and innovating ways to capture not only these family forms but the sociocultural values implicit within their construction. I am also particularly enthusiastic about family formation research that highlights the interactional perspective of “doing family” because, as I have elucidated, family planning is not an individual, medical endeavor, but a social one. Indeed, this approach can offer rich detail and context that both identifies diverse family planning considerations as well as their value.

Third, family planning, currently conceived, is located almost exclusively in the medical domain and therefore, policy approaches are health-promotion based. However, as I show in Chapter 6, structural level factors greatly affect women’s outcomes. I see the potential for family policies, under this new conceptualization, to better target and improve upon existing social problems. Indeed, *family* policies are at the heart of improving outcomes related to *family* planning within this new framing. For example, Jen could not finish high school because of childcare costs and education policies that barred her from bringing her child to school. Violet had to leave college her senior year because there was no institutionalized family leave policy. Therefore, measures like family leave, universal pre-Kindergarten, reductions in childcare costs, and expanding Medicaid coverage could have had dramatic effects on women like Violet and Jen or Minnie and her daughter.

A fourth justification for reconceiving of family planning is experiential. The current conceptualization of family planning as a medical paradigm neglects the needs and desires of women, instead centering family planning guidelines. Consequently,

almost no research has examined women's experiences as they attempt to *apply* family planning guidelines in their lives. As I observed, women's attempts to achieve idealized families and motherhood are ripe with challenges and conflict. The current construction of family planning, whereby there are clear "right and wrong" decisions, can harm women by, for example, stigmatizing them on par with ways "welfare queens" have been stigmatized—as deficient and a social liability (James & Rashid, 2013).

Taken together, I hope that this initial attempt to redefine family planning offers a new view through which to challenge its assumptions and stimulate new research in its regard. Ideally, this new research, broadened policy foci, and new theoretical perspectives can start to address the many inequalities inherent within family planning such as the overemphasis on women in general relative to men, and marginalized women in particular, as well as the establishment of deviant pregnancy categories which can devalue and delegitimize some children and families. Indeed, these deviant pregnancy categories and their purported consequences support the passage of policies that further stratify reproduction rather than address the much needed structural and institutional factors that have actually led to family decline, e.g., welfare caps based on family size or tax incentives that benefit married couples. In many ways, family planning has scapegoated women and families, assigning disproportionate blame to marginalized women and impoverished families. Indeed, family planning, as currently defined, undermines rather than assists women and children to achieve their ideal family, and by extension, their American Dream.

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Appendix A

PARTICIPANT CHARACTERISTICS, 2016, 2018, 2020

Overview of participant characteristics	2016	2018	2020
No. of women	86	59	49
Age range	16-44	18-46	21-49
Ave age	29	30	31
Ave Interview Length (mins)	66	73	95
Race/ ethnicity (%)			
White	49	44	43
Black/ African American	31	32	33
Hispanic	12	12	12
Asian	5	7	6
Multiracial	3	5	6
Socioeconomic status (SES) (%)			
High	49	53	51
Low	51	47	49
Recruitment (%)			
General population	52	56	56
Health clinics	48	44	44

Appendix B

STUDY IRB APPROVAL



Institutional Review Board
210H Hulihan Hall
Newark, DE 19716
Phone: 302-831-2137
Fax: 302-831-2828

DATE: June 9, 2020
TO: Ann Bell, PhD
FROM: University of Delaware IRB
STUDY TITLE: [906913-15] Attitudes, Beliefs, & Behaviors of Contraception
SUBMISSION TYPE: Continuing Review/Progress Report
ACTION: APPROVED
APPROVAL DATE: June 9, 2020
EXPIRATION DATE: June 14, 2021
REVIEW TYPE: Expedited Review
REVIEW CATEGORY: Expedited review category # (9)

Thank you for your Continuing Review/Progress Report submission to the University of Delaware Institutional Review Board (UD IRB). The UD IRB has reviewed and APPROVED the proposed research and submitted documents via Expedited Review in compliance with the pertinent federal regulations.

In-person research interaction with subjects cannot begin until the UD moratorium in response to the declaration of national emergency related to the COVID-19 pandemic is lifted. Please continue to reference <https://research.udel.edu/coronavirus> for the most up-to-date recommendations.

As the Principal Investigator for this study, you are responsible for and agree that:

- All research must be conducted in accordance with the protocol and all other study forms as approved in this submission. Any revisions to the approved study procedures or documents must be reviewed and approved by the IRB prior to their implementation. Please use the UD amendment form to request the review of any changes to approved study procedures or documents.
- Informed consent is a process that must allow prospective participants sufficient opportunity to discuss and consider whether to participate. IRB-approved and stamped consent documents must be used when enrolling participants and a written copy shall be given to the person signing the informed consent form.
- Unanticipated problems, serious adverse events involving risk to participants, and all non-compliance issues must be reported to this office in a timely fashion according with the UD requirements for reportable events. All sponsor reporting requirements must also be followed.

Oversight of this study by the UD IRB REQUIRES the submission of a CONTINUING REVIEW seeking the renewal of this IRB approval, which will expire on June 14, 2021. A continuing review/progress report form and up-to-date copies of the protocol form and all other approved study materials must be submitted to the UD IRB at least 45 days prior to the expiration date to allow for the required IRB review of that report.

If you have any questions, please contact the UD IRB Office at (302) 831-2137 or via email at hsrb-research@udel.edu. Please include the study title and reference number in all correspondence with this office.