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Defining Family Planning in a São Paulo Clinic: Healthcare Providers and Patients' Varied Conceptualizations of "Planned" and "Unplanned" Pregnancies

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Abstract

Defining Family Planning in a São Paulo Clinic: Healthcare Providers and Patients' Varied Conceptualizations of "Planned" and "Unplanned" Pregnancies
By Daniella Gonzalez

This honors thesis explores the varying conceptualizations healthcare providers and pregnant patients have about family planning. The thesis is a case study of the Bom Retiro UBS, a public primary healthcare clinic in the Bom Retiro neighborhood in São Paulo, Brazil. This thesis intends to demonstrate that the municipal government's categorization of pregnancies as either planned or unplanned does not reflect the complexities of a woman's pregnancy experience. This thesis also highlights the negative perceptions of providers and patients against unplanned pregnancies. These perceptions make the reporting of pregnancies as planned or unplanned problematic without a shared definition of both terms in the neighborhood. Lastly, this thesis provides proposed solutions to challenge the current family planning discourse in the clinic and community.

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Introduction

Valeria's Story as a Young, Immigrant Women with an Unplanned Pregnancy

My day started like most others had as a researcher in the Bom Retiro neighborhood of São Paulo, Brazil. I began my morning in the UBS clinic by greeting the health professionals and staff around the building. I previously made plans with Lucas, a nurse in the clinic, to join his medical appointments with young children, also known as *puericultura*. As I waited for Lucas, a young woman walked into the clinic with a young baby that looked to be no older than four months old. The woman had physical features common within the Bolivian and Paraguayan communities, including a short stature and sleek, dark brown hair. The young woman set next to me in the waiting hallway, and after I struck-up a conversation she introduced herself as Valeria, a 15-year-old woman originally from Paraguay and then introduced her baby, named Isabella.

Shortly after, Lucas called me and Valeria into the consult room to join him. Valeria was confused when hearing both of our names called, but she agreed to have me in the room once Lucas explained my research. Nurse Lucas weighed Valeria's daughter, checked her heartrate, height, and temperature while asking Valeria about her future in school and Brazil. Valeria shared her hopes of one day returning to Paraguay with greater economic security for her daughter, but did not think it would be possible to return to school given the demands of motherhood. I then asked Valeria if she would be willing to share more about her experiences with family planning. Valeria spoke about her unplanned pregnancy, and described the news as scary and difficult to accept at first. Valeria's family had left Paraguay a few years prior to work in the textile-industry in hopes of greater economic opportunity. However, her plans came to a halt after learning she was expecting a child with a young 15-year-old Paraguayan she referred to as her boyfriend.

Once Valeria left the room, Lucas began sharing his own memories of Valeria's pregnancy. Lucas explained to me that Valeria's physician used to be an older Brazilian man that left the clinic months before my arrival. When Valeria was fourteen, she came to the clinic to ask for contraception. However, her physician did not believe such a young girl should be having sex or taking birth control, and thus did not prescribe any contraception. A few months later, Valeria returned to the clinic and took a test that confirmed she was pregnant. Lucas remembered seeing Valeria break down in tears due to the news. He described her as distraught and inconsolable throughout the remainder of her time in the UBS. This story made me want to learn more about these experiences from Valeria. This is when I turned to her community agent, a health professional that visits her home and informs her physician of any alarming symptoms or conditions. The following day, the community agent walked me to Valeria's home and introduced me to Valeria's family members. Valeria recognized me from the clinic and gave me a brief hug. We walked over to the kitchen for more privacy and I explained my interest in her story and why I decide to see her in her home. As a young, Hispanic woman, I felt a strong desire to get to know Valeria and use her experience to help demonstrate the importance of the patient and provider relationship within family planning services.

Valeria denied she had ever not been given contraception from her provider. Rather, Valeria explained to me that her mother had obtained birth control pills for her, and her pregnancy resulted from forgetting to take the Pill every day. Valeria agreed to share more of her story with me, but she denied she had ever been negated her contraception. Rather, Valeria explained her mother had obtained birth control pills for her, and her pregnancy resulted from forgetting to take the Pill every day. The disparities in Valeria's and Lucas' stories confused me, but I assumed either 1) Lucas confused Valeria's story with another young woman, 2) Valeria

did not want to retell the details of a sensitive time in her life, 3) Valeria felt a cultural and familial pressure to assume responsibility for the pregnancy and changed her narrative, or 4) Valeria felt comfortable enough to share her misuse of contraception with another young Hispanic woman rather than with her male, Brazilian healthcare providers.

Regardless of the narratives' inconsistencies, these experiences with family planning exemplify why my thesis matters. In Lucas' narrative, Valeria was a young, immigrant woman that came into the clinic for greater control over her body, only to be rejected by an older, Brazilian male physician. The physician's judgment, based on his ideas on appropriate family planning affected the level of care made available to Valeria. This is an example of providers and patients having different conceptualizations of family planning. This dissonance resulted in inadequate care and changed Valeria's life forever. Valeria's narrative highlights the large impact family planning education and one's relationship with their healthcare provider can have in a woman's life. In Brazil, a country where abortion is illegal, Valeria had no choice but to have a child. After interactions with women such as Valeria, I knew understanding how women and their healthcare professionals thought about family planning was an important matter that I wanted to research.

Methodology

After my first few days joining physicians and nurses during their medical appointments, I noticed the pregnant women's medical files had the words *planejado* (planned) or *não planejado* (not planned) on a top corner of the page. Dr. Alessandro, a physician of the clinic, explained to me that all health professionals consulting pregnant women had to report whether the pregnancies were planned or unplanned in a daily activity log. The municipal government used the data in the activity logs to assess how many pregnancies were unplanned and to better

understanding the shortcomings of current family planning services. However, I questioned whether everyone even shared the same definitions for planned or unplanned, and what it meant to plan a pregnancy. With such a diverse neighborhood, I hypothesized that providers and patients conceptualized family planning in different ways. I not only identify in my thesis how ideas on family planning differ, but how these conceptualizations interacted in the clinic.

My research was a two-part project incorporating an analysis of data that the clinic's administrator provided to me and oral histories patients shared with me in the clinic. I gathered demographic information from the prenatal medical files, including nationality, age, marital status, monthly income, and completed educational level of the registered pregnant patients. Other points of information I recorded included whether the women reported their pregnancies as planned or unplanned, and whether the women were using contraception at the time of their pregnancy. I organized all the data in a password-protected Excel spreadsheet and conducted statistical tests of significance to test whether women with unplanned and planned pregnancies differed in any one of the points mentioned.

Additionally, physicians and nurses of the clinic allowed me to join them during their medical appointments with pregnant women and young children accompanied by their mothers. Community health agents also took me to their patients' home visits to see recently born babies and new mothers. Both the medical appointments and home visits served as opportunities to talk to women about their pregnancies and family planning. I then conversed with physicians, nurses, and community agents about family planning during their free time. In these cases, my questions focused more on any differences the professionals perceived between women with planned pregnancies and women with unplanned pregnancies. Ultimately, I used the data collected from

the medical files and the interview responses to research in a multidisciplinary manner how healthcare professionals and patients defined family planning.

My research approach led me to significant findings, including the fact that women with unplanned pregnancies were not more likely to engage in less adequate medical care during their pregnancies than women with planned pregnancies. Through my interviews, I identified negative associations against unplanned pregnancies and immigrant women, including the notion of more medical appointment absences. When I tested these statements with my demographic data, I found them to not be true of the women during my five weeks in Bom Retiro. Thus, the discourse of the providers and patients maintain stereotypes about unplanned pregnancies that are not representative of the reality in the clinic. This can be attributed to the current discourse that does not consider each woman's unique experience with family planning and the different ways in which the women define planning a pregnancy. Additionally, family planning programs and providers do not, at present, challenge the stereotypes or attempt to engage in conversations with patients about their own ideas about family planning.

A Summary of the Chapters

The first chapter of my thesis contextualizes family planning, as defined by the United Nations, and its significance in increasing economic opportunities for women and reducing maternal mortality. I provide information on contraception options for men and women available in Brazil to prevent a pregnancy, the illegality of abortion and its social implications, and the United Nations' guidelines on maintaining a healthy pregnancy. I also elaborate on the history of women's health policies in Brazil, beginning in 1930 with the pro-natalist policies of Getúlio Dornelles Vargas to the current-day Brazilian healthcare system, SUS, and its services for women. I conclude my first chapter with my first impressions of the Bom Retiro neighborhood

and its primary healthcare clinic, the location in which I conducted most of my research. I detail a typical day in the health clinic and the medical teams that work together to serve the clinic. My first chapter aims to demonstrate evidence for the positive impact of effective family planning services, and describe the national health system (SUS) and primary clinic (UBS) that would benefit from addressing the contemporary issues identified in my second chapter.

In the second chapter of my thesis I elaborate on the conceptualizations of family planning I noted in the clinic, and the problematic nature of providers and patients utilizing words such as planned and unplanned without sharing the same definitions. I begin my chapter with an explanation of the role of the physicians, nurses, and community agents (termed collectively as healthcare providers) and their definitions of family planning. I then discuss the differences providers perceived between women with planned and unplanned pregnancies in my interviews. In the following section, I provide my data and analyses of the demographic and prenatal information I collected on all registered pregnant patients of the clinic to demonstrate women with planned and unplanned pregnancies are more similar than they are different. I conclude my chapter focusing on frequent interview responses I collected from women during their medical appointments. I elaborate on the implications of having a quarter of the women tell me they did not know what family planning was, the power dynamics in relationships between men and women in family planning, and issues with interchanging the words "planning", "loving", and "desiring." Thus, my second chapter details the results of my multidisciplinary research and highlight the disparities between the discourse I noted in the clinic and the reality depicted in my observations and the statistical data I collected.

Ultimately, I demonstrate that providers and patients conceptualize family planning differently, and propose solutions to close the gap between the medicalized definition of family

planning of the United Nations with the real lives of the people living through family planning. Without recognizing the differences in the ways people think about family planning, healthcare professionals and legislators creating services will fail to bridge the gap in discourse between provider, patient, and the community at large. The negative associations against unplanned pregnancies and immigrant women in the current discourse are in part maintained by this gap because it does not allow for conversations that challenge these notions. Additionally, the State-established dichotomy of pregnancies encourages a simplified and unrepresentative categorization and fails to offer indicative information that would improve future family planning services. I lastly explore the fundamental role providers can play in challenging current notions on family planning and encourage an exchange of ideas between professional and patient to optimize Brazilian family planning services.

Chapter 1: The Significance of Family Planning and Brazilian Legislation on Family Planning Services in Public Policy

This chapter defines family planning per the United Nation's guidelines and details the role of family planning services in Brazilian federal legislation on women's health. This chapter has five sections, in which the first, titled "What is Family Planning and What is its Significance?," defines family planning and elaborates on the economic and health benefits of family planning intervention programs. The second section, "The Maintenance of Healthy Pregnancies and Access to Contraception for Pregnancy Prevention," provides information on the female reproductive system, contraception methods and their effectiveness levels, and the illegibility of abortion in Brazil. The third section, "Brazilian Federal Legislation on Women's Health," focuses on women's health legislation in 20th and 21st-century Brazil. I begin the section with the Vargas dictatorship and legislation that only considered women in healthcare when bearing children. I then move on to discuss international family planning intervention programs in Brazil and ultimately the creation of the current national health system, SUS. The fourth section, "A Breakdown of The National Health System (SUS) and its Funding," explains current funding of the SUS program and its three levels of care, of which my research is conducted in the primary level. In my final section, "My First Impressions of the UBS and Bom Retiro Neighborhood." I provide my first impressions of the clinic, explain the daily workings of the UBS and its health professionals, and introduce some of the negative attitudes I found prevalent in the UBS. Overall, this chapter serves to describe the health system and neighborhood in which I conducted my five weeks of research on family planning services.

What is Family Planning and What is its Significance?

Family planning. According to the World Health Organization, an estimated 87 million unplanned pregnancies occur annually (The World Health Report, 2005). Public health

researchers have correlated unplanned pregnancies with economic hardship, maternal death, and unhealthy infants. These correlations stress the significance of family planning. To begin my discussion on the positive outcomes associated with family planning, I am going to utilize the definition provided by the United Nations. Per the United Nations Population Fund, family planning is comprised of “the information, means and methods that allow individuals to decide if and when to have children” (“Family planning,” n.d.).

Contraception, defined by the Centers for Disease Control and Prevention as the behaviors and medicines utilized by men and women to avoid a pregnancy by preventing fertilization, plays a key role in family planning (Centers for Disease Control and Prevention, 2018). Forms of contraception include, but are not limited to, hormone pills, implants, condoms, and surgical sterilizations (“Family planning/ Contraception,” 2018). The World Health Organization on its webpage titled “Family planning/ Contraception,” directly links contraception with successful family planning. According to the WHO, family planning “allows people to attain their desired number of children and determine the spacing of pregnancies” (“Family planning/ Contraception,” 2018).

Successful family planning can have positive impacts across educational, economic, and health domains. In fact, the United Nations establishes family planning as one of their goals of their 2015 Sustainable Development Goals (SDGs), a document outlining 17 goals meant to reduce poverty and inequality. Goal 5 promotes family planning as a channel to improve gender equality and women’s empowerment (Sustainable Development Goals, 2015). The provision of safe, effective, and affordable contraception ensures women’s rights to timely and evidence-based care. The dissemination of information and distribution of birth control methods demonstrate a government’s respect for women’s choice of family size. Research in the field has

provided strong evidence in favor of the emphasis international organizations such as the World Health Organization and the United Nations have placed on family planning. In Brazil's case, officials collect information on planned and unplanned pregnancies due to the positive outcomes that are analyzed below. However, simply asking a woman a dichotomous question on family planning will not provide insight on pressing issues such as maternal mortality or economic development because each woman defines family planning differently.[1]

Poverty reduction through family planning. Access to family planning resources can reduce poverty worldwide by improving economic outcomes for women (Ewerling, 2018). Davidson Gwatkin, a former advisor on health and poverty to the World Bank, studied the link between poverty and childbearing. His work focused on women's fertility rates, the average number of children had by each mother, in 56 developing countries. From these 56 countries, on average, the poorest fifth of women had nearly twice as many children with a fertility rate of 6, in comparison to women in the wealthiest fifth with a rate of 3.2 (Gwatkin et al., 2007). The chart below (Figure 1) shows the fertility rates of women in Latin American countries per their socioeconomic status. Brazil's poorest fifth of women had a fertility rate of 4.8 while the most prosperous fifth had a rate of 1.7 (Gwatkin et al., 2007). Some of the studied countries have implemented intervention programs that increase access to family planning resources. In such cases, the difference in fertility rates between the poorest and wealthiest fifth have decreased (Gwatkin et al., 2007). John Cleland, a professor of medical demography at the London School of Hygiene and Tropical Medicine, argues these findings demonstrate that the larger average family size among poor couples is in part due to the couples' unmet need of contraception. As

[1] I will elaborate on the conceptualizations of family planning of the women in the Bom Retiro neighborhood in the following chapter.

the size of the family increases, poor households are less likely to recover from poverty (Cleland, 2006). If poor households have access to contraception and information, the large difference in fertility rates between the poorest fifth and wealthiest fifth households is decreased, and families have a greater chance to prosper economically.

C. LATIN AMERICA, CARIBBEAN	5.9	4.5	3.5	2.9	2.1	3.6	2.788	3.809	-0.19886	0.01446
Bolivia 1998	7.4	5.8	4.4	3.0	2.1	4.2	3.524	5.300	-0.24288	0.00057
Bolivia 2003	6.7	5.0	4.0	2.9	2.0	3.8	3.448	4.779	-0.23305	0.04890
Brazil 1996	4.8	2.7	2.1	1.9	1.7	2.5	2.824	3.100	-0.20237	0.00075
Colombia 1995	5.2	3.7	2.8	2.3	1.7	3.0	3.059	3.500	-0.20999	0.00062
Colombia 2000	4.4	3.3	2.4	1.9	1.8	2.6	2.444	2.600	-0.18440	0.00048
Colombia 2005	4.1	2.8	2.4	1.8	1.4	2.4	2.919	2.672	-0.20043	0.04581
Dominican Republic 1996	5.1	3.6	3.3	2.5	2.1	3.2	2.429	3.000	-0.17064	0.00061
Dominican Republic 2002	4.5	3.5	2.9	2.4	2.1	3.0	2.092	2.327	-0.14274	0.03175
Guatemala 1995	8.0	6.9	5.6	3.9	2.4	5.1	3.333	5.600	-0.22487	0.00066
Guatemala 1998/99	7.6	6.8	5.1	4.1	2.9	5.0	2.621	4.700	-0.19280	0.00068
Haiti 1994/95	7.0	6.2	5.5	4.0	2.3	4.8	3.043	4.700	-0.21016	0.00432
Haiti 2000	6.8	6.0	5.0	4.4	2.7	4.7	2.519	4.100	-0.17012	0.00060
Nicaragua 1997/98	6.6	4.6	3.5	2.7	1.9	3.6	3.474	4.700	-0.23476	0.00055
Nicaragua 2001	5.6	3.9	3.1	2.4	2.1	3.2	2.667	3.500	-0.19719	0.00054
Paraguay 1990	7.9	6.3	4.3	3.9	2.7	4.7	2.926	5.200	-0.21024	0.00071
Peru 1996	6.6	4.6	3.4	2.6	1.7	3.5	3.882	4.900	-0.25255	0.00040
Peru 2000	5.5	3.7	2.6	2.0	1.6	2.8	3.438	3.900	-0.24080	0.00039

Figure 1. Fertility Rates of Women in Latin American Countries. The fertility rates of the women are divided into five different socioeconomic groups with the lowest socioeconomic group on the far left. The following numbers to the right are for women in increasing quintiles of socioeconomic status, followed by the average of all women.

Additionally, rapid population growth often exacerbates unemployment and lack of food security. These issues can be relieved by the increased prevention of unintended pregnancies (Ewerling, 2018). Robert Eastwood and Michael Lipton conducted a study on 45 countries using cross-sectional analyses of household surveys and found that if the crude birth rate had fallen by 5 per 1000 people in the 1980s, the proportion of people now living in poverty would be reduced by a third (Eastwood and Lipton, 1999).[2] Thus, family planning can play a critical role in reducing world poverty by giving couples lacking resources a greater chance to recover from poor living conditions.

[2] Eastwood, R., & Lipton, M. (1999). The impact of changes in human fertility on poverty. *The Journal of Development Studies*, *36*(1), 1-30.

Reducing maternal and infantile mortality through family planning. Family planning has an undeniable impact on women's reproductive health by aiding in the prevention of thousands of maternal deaths. Maternal mortality is defined by the World Health Organization as the death of a woman due to complications during and following their pregnancy and childbirth ("Maternal mortality," n.d.). Seventy-five percent of all maternal deaths are associated with pregnancy complications from either severe bleeding, infections, high-blood pressure, childbirth complications, and unsafe abortions ("Maternal mortality," n.d.). John Cleland argues 150,000 annual maternal deaths can be prevented by simply increasing access to contraception (Cleland, 2006). Dr. Bela Ganatra, a scientist at the Department of Reproductive Health and Research at the World Health Organization, explains the benefits of contraception to maternal deaths in part lies in the increasing inter-birth period between pregnancies. The inter-birth period is defined as the time taken between the end of one pregnancy and the start of another (Ganatra, 2016). Following childbirth, a woman's body needs to recover from the nutritional depletion. If a new gestation begins shortly after childbirth, the woman's body does not have ample time to recover (Ganatra, 2016). A common health consequence to shorter birth intervals is anemia which increases the risk of maternal mortality (Ganatra, 2016).

The survival benefits are not only applicable for mothers, but for their children as well. Cleland claims the risk of fetal death, low birthweight, and dangerously small-sized infants are higher when conception takes place within 18 months of the previous live-birth (Cleland, 2006). He argues 1 million of the 11 million annual deaths of children younger than 5 years old can be avoided by eliminating birth intervals of less than 2 years (Cleland, 2006). The convincing evidence in support of family planning intervention programs is the reason why Brazilian public health officials gather statistical data from pregnant women. However, categorizing pregnancies

as planned or unplanned does not consider that individuals conceptualize family planning differently and cannot provide a full picture on the outcomes of interventions in the country.

The Maintenance of Healthy Pregnancies and Access to Contraception for Pregnancy Prevention

The female reproductive system and the maintenance of healthy pregnancies.

Educating women on the workings of their menstrual cycle and fertility are important educational aspects of sexual health and family planning. When I researched the biological component to pregnancies, I found a fact sheet from the U.S. Department of Health and Human Services, titled "Your menstrual cycle", via their website. The fact sheet states that the female body prepares for pregnancy through a monthly hormonal cycle during which a woman's levels of sex hormones estrogen and progesterone change. One of these phases is menstruation, often called a "period," and involves the release of the monthly build-up of blood tissue on the uterine lining through the vagina ("Your menstrual cycle," 2018). Ovulation is the release of an egg from the female ovary later in the menstrual cycle ("Your menstrual cycle," 2018). It is at this point where a female is fertile and may become pregnant. A pregnancy begins with the fertilization of a female egg by male sperm, and the following 40 weeks of the pregnancy are referred to as the gestational period ("Your menstrual cycle," 2018).

A "positive" pregnancy experience, as defined by the World Health Organization, 1) maintains the physical and sociocultural normality of the woman, 2) maintains a healthy pregnancy for the mother and baby by preventing and treating risks, 3) effectively transitions to positive labor and birth and 4) achieves positive motherhood through maternal competence, autonomy, and self-esteem ("WHO recommendations on antenatal care for a positive pregnancy experience," 2016). Abstract terms such as physical and sociocultural norms can be difficult to conceptualize into proactive measures, but the WHO does provide some concrete suggestions.

For example, the WHO recommends that healthcare providers encourage healthy eating to avoid excessive weight gain during pregnancy. Providers should prescribe daily iron and folic acid oral supplements to reduce the chances of a preterm birth and maternal anemia. A complete maternal prenatal assessment should include gestational diabetes blood exams, substance use interventions, HIV screenings, and syphilis exams ("WHO recommendations on antenatal care for a positive pregnancy experience," 2016).

Contraception methods and pregnancy prevention. Family planning not only involves the healthy maintenance of existing pregnancies, but also the prevention of pregnancies when a woman does not wish to expect a child. At this point, contraception is essential. Although many forms of contraception exist, they all aim to avoid pregnancy by blocking the fusion between the egg and sperm. Their impact is indisputable as the WHO reports contraceptive use prevented 218 million unintended pregnancies in developing countries in 2012 alone ("Family planning/ Contraception," 2018). Of these 218 million prevented pregnancies, the WHO estimates 55 million unplanned births, 138 million abortions, 25 million miscarriages and 118,000 maternal deaths were also avoided ("Family planning/ Contraception," 2018).

The Centers for Disease Control and Prevention (CDC) has a Department of Reproductive Health that provides a visual, shown below, with the various forms of contraception along with their effectiveness via their website (Figure 2).[3] Effectiveness of these forms is measured in percentages of pregnancy incidence when using that contraceptive. The value represents the percentage of women per 100 women in a year that have a pregnancy despite their use of said method. I decided to use the percentages provided by the CDC because

[3] Figure 1 can be found on the Center for Disease Control and Prevention's website under the Reproductive Health webpage. https://www.cdc.gov/reproductivehealth/contraception/index.htm

they present a more realistic representation of contraception use than other statistics that do not consider human error. Methods that require a more frequent administration have lower rates of success due to their increased susceptibility to human error, including forgetting or a delay in administration. Figure 2 is just one of many visuals providing information on contraceptive options. The large disparity between female and male options highlights the fact that providers often portray pregnancy prevention as a woman's responsibility given the many hormonal methods. The incidence rates of the chart make family planning seem easy enough if women simply choose a method from the top of the chart. However, choosing a contraceptive method is not as simple as just pointing at one method at the top of the chart. Given the effects of hormone administration on the body, finding a contraceptive method that suits an individual's body can be challenging. Additionally, one must also consider accessibility to the methods and the means of education. In the case of Figure 2, only women that are literate, have access to the internet, and can navigate the CDC website have access to this chart.

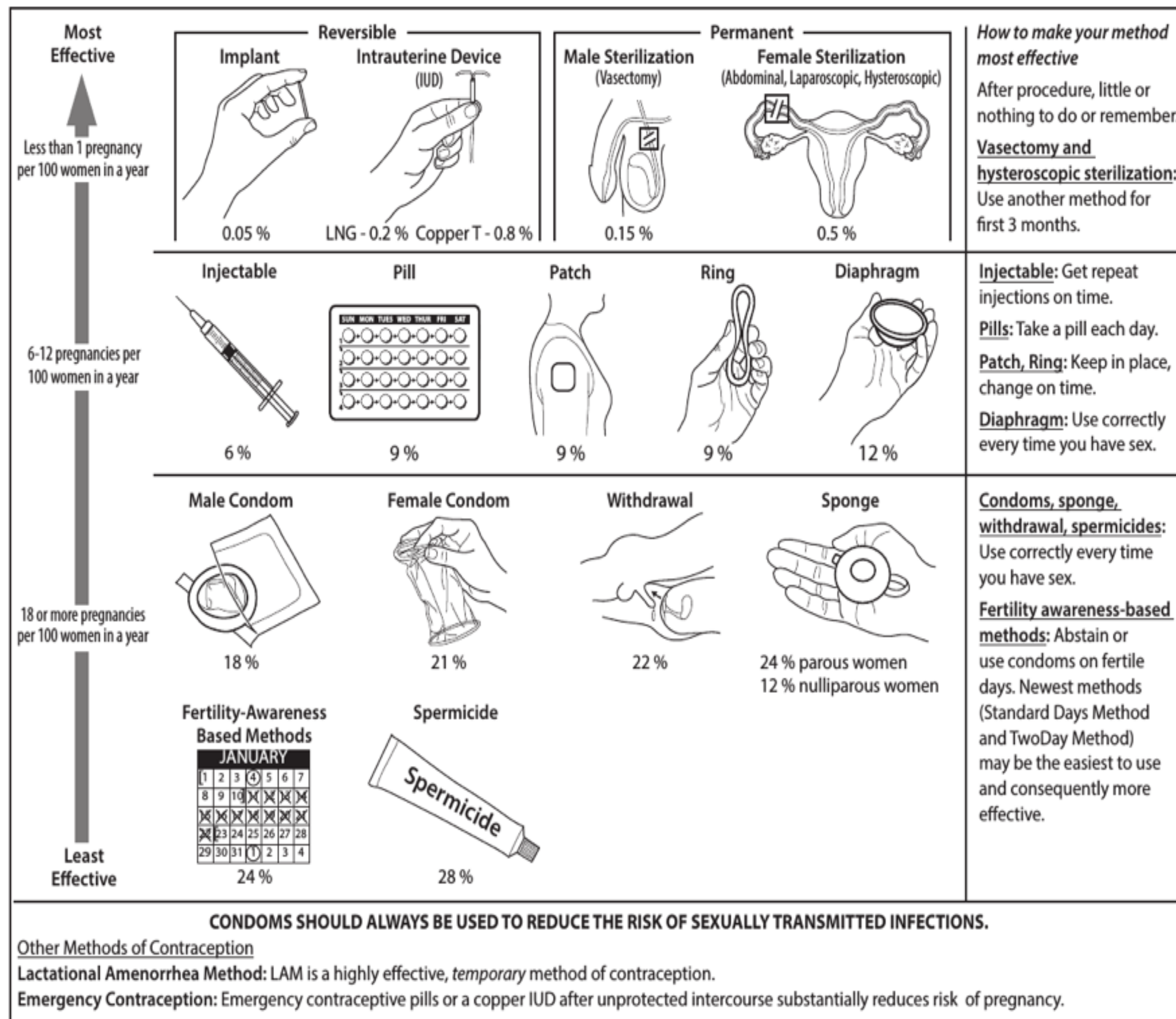

Figure 2. Effectiveness of Family Planning Methods. A visual explaining the various methods of contraceptives in order of effectiveness when considering human error and the realistic manner of use for these methods. Methods of contraception are presented from the bottom to the top of the visual according to their effectiveness, with the most effective options at the very top.

Among the least effective forms of birth control we find the calendar system, withdrawal, and condoms ("Effectiveness of Family Planning Methods," 2011). Coitus interruptus, also known as the withdrawal method, stops fertilization by withdrawing the male penis from the female vagina prior to ejaculation ("Family planning/ Contraception," 2018). This method keeps semen outside of the woman's body, but the incidence rate is comparatively high to other options

at 22% ("Effectiveness of Family Planning Methods," 2011). Partners using the calendar method avoid having unprotected vaginal sex during the woman's first and last days of ovulation. Women keep track of their menstrual cycle for a minimum of six months to calculate the first and last days of ovulation ("Family planning/ Contraception," 2018). The calendar method has a similar effectivity to the withdrawal method with an incidence rate of 24% ("Effectiveness of Family Planning Methods," 2011). Interestingly, condoms, the thin plastic barriers used during sex, have a similar incidence rate as withdrawal and the calendar method with 18% for male condoms and 21% for female condoms ("Family planning/ Contraception," 2018). The rate is in part due to the highly inconsistent use of condoms. During my time researching in the clinic, several women commented on condoms affecting pleasure. They preferred hormonal options that would effectively avoid pregnancy and would not affect enjoyment.

Several hormonal options exist for women, including the birth control pill, progestogen-only pills, and the emergency contraception pill. The birth control pill is a combination of estrogen and progestin synthetic hormones resembling estrogen and progesterone. It prevents pregnancy by inhibiting ovulation ("Family planning/ Contraception," 2018). Progestogen-only pills, also known as "mini-pills" thicken the cervical mucus of the woman to block sperm from meeting with the egg ("Family planning/ Contraception," 2018). The emergency contraception pill stops pregnancy up to five days after unprotected sex ("Family planning/ Contraception," 2018). When excluding emergency contraceptive pills, this oral form of contraceptive has an incidence rate of 9%, proving to be relatively effective ("Effectiveness of Family Planning Methods," 2011). When I spoke to women about birth control pills, many voiced their concerns about forgetting the daily pill. I met several women that were pregnant due to an inconsistent use

of oral contraception. This prompted these women to seek longer-lasting hormonal contraceptives after their pregnancy.

Longer-lasting hormonal contraceptives include implants, injectable birth control, and intrauterine devices (IUDs). Implants are small progestogen-containing rods or capsules that are placed under the skin of the woman's upper arm by a healthcare provider. One implant serves as an effective form of birth control for 3-5 years by thickening cervical mucus ("Family planning/ Contraception," 2018). The progestogen-only injectable is administered into the woman's muscle every 1 to 3 months and prevents pregnancy by thickening cervical mucus. The other injectable option is a monthly administration of estrogen and progestogen into the muscle. Intrauterine devices (IUDs) are small plastic devices inserted into the uterus that prevent pregnancy in one of two ways, either copper or levonorgestrel. Copper-containing IUDs damage and block sperm and levonorgestrel-containing IUDs thick cervical mucus. ("Family planning/ Contraception," 2018). Among these forms of birth control the most effective forms are the implant (0.05%) and the levonorgestrel- containing IUD (0.2%) ("Effectiveness of Family Planning Methods," 2011).

Two permanent, surgical forms of sterilization are available. The male surgical procedure is the vasectomy and female sterilization is tubal ligation. During a vasectomy, a healthcare provider cuts the vas deferens tubes that carry sperm from the testicles to keep sperm out of ejaculated semen ("Family planning/ Contraception," 2018). Tubal ligation involves the cutting of a woman's fallopian tubes by a healthcare provider to block eggs from meeting sperm. Both forms of sterilization are incredibly effective with an incidence rate of 0.15% for vasectomies and 0.5% for tubal ligations.

The contraceptive methods above highlight the large difference in contraception options for men and women. Of the 15 options shown in Figure 2, 12 contraceptive methods are only for

women. The emphasis on the woman's body in questions of fertility and reproduction has made family planning a woman's responsibility more so than one between partnerships. Should a pregnancy occur when not expected, partners, family members, and even other women often blame a woman for improperly using contraception. Many people expect women to meet with their provider to discuss all the options mentioned above to find a good fit, but do not expect a man or a stable union to do the same together. Now, there is one facet of family planning that most Latin American legislators have not placed in the hands of women, abortion. A woman is responsible for preventing pregnancy, but once she is pregnant, her reproductive choices are limited to one, having a child.

The benefits of access to legal abortion and Brazil's restrictive legislation on the practice. The positive impact of access to safe abortions on reducing maternal deaths is indisputable. In 2000 alone, Cleland (2006) estimated 90% of global abortion-related deaths could have been avoided with access to safe abortions in the early stages of gestation. However, legal access to abortion remains hotly contested in many modern democracies (Htun, 2003). In Latin America, most countries' policies on abortion have barely changed since the 19th and 20th centuries and continue to penalize women seeking illegal terminations to their pregnancies. In Brazil, the Penal Code of the Republic (1890) prohibited all abortions and severely penalized both providers and women involved in the procedures. Despite opposition and pressure from the Catholic church, the Penal Code of 1940 during the Vargas Era introduced policies that decriminalized abortions in two situations. Article 128 states the government will not punish a woman for attempting an abortion if the gestation puts her life at risk or if the pregnancy results from rape (*Código Penal*, 1940). Article 128 marked a change from previous policy, but the Penal Code generally continued to treat abortion as a crime against life. In fact, Article 124 of

the Penal Code sentenced women consciously seeking an abortion to 1 to 3 years of imprisonment (*Código Penal*, 1940).

Despite the various changes in the political landscape of Brazil during the latter half of the 20th century including a military dictatorship (1964-1985) and re-democratization, abortion policies of the 1940 Penal Code remained unchanged. 1988 was of great significance for women's health with the implementation of PAISM, the country's first federally funded family planning program. Women's health policies transitioned from a materno-infant focus, in which women's health was inseparable from their infants' health, to a holistic approach also covering care outside of reproduction. Yet, the family planning services provided within PAISM did not include abortion and the practice remained illegal.

Countries such as Brazil with legal restrictions on safe abortions have higher incidence rates of unsafe abortions. The Guttmacher Institute and World Health Organization found that 3 in 4 abortions are unsafe in countries where abortions are illegal or only legal in cases where a woman's life is at risk. Meanwhile, 1 in 10 abortions are unsafe in countries in which abortion is legal on broader grounds.[4] In countries with legal restrictions, women of higher socioeconomic status can turn to private providers or international travel to seek an abortion. However, many women cannot afford to seek an abortion through a private provider, and thus turn to unsafe practices (Ganatra, 2016). The WHO defines abortion as a "pregnancy termination prior to 20 weeks' gestation or a fetus born weighing less than 500 grams" ("Safe abortion: technical and policy guidance for health systems," 2012). Safe abortions can be done by healthcare providers

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[4] Worldwide, an Estimated 25 Million Unsafe Abortions Occur Each Year. (2017, October 06). Retrieved from https://www.guttmacher.org/news-release/2017/worldwide-estimated-25-million-unsafe-abortions-occur-each-year

in a primary-care setting via surgery or medical induction ("Safe abortion: technical and policy guidance for health systems," 2012). Ganatra defines an unsafe abortion as one in which either the person performing the procedure lacks the necessary skills or the procedure is done in a location failing to meet minimal medical standards (Ganatra, 2016).

From 2010 to 2014, approximately 56 million women from around the world had an abortion annually ("Preventing unsafe abortions," 2018). Over 40% of these abortions (25 million) were unsafe, and 30% of these unsafe abortions resulted in a hospitalization annually ("Preventing unsafe abortions," 2017). These are staggering numbers, and statistics fail to capture just how large the issue truly is. The WHO collects statistical information on unsafe abortions from reported hospitalizations, surveys of women, and published studies (Sedgh, 2012). However, many women do not report self-induced abortions due to fear of potential penal action, leaving researchers with an estimate that does not represent the entire reality of abortion in the country. In Brazil, a 2016 poll reported 1 in 5 Brazilian women younger than 40 have undergone an abortion (Lopes, 2018). An estimated 250,000 women were hospitalized from complications from abortions, and 200 women died from the complications in a year, and these numbers are certainly underestimates. (Khazan, 2018). Women with greater economic resources can visit an illegal abortion clinic, but others with less resources try to purchase misoprostol, the oral medication that induces an abortion, from the black market and try to seek instructions from the internet (Khazan, 2018). Hundreds of thousands of women using misoprostol at home go to the hospital due to complications. Brazil is one example proving that abortion restrictions do not prevent abortions, but rather just increase the frequency of unsafe abortions with potentially fatal consequences.

The illegality of the procedure leaves women with little to no choice should a pregnancy result. Thus, educating women on their reproductive cycles, fertility, and proper use of legal contraception is needed to minimize the number of women seeking clandestine procedures when getting pregnant. Legalizing abortion is not the only answer to reaching the positive outcomes associated with family planning. Educating and providing contraception are vital to pregnancy prevention, while abortion serves as an expansion to family options in cases where a pregnancy is not prevented. Both facets of family planning, contraception and abortion, contribute to the positive outcomes analyzed in my previous section.[5]

Brazilian Federal Legislation on Women's Health

Pronatalist Brazil: Vargas' "paternalistic" dictatorship and the creation of infant-focused public health departments. The early twentieth century marked the beginning of Brazil's second century as an independent country. As a young republic, the Brazilian government struggled to form a national identity (Maes, 2011). Tense ideological conflicts among the existing political parties compounded these unification issues. In 1930, a military junta brought an end to Brazil's Old Republic and installed Getúlio Dornelles Vargas as the provisional chief of state (Levine, 1970). The new provisional government began a new and dynamic chapter in Brazilian life, yet the country remained conservative and paternalistic under Vargas' first rule until 1945 (Levine, 1970). Getúlio Vargas won the 1950 presidential election after the military ousting of 1945, but I am focusing on his first 15 years of power, known as the Vargas Era (Maes, 2011). Officials of the Vargas Era utilized "*a criança,*" the youth, as a symbol of rebirth and national character (Maes, 2011). The Ministry of Health and Education

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[5] See "Defining Family Planning: its Significance on the Economic and Health Domains of the Global Population."

(MES) focused on children in their public health campaigns to reiterate the paternalistic role Vargas strived for in his dictatorship (Fonseca, 2007). Government officials promoted childcare to symbolically unify the country and create the notion of a national family (Fonseca, 2007). In Vargas' political scheme, emphasizing healthy children in part meant maintaining his rule as the "father" of the children and the poor (Maes, 2011).

This public health legislation is manipulative in its attempt to keep the population under control, but the policies did expand infantile and children's care. However, discourse on women's health was limited to their pregnancies, postnatal care of their infants, and maintaining their families. Arguably, the Brazilian government was only concerned with women's health when viewed as vehicles carrying the next generation. Changes in public policy on children's health began in 1934 with the replacement of the *Departamento Nacional de Saúde Pública* (National Department of Public Health, DNSP), Brazil's first public health department, with the *Directoria de Proteção á Maternidade e á Infância de 1934*. The new program emphasized the well-being of Brazilian infants, pushing forward the pronatalist agenda of the Vargas dictatorship. To govern meant to populate and an increasing population meant more metaphoric children under Vargas as their "father." In 1937, the Ministry of Education and Health created the *Departamento Nacional da Criança* (DNC) to replace the DNSP.

The DNC would stay intact until the 1970s, much longer than its predecessor. In the 1930s and 40s, women participating in the workforce also gained the right to maternity leave and a work schedule that allowed for breastfeeding when needed (Caldwell, 2017). Here we see an expanded approach to women's health, but the focus remains on her as a mother, even in the work force. The Criminal Infractions Law of 1941 banned the advertisement of all birth control, furthering pronatalist ideals in Brazil (de la Dehesa, 2018). The lack of promotion of

contraception and the expanded protection of women in the work force encourage the conceptualization of family planning as a practice to balance work and family life without the consideration of pregnancy prevention when desired.

Non-profit interventions for family planning: the introduction of the birth control pill to target regions of Brazil. Women's groups began strongly challenging the pronatalist discourse in the 1960s. A sexual revolution swept across the Americas as younger generations accepted and engaged in premarital, non-procreative sex (Cowan, 2016). As couples gained access to birth control pills, safe, non-reproductive sex seemed more accessible than ever (Cowan, 2016). Women were joining the workforce at increasing rates, and young women were attending universities at unprecedented levels (Cowan, 2016). Despite the oppressive military regime of the time, Brazil was not immune to these cultural and commercial changes. The government's lack of a definitive and united stance on birth control paved the way for the International Planned Parenthood Fund's intervention to provide birth control pills. Contraception became an accepted and normalized aspect of many women's reproductive health in Brazil. However, this normalization also happened amid the thoughtless orientation of women in regards to their reproductive health.

The military dictatorship (1964-1985) failed to take a firm stance on fertility control as the sexual revolution reached Brazil. Consumption of the birth control pill not only meant an increase in recreational sex, but also an opportunity for population control in poorer communities. Some members of the government supported the distribution of contraceptives to control fertility in poor, target regions of the country. Other members, with the backing of the Catholic Church, labelled such a distribution an attack on the morals of the country (Martins and Fiere, 2011). The division of opinion within the militants led to a government that did little to

either promote or repress fertility control. This set the stage for the implementation of IPPF's intervention programs. The IPPF created the *Sociedade Civil de Bem-Estar Familiar* (BEMFAM) in 1965 and the *Centro de Pesquisas de Assistência Integrada à Mulher e à Criança* (CEPAIMC) in 1975 to tackle their concerns over large, unmanageable population growth in Brazil (Martins and Fiere, 2011). BEMFAM is a private, nonprofit organization providing family planning services to Brazil (de la Dehesa, 2018). Today the organization no longer has the prominence it once had, but BEMFAM created contraceptive clinics in poor communities and distributed contraception and disseminated educational materials on family planning (Caldwell, 2017). CEPAIMC provided medical training and materials to doctors performing surgical sterilizations (Caldwell, 2017). CEPAIMC and BEMFAM were the only organizations legally providing contraception for women outside of the private market until the 1980s.

1975 not only marked the creation of CEPAIMC, but also marked the first formalized feminist public forum, the *Seminário sobre o Papel e o Comportamento da Mulher na Sociedade Brasileira* (Seminar on the Role of Action of Women in Brazilian Society) in Rio de Janeiro (Machado, 2016). Women addressed female physical and mental health as one of the main issues to focus on moving forward. Newspapers such as *Brasil Mulher* and *Nós Mulheres* called for unity among feminist groups to seek change in domains of women's issues, including health. It is worth noting that not all women belonged to a single growing feminist movement. Women's views were on a spectrum on which some supported more conservative family values while others supported what they deemed to be more progressive views. On the conservative front, hundreds of thousands of women had participated in a large conservative demonstration in 1964

calling for the ousting of president João Goulart in the name of protecting family values.[6] The military was aware of this female support and used "traditional symbols of female piety, spiritual superiority, and motherhood" in part to legitimize their authoritarian agenda (Htun, 2003). Conservative females continued to support the protection of their family values while feminist movements continued to grow to larger organizations including the Brazilian Women's Center.

Women of the growing movement supported access to contraception, but criticized BEMFAM and CEPAIMC for being pro-control rather than pro-women's health. Critics claim BEMFEM widely distributed birth control pills without a proper medical appointment or follow-up (Congresso Federal, 1993). Critics also argue CEPAIMC and BEMFAM both prioritized sterilization for women coming into the clinic (Congresso Federal, 1993). This thoughtless distribution placed women in potentially dangerous situations and demonstrated the little consideration given to the health of women using the products. Arguably, poor administration of contraception can be more harmful than not providing contraception at all. Both in the 1970s and now, the birth control pill is a hormonal treatment that providers must prescribe with careful consideration of the women's body and medical history. Hormones change a woman's body, and when not used correctly, the pill can negatively affect a woman's quality of life and result in a pregnancy. These potential side effects need to be discussed and followed-up on for women choosing the pill as their birth control option.

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[6] The March of the Family with God and Liberty was a public demonstration in São Paulo, Brazil in 1964 calling for the replacement of then President Goulart. 500,000 Brazilians are estimated to have participated in the March, and many of them were middle-class women brought together by various Catholic Church organizations. This demonstration is a clear example of the strong influence and presence of the conservative faction of women in the country.
Amigos, C. C. (2007). A ditadura militar no Brasil: a história em cima dos fatos. *São Paulo: Editora Casa Amarela*.

Without properly educating women, both organizations failed to truly provide family planning services as described by the United Nations Population Fund today. Rather than promoting educated choices, both organizations targeted limiting fertility among poorer communities. CEPAIMC and BEMFAM ultimately lost their prominence with legislative changes of the following decade. The Brazilian feminist groups brought forth public debates on the State's obligation to offer family planning services and to protect reproductive freedoms (Arilha, 1998). The discourse of the largely middle-class based movement shaped the health policies implemented in the 1980s (Htun, 2002). PAISM, my policy of interest for this next section, broke away from the emphasis on population control or maternal-infantile women's care to reimagine a more holistic image of women's health in the public domain.

PAISM and comprehensive women's care: shifts from materno-infantile women's care to women as independent entities in healthcare in the 20th century. The changes on women's health policies of the 1980s would not have been possible without the military government's goal of creating a new, modernized Brazil. To modernize, military rulers created special commissions of experts to propose reforms that would modernize Brazil (Htun, 2003). These commissions included legal experts and feminist leaders rather than military leaders. This allowed for more liberal reforms in Brazil that commission members justified as steps in the right direction towards a modern, scientifically advanced Brazil (Htun, 2003). Some of the councils created by the government focused on women's health and rights, including the Council on the Condition of Women in São Paulo in 1983 (Machado, 2016). The councils served as advisory bodies without executive power, but the military officials considered their proposals for implementation (Machado, 2016). One of these reforms included a new program targeting women's health, the *Programa de Assistência Integral á Saúde da Mulher* (Program for

Integrated Women's Health Care; PAISM). In 1985, the New Republic replaced the military dictatorship and implemented PAISM as the first family planning program of the Brazilian government (Martins and Fiere, 2011).

PAISM served as a comprehensive approach to women's health rather than focusing on women as reproductive secondary players to infantile health. This concept of "comprehensive care" was new for women's health policies in Brazil, and contrasted from previous legislation focusing on their role as mothers and maintainers of the family. Simone Diniz, an anthropologist, defines comprehensive care as "the notions of primary, secondary, and tertiary care; the physical, emotional and social aspects of health, and of care for women from infancy until old age, not only for reproductive years" (Diniz, 2012). PAISM prioritized helping women on a lifelong basis. Legislation expanded women's health to include cancer prevention, gynecological care, contraception, and fertility treatments. Women became subjects for the first time in a Brazilian social health program. The empowering objectives of this program were ironically instituted during a restrictive and silencing dictatorship, highlighting the significance of such changes.

In 1984, the women's movement proposed a national council focused on gender-related concerns in need of government attention (Caldwell, 2017). This would become the *Conselho Nacional de Direitos da Mulher* (National Council on Women's Rights, CNDM) (Caldwell, 2017). The CNDM played a critical role in supporting the women's movement to promote reproductive rights. In fact, the CNDM helped in the implementation of PAISM and its aim of promoting the comprehensive care of women. By 1988, the CNDM led to the formation of the *bancanda do batom* (Lipstick lobby) that presented the "Women's Charter" to government officials (Pinto, 2003). The letter demanded the expansion of women's rights in work, health, property, combating domestic violence, and the redefinition of rape in the Penal Code.

According to the former president of the CNDM, Jacqueline Pintanguy, 80 percent of the proposals in the Women's Charter were included in the final text of the Constitution (Pintanguy, 1996). Approved proposals included guaranteeing men and women have equal rights in the family and establishing the State's obligations in providing family planning services (Htun, 2002). Article 226, paragraph 7 of the Constitution claimed family planning as the "free decision of the couple" and bestowed upon the state the responsibility to "provide educational and scientific resources for the exercise of this right and to impede any coercion on the part of official and private institutions" (*Constituição da República Federativa do Brasil*, 1988). The Constitution recognized family planning and health as the rights of all Brazilians.

Congress amended the 1988 Constitution with the Family Planning Law of 1996 that legalized female and male sterilizations (Soara and Brollo, 2013). Tubal ligations are the second most common form of birth control in Brazil, and the law implemented several requirements to ensure informed consent for this commonly used form of contraception. The person undergoing the procedure must be 18 years old with at least two living children or 25 years old (Soara and Brollo, 2013). Sterilizations now require a 60-day waiting period after the individual's initial request along with the partner's or spouse's consent (Soara and Brollo, 2013). These regulations recognize the high incidence rate of sterilization in Brazil and seem to protect individuals desiring sterilization.

Dr. Alessandro, a physician of a primary health clinic, explained to me that adults usually do not have the mental maturity to make this permanent decision prior to the age of 25. He claims younger women often change their minds about having a family as they get older. These claims are valid, but nonetheless, the measures still restrict the options of young women. Interestingly, the women seeking gestational care in the clinic during my five weeks of research

were on average 25 years old. This suggests women are already having children and may already have multiple children by 25. If professionals claim women do not have the mental maturity to choose sterilization, it seems faulty to believe these women have the mental maturity to raise children. The hesitation in providing access to sterilization for younger women highlights the emphasis still placed on reproduction in women's lives despite women's growing involvements in other sectors of society. The required consent of a spouse demonstrates that family planning is guaranteed as a right at a partnership level more so than on an individual level. Under Brazilian public policy, family planning happens at the level of a partnership, yet there is a dissonance between law and the attitudes of many men and women in which family planning is a woman's role. Rather than ensuring a discussion between man and woman about sterilization, the policy has in part unintentionally made a man's affirmation the final say for cases in which a woman independently seeks sterilization. The regulations on tubal ligation have indirectly contributed to the unequal gender relations still present in Brazil.

Women's health in the 21st century: Lula, Dilma, and the future of family planning in Brazil. Brazil entered the 21st century as the fifth largest country of the world territorially and demographically with over 174 million people. The large population experienced a significant decrease in their fertility rate from 6.3 children per woman in 1960 to 1.9 children by 2010 (Corrêa, 2016). This decline has been attributed to social security systems, the implementation of the public healthcare program, SUS, and the expansion of communication networks including television (Corrêa, 2016). The State implemented infrastructure investments and new programs aimed at reducing poverty. One of these programs continues to provide financial support to women that successfully attend all prenatal medical consults and newborn consults once the infants are born. The financial support encourages women to continue their medical care

throughout their pregnancies, but some argue the policies emphasize the role of women as reproductive objects. Such financial support for gynecological consults and cancer prevention screenings would encourage a more comprehensive approach as originally intended by the PAISM reforms of the 1980s. However, access to abortion was, and continues to be, the most publicly discussed point of family planning in the 21st century. The divisiveness on legalizing access has impacted both the election campaigns and presidencies of Brazilian leaders including Luiz Inácio Lula da Silva and Dilma Rousseff.

The Workers' Party (PT) won the presidential election of 2002 with Luiz Inácio Lula da Silva. Women's groups including SOS, the National Forum of Black Women, and the Brazilian League of Lesbians, among others, were hopeful for changes in women's health policies with the victory of Brazil's democratic socialist party (Machado, 2016). One of Lula's government's promising initiatives for change on women's health policies, particularly abortion, was the creation of the Special Secretariat of Policies for Women (SPM). The Secretary established a public space for open dialogue between feminist movements and created a national conference dedicated to women-centered policies (Machado, 2016). In March of 2004, the commission focused on changing the 1940 Penal Code's restrictions on abortion, but efforts came to a halt in August of 2004 as political corruption controversies erupted (Corrêa, 2016). The commission may have broken down, but this did not settle the tension between those supporting access to abortion and those in support of existing regulations. The debate continued to grow with Dilma Rousseff's presidential campaign and election.

Dilma Rousseff became the first, and thus far the only, female president of Brazil in 2010. Prior to her presidency, Rousseff spent 1970 to 1972 imprisoned for her resistance against the military dictatorship (Diniz, 2012). After her release, Dilma Rousseff became politically

active in the Workers' Party. During her presidential campaign, religious fundamentalists and opposing, right-wing politicians used her past imprisonment to isolate her as an "atheist, terrorist, and cold-hearted abortionist" (Diniz, 2012).[7] Even though national polls suggested abortion was not the central issue of the election, religious groups and politicians utilized the divisiveness on access to abortion to weaken her campaign. One year prior to her campaign, Rousseff publicly declared that abortion should be considered a major public health issue and legalized. However, strong attacks against her character resulted in what Corrêa describes as a "strategic retreat" on her political positioning. Dilma released *Carta Aberta ao Povo de Deus* (Open Letter to the People of God) to appeal to Christian voters (Caldwell, 2017). She described family as the root of a healthy society; "the more structured the family is, the less social chaos we will have" (Open Letter to the People of God, 2010). Her shift in stance on abortion is evident in her second letter called *Mensagem da Dilma* (Message from Dilma) in which she claims she would not attempt to make changes to legislation on abortion if elected (Message from Dilma, 2010).

Despite this conflict, Dilma won the second-round run-off vote with 56% of the votes. Her presidential victory cannot only be attributed to her change in stance on abortion, but the fact that Dilma Rousseff had to change is a reflection on Brazilian values. Dilma Rousseff could not present herself as a progressive woman fighting for women's rights. Rather, Dilma had to promote herself as a woman protecting familial values. Opposing politicians insulted her character as both a politician and a woman, as is evident in the claims made against her during her campaign. The dissonance between Dilma's character and the role of women within traditional values as motherly caregivers caused additional scrutiny not faced by Dilma's male

[7] Dilma Rousseff's political positioning on legal access to abortion and the resulting pressures throughout her presidential campaign are further discussed in the section of my chapter titled "Abortion." Refer to this section for more information.

counterparts. A woman in the highest executive office may lead one to idealistically believe in large expansion for women's health legislation. However, Dilma's presidency was not immune to the enormous rift between religious leaders claiming to protect Brazilian familial values and legislators claiming to expand women's rights.

Dilma Rousseff introduced a novel policy on family planning called the "Stork Network." Although never implemented, the program aimed to reduce maternal mortality. Contraception and reducing unsafe abortions were rarely mentioned in legislation meant to reduce maternal mortality despite their indisputable impacts. Controversy in reproductive health policies continued with the issuing of *Medida Provisória* 557 (MP557) in 2011. The most polemic section of the proposal promoted the creation of a national registration system for all pregnant women (Caldwell, 2017). Some viewed the proposed National System of Registration, Tracking and Follow-Up of Pregnant and Puerperal Women for the Prevention of Maternal Mortality as a tool for expanding prenatal and infantile care. Others strongly opposed the provision as a surveillance system of all pregnant women allowing for the pursuance of penal action should an illegal abortion be suspected (Caldwell, 2017). The provision expired before a Congressional vote in 2012, but it is a clear example of policies meant to improve women's rights in healthcare that are rigged with controversy. 2012 marked some expansion to the abortion policies of the 1940 Penal Code. After eight years of judiciary hearings, the Supreme Court recognized anencephalic fetus cases as an exemption due to the severe health repercussions for the fetus. However, the dragged-out hearings and injunctions place a spotlight on the resistance to change at the federal level. From this evidence, it's easy to predict that abortion will continue to be a heated point of discussion drawing anger from feminist groups supporting the legalization of abortion and religious groups supporting the upholding of current

restrictions. As a woman, Dilma Rousseff faced the difficult task of compromising with right-wing politicians and religious leaders to move legislation forward. Rousseff's efforts came to a halt with her 2016 impeachment on charges of manipulating the federal budget.[8] This left Michel Temer as President until the election of the current leader, Jair Bolsonaro.

On October 28th, 2018, over 55% of voting Brazilians elected Jair Bolsonaro, a far right-wing politician, as their next president. During his political campaign, millions of women denounced Bolsonaro's platform as repressive in the #EleNão (#NotHim) social media campaign ("Jair Bolsonaro: Large protests against the Brazil election front-runner," 2018). Bolsonaro made a series of statements defending Brazil's gender pay gap and promised religious voters to stop any changes to the Penal code criminalizing abortion (Nugent, 2018). The Brazilian Supreme Court is currently considering legalizing abortions up to 12 weeks of pregnancy, but the election of Bolsonaro leaves little chance for such change. His campaign not only incited strong emotions both against and in support of his leadership, but highlighted the fact that the conceptualizations of family planning and women's health are still subject to change. Changes to legislation cannot be predicted, but recent announcements have reminded me of the materno-infantile attitudes towards women's rights.

On December 6th, 2018, Bolsonaro announced his intention to abolish the Human Rights Ministry and replace it with a ministry grouping together women, family rights, and indigenous people under an evangelical pastor as its leader (Phillips, 2018). Damares Alves, the proposed leader, has publicly announced her opposition to legalizing abortion and believes women are

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[8] For more information on Dilma Rousseff's impeachment proceedings, please refer to: Romero, S. (2016, August 31). Dilma Rousseff Is Ousted as Brazil's President in Impeachment Vote. Retrieved from https://www.nytimes.com/2016/09/01/world/americas/brazil-dilma-rousseff-impeached-removed-president.html

meant to be mothers (Phillips, 2018). A leader that wants to protect family values will be able to push aside women's issues that go beyond the traditional role of a woman in the household. Women's health policies are always subject to change with new leadership, but Bolsonaro's new ministry is a regression from the comprehensive initiatives that are considering issues such as gender pay equality and access to abortion. The recent announcements suggest that there will be a protection and emphasis on familial values should there be changes to family planning policies.

A Breakdown of The National Health System (SUS) and its Funding

Brazil's health network has three subsectors that make up a complex network of public and private providers: 1) the public sector (SUS), 2) the private subsector, and 3) the private health insurance subsector (Paim, 2011). Legislators created the National Health System (SUS) in the 1988 Constitution that obligated the State to provide access to medical care to all residing in Brazil (*Constituição da República Federativa do Brasil*, 1988). SUS guarantees the consistent care of all Brazilians regardless of their ability to pay for services within the private sector (Paim, 2011). Consistent care includes access to three fundamental levels of the SUS system: 1) primary health care clinics, 2) secondary specialist visits, and 3) tertiary hospitalizations. Health professionals provide primary-level care to patients in clinics called *Unidade Básica de Saúde* (UBS). I conducted my research in a UBS clinic of the Bom Retiro neighborhood in São Paulo given the gestational care and family planning services provided at the primary level of care.

Federal, state, and municipal officials all work together to finance SUS services. The state and municipal governments are responsible for buying into the National Health System and implementing the primary, secondary, and tertiary levels of care (Gragnolati, 2013). However, state and municipal government health budgets are often not large enough to fully fund all SUS services in the region. The federal government aids state and municipal governments by

providing funds from the federal health budget. The federal health budget relies on federal taxes and social contributions (taxes specifically for social programming) (Gragnolati, 2013).

The Bom Retiro UBS adheres to the municipal government of the municipality of São Paulo, called the *Prefeitura de São Paulo* (Prefecture of São Paulo). As described on the municipal government's website, the Prefecture has many responsibilities, including the financing of SUS services. The sub-branches of care include basic consultations, vaccinations, women's health, infantile health, mental health, and geriatric care among others ("*Saúde e Bem-estar," 2009)*. The government's website has a webpage dedicated to the various facets of women's health including gynecological care, legal abortion services, sexual and reproductive health, menopause, breast cancer prevention, and the protection of women experiencing domestic violence ("*Saúde da Mulher," 2009)*.

The Prefecture recognizes the right of all individuals to "freely and responsibly" decide the number of children they wish to have. The municipal government also recognizes the basic right to reproductive health information and access to contraception (*Saúde Sexual e Reproductiva*). In 1996, Federal Law 9.263 obliged all levels (primary, secondary, and tertiary) of the SUS network to uphold the right to family planning guaranteed by the Constitution. In other words, SUS providers must assist individuals seeking conception and contraception methods (*Constituição da República Federativa do Brasil*, 1988). The Protocol for the Regulation of Birth Control Distribution provides a set of guidelines all UBS health clinic of the Prefecture must follow. Per the Protocol, all clinics must educate women on contraceptive options during gynecological appointments. All women are ensured private and individualized orientation from their providers for an effective contraceptive method best suited for their needs ("*Protocolo de Regulamentação de Oferta de Métodos Contraceptivos*," 2009). I saw these

orientations happen first hand by joining healthcare providers during medical appointments, a family planning workshop, and patient home visits.

My First Impressions of the UBS and Bom Retiro Neighborhood

Bom Retiro and its UBS. Upon my arrival in Brazil, I had no idea what to expect from a public health clinic or the Bom Retiro neighborhood. My journey to the clinic began in the *Brigadeiro* metro station on *Avenida Paulista*, one of the largest avenues in São Paulo city. With over 12 million residents, São Paulo is the largest city of the country. Many Paulistanos, residents of the city, begin their day on the city's public transportation network. By 7 AM, the *Brigadeiro* metro station was packed to the brim with thousands of people going about their day. I boarded the metro, and thirty minutes later I was in *Luz* (Light) station right on the border of the Bom Retiro entrance. The skyscrapers of *Avenida Paulista* felt distant as three and four-story clothing stores took their place on the streets. Some individuals sold pastries and coffee from mobile carts and the trunks of their cars. Others distributed flyers from their respective clothing stores. Casual lunch sites occasionally interrupted the endless line of clothing stores.

After a twenty-minute walk down Jose Paulino street, the UBS was finally in sight. The clinic was a small building only identifiable as a clinic by its green "UBS" sign hanging from the exterior. On the outside, the clinic was not an impressive sight, but once I stepped inside, the activity was nonstop. The most notable site was the small hallway filled with patients awaiting their consults with physicians and nurses. The constant activity never changed for the next five weeks. The small site serves over 20,000 residents of the neighborhood with just five different medical teams. Each team is composed of one physician, one nurse, and six community agents respectively. Although the roles of the healthcare providers in a team differ, their collective work provides medical care to over 4,000 patients. These healthcare professionals continuously passed

through the hall to enter the various rooms of the building. The hall connected five consultation rooms, an administrative office, a meeting room, the patient registrar, and a triage room. Figure 2 is a drawing of the clinic's floor plan.[9] Spanish and Portuguese filled the hallway of the clinic as patients spoke to each other and their family members. The healthcare staff of the clinic is also diverse. Most of the providers are Brazilians, but I also met immigrant staff including Dr. Laura, a Bolivian physician improving her Portuguese as she met with more patients. As the days progressed, I gained a better understanding of the clinic and its daily workings.

[9] The clinic's floor plan was acquired from Doris Chikopana's undergraduate thesis on accessibility in Brazil's SUS system and the UBS. "A Case Study of a São Paulo Health Clinic: Accessibility to Health Services by Patients Who Do Not Speak Portuguese as a First Language."

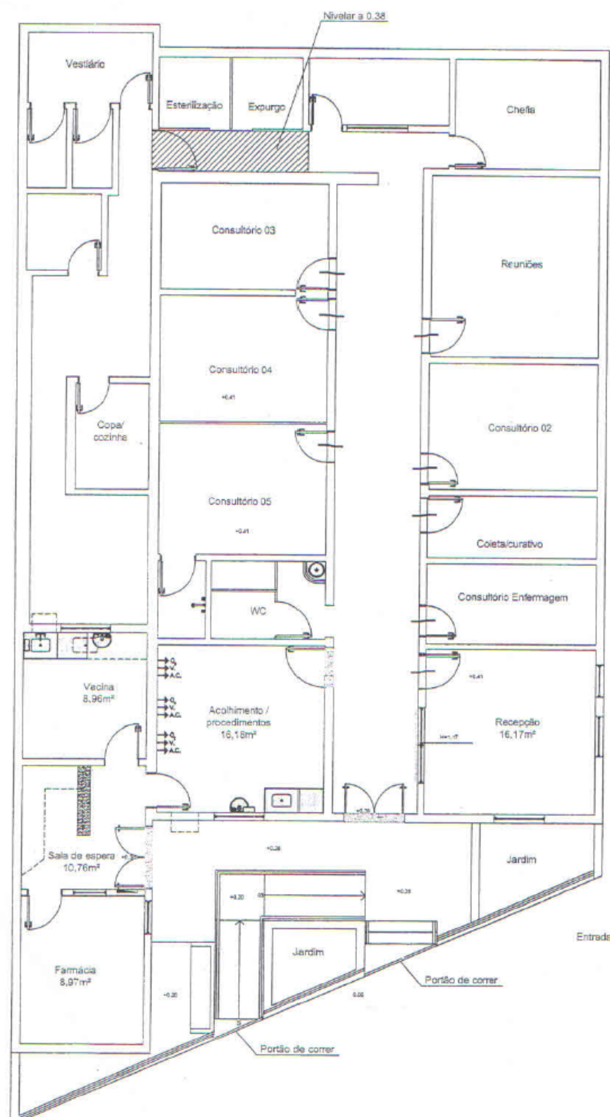

Figure 3. Floor plan of the UBS Bom Retiro (Source: UBS Bom Retiro).

A typical day in the UBS begins at 7 AM and ends around 7 PM. Patients check-in at the registrar office for their consultations, laboratory exams, or vaccinations using their SUS identification card. From there, patients wait for their consultations in the hallway. Physicians and nurses typically spend 15 minutes on any given consult given the high volume of patients. Staff from the registrar typically schedule similar consults together on a weekly basis. This allows the physician or nurse to focus on one target population for a morning or afternoon time

block. For example, Dr. Alessandro, the physician of the green team, consults pregnant women every Tuesday afternoon from 1 PM – 4 PM. I joined physicians during their prenatal and infantile consults. I took notes on the conversations between patients and providers, including questions women had about their health and future contraceptive use. As soon as the physicians wrapped up their consults, I briefly spoke with the women to ask about their pregnancies and perceptions on family planning. It was during this time I gained most of my insight on the widely contrasting experiences women have with family planning elaborated on in the following chapter.

Negative attitudes in the clinic: Maria's first pregnancy test. Moving forward, I will share the conceptualizations of family planning shared by the patients seeking gestational care and the healthcare providers of the clinic. I noticed many factors influence a woman's experience with family planning including religion, gender roles, and immigrant stereotypes. For example, I witnessed the impact of immigrant stereotyping in the UBS during a consultation between a patient named Maria and a female nurse named Lana. Maria, a Bolivian immigrant in the neighborhood that did not speak Portuguese, came into the clinic to take a pregnancy test. A woman registering and checking-in patients asked me to translate for Maria knowing I was fluent in Spanish and communication with Maria would be nearly impossible in Portuguese. When I approached Maria, she was nervous and quiet. We sat next to each other in the hallway of the clinic, but she rarely spoke a word. I introduced myself and offered to translate the appointments with the medical technician, the person recording her personal information, and the nurse. Shortly after, Maria opened up about her life in Brazil, sharing that she had immigrated no longer than a month ago. She moved to the Bom Retiro neighborhood to work in a sweatshop, and this pregnancy came as a complete surprise. She never brought up a husband or partner, and no one

seemed to have accompanied her to the clinic. Her silence not only came from the inability to speak Portuguese, but from the shocking realization would she would become a mother in a new and unfamiliar country.

An hour later, the female technician called Maria's name for her appointment in the triage room. The medical technician sat down with Maria to record her personal information and asked me to translate throughout their interaction. The technician was very grateful for the ability to communicate with Maria, however Lana, the nurse that would soon speak to Maria, asked me to stop translating for her portion of the medical appointment. I reminded Lana of Maria's inability to speak Portuguese, but she insisted the appointment had to continue without any translation. Lana slowly began to speak to Maria; she explained that a slow-speaking Portuguese speaker should be able to communicate with a slow-speaking Spanish speaker, and vice-versa. Lana emphasized the fact that Maria was going to be a mother soon and was now responsible for two lives. Thus, Lana believed Maria should not rely on the help of a translator that would not be present throughout her entire gestation. Lana provided instructions for the urine, fecal, and blood exams Maria had to complete the following day in the clinic. I stood about five yards away from the desk where Lana was speaking to Maria. The medical appointment was not a conversation between patient and provider. Maria constantly looked over in my direction as she struggled to respond, often just nodding her head while Lana continued to speak.

Maria left the triage room with an informational pamphlet on pregnancies given to all women, written in Portuguese, and fecal examination test tubes to use back home. I quickly ran to her as she left the clinic and began speaking to her in Spanish. I asked Maria whether she understood the instructions provided to her in the clinic, to which Maria responded she had understood having to return to the clinic the following morning. I explained the laboratory exams

and provided instructions for the fecal exams the nurse asked her to complete at home. Maria's relief was evident in her facial expression as I continued translating the information given to her. The shock of her pregnancy was still present, but the ability to communicate in Spanish allowed for a sense of comfort and support in a time of major life changes. Maria thanked me for my time and left the clinic. To my surprise, a man was waiting for her outside the gates of the clinic. The man never went into the clinic; I assume he waited for several hours while Maria was attended to inside.

As I walked back into the clinic, Lana quickly approached me to defend her choice to not use a translator, but it still seemed incredibly perplexing to me. Why would Lana choose to make her life and Maria's life much more difficult than needed? Lana showed no sympathy for Maria, an immigrant woman going through a life-changing moment that obviously left her shocked. One would expect a greater connection between a female nurse and female patient given that family planning and pregnancies are often portrayed as female matters. However, Lana failed to connect with Maria as a fellow woman or simply as her healthcare provider. Maria would have left the clinic with almost no understanding of her upcoming exams if I had not approached her after the consultation. Lana insisted immigrant women need to assume responsibility for their actions after getting pregnant. However, she failed to provide the best level of care possible to an immigrant woman attempting to responsibly care for herself and her future child. Lana did not prioritize providing the best level of care possible when refusing to use a translator. Lana's interaction with Maria was a clear example of placing immigrant women seeking care in the clinic into an "other" category that is assumed to be irresponsible.

Maria's story is one of many experiences I continue to elaborate on in the following chapter. I detail the type of women seeking gestational care in the UBS, their conceptualizations

of family planning, the issues associated with categorizing pregnancies as planned or unplanned, and the perceptions of family planning of healthcare providers. In this first chapter, I contextualized the health system (SUS) and the clinic in which I researched the above points. The information analyzed in the first chapter, such as the illegality of abortions, the bulk of reproductive responsibility socially placed on women, and the healthcare professionals the women interact with in the clinic all shape how women describe their pregnancies and their experiences with family planning.

Chapter 2: The Conceptualizations of Family Planning of the UBS Clinic and Patients

Public health researchers associate successful family planning with poverty reduction, improved economic outcomes for women, and reduced maternal mortality (Ewerling, 2018; Cleland, 2006; Ganatra, 2016). These positive impacts make family planning services a priority for organizations such as the United Nations, as is evident in their Sustainable Development Goals of 2015 that sets family planning as a standard for good health and overall well-being (Sustainable Goals, 2015). The United Nations' definition of family planning as "the information, means and methods that allow individuals to decide if and when to have children" contextualizes family planning as a simple term. However, my research in Bom Retiro demonstrated to me that family planning was much more complex in practice. As I joined more medical appointments with physicians and nurses, and visited more homes and workspaces with community agents, I realized members of the community had different ideas about what it meant to plan a pregnancy. Individuals experienced family planning in varying ways given factors such as familial support, sexual trauma and religion. The simple definition I obtained from the United Nations fell short of considering the realities individuals shared with me during interviews or casual interactions.

This chapter demonstrates the nuances of family planning and explains why categorizing pregnancies as planned or unplanned is problematic in Bom Retiro. My second chapter has five sections that detail the family planning discourse of providers and patients, and utilizes statistical data to test claims made against unplanned pregnancies in the clinic. The first section, "Interviewing Providers: Acknowledging Differences Perceived between Planned and Unplanned Pregnancies" provides an explanation of the physicians, nurses, and community

agents that together make up the “providers.” I then discuss their definitions of family planning and the differences in prenatal care most claimed to see between women that planned their pregnancies and those that did not plan their pregnancies. I continue with my second section, “Pre-Natal Medical Files: Gaining a Greater Understanding of the Pregnant Female Patients” to describe why I decided to collect demographic information from medical files and how I gained access to this information. The third section, “Demographic Information of all Pregnant Women Registered in the Bom Retiro UBS”, provides figures and analyses of all 154 pregnant women, including their nationalities, race, and marital statuses. I then continue with my analyses of the data in my fourth section, titled “Unplanned verses Planned: Are there Demographic Differences?.” In this section, I demonstrate that women with planned and unplanned women are far more similar than different, with statistical differences in only one demographic point, marital statuses. Finally, in my fifth section, I provide various conceptualizations of family planning the women shared with me in the clinic. I discuss the implications of having women explicitly state that they do not know what family planning means, gender relations in the clinic, and the interchangeable use of planning, loving, and desiring in discourse. The information presented throughout this chapter aims to demonstrate the harmful implications of categorizing pregnancies as planned or unplanned when residents of Bom Retiro and their healthcare providers think about family planning in different ways.

Interviewing Providers: Acknowledging Differences Perceived between Planned and Unplanned Pregnancies

Healthcare providers of the Bom Retiro UBS: physicians, nurses, and community agents. The Brazilian Federal Constitution of 1988 establishes access to health care as a right of all individuals residing in Brazil (*Constituição da República Federativa do Brasil*, 1988). SUS is the public healthcare system that is available to all Brazilians, regardless of their ability to pay

for private healthcare (Montekio & Aquino, 2011). The SUS networks provides care at the primary, specialist, and hospital levels. The Ministry of Health defines primary care, also known as basic care, as the promotion of health, the prevention of diseases, diagnosis, treatment, and the maintenance of health (*Ministério de Saúde*, 2006). Federal legislators created the Family Health Program in 1992 to help meet the demands for primary care in Brazil (Paim, 2011). Originally a program that worked alongside SUS and focused on maternal and child health, the Family Health Program is now the main way municipal health systems provide primary care (Paim, 2011). Under the Family Health Program, family members residing in the same home seek primary medical care from the same medical team made up of one doctor, one nurse, one auxiliary nurse, and four to six community agents (Paim, 2011).

As I explained in Chapter 1, the Bom Retiro UBS has five medical teams that are made up of one doctor, one nurse, and six community agents. Each medical team serves roughly 4,000 patients per their residential address in the neighborhood. The community agents serve specific streets that belong to the larger residential area of their team. Each of these health professionals play a role in family planning services, including prenatal care. The Ministry of Health defines prenatal care as the health services between the time of conception and the child's delivery that assist in assuring a healthy pregnancy (*Atenção ao Pré-Natal de Baixo Risco*, 2012). Throughout my five weeks of research in the clinic, I joined and observed physicians, nurses, and community agents as they provided prenatal care. My involvement included observing medical appointments between physicians, nurses, and pregnant female patients, as well as joining community agents and nurses when visiting the homes of women that had recently delivered their babies.

I joined three physicians during their medical appointments with pregnant women. I noted that the physicians looked over the results from blood, urine, and fecal exams, went

through ultrasound images, weighed the women, measured their blood pressure, and listened to the fetus' heartbeat once the pregnancies reached 20 weeks of gestation. Dr. Alessandro explained to me that pregnant patients alternate between medical appointments with their physicians or nurses from month to month until the 32nd week of gestation. After this point, the women only see their physicians during their medical appointments every 15 days until the 37th week of gestation. At this point, the women see their physicians on a weekly basis until the delivery of their babies. Once the women reach this stage of their pregnancy, the physicians instruct the women to miss her next scheduled appointment once the baby is born. This absence lets the medical team know when to visit a woman's home and check-up on her health and her new-born baby. The nurse and community agent complete the domiciliary visit together. During this home visit, the nurse takes notes on the health of the baby and explains proper bathing, feeding, and dressing to the mother. Should the home situation or health of the baby be alarming, the nurse then discusses the case with the physician at a weekly medical team meeting. The community agent provides instructions to the mother on registering her new-born baby at the clinic.

Kluthcovsky and Takayanagui describe the community agents as a bridge between the physicians, nurses, and patients (Kluthcovsky & Takayanagui, 2006). They are the translators of the medicalized discourse in the clinic for the members of the community (Kluthcovsky & Takayanagui, 2006). The Ministry of Health implemented the Community Health Agent Program in 1991 and later incorporated the agents into the medical care teams created in the Family Health Program of 1992 (Kluthcovsky & Takayanagui, 2006). The responsibilities of the community agents include domiciliary visits to patients' homes, the inscription of family members to the UBS, and mapping the community as inhabitants move in or move out of their

corresponding streets (Kluthcovsky & Takayanagui, 2006). In relation to family planning, community agents referred to themselves during their interviews as a point of contact for women during their home visits when asked about contraception and family planning. The community agents encourage the women to visit the clinic to obtain more information from the physicians and nurses.

Given the crucial role of physicians, nurses, and community agents in providing proper prenatal care, I decided to research the healthcare provider's conceptualizations of family planning. I also investigated whether the providers perceived a difference in their interactions with women with planned pregnancies and those with unplanned pregnancies. Most healthcare professionals acknowledged a difference in prenatal care between planned and unplanned pregnancies during our conversations. The professionals referred to missing consultations, missing medical exams, and a lack of excitement when elaborating on unplanned pregnancies. Meanwhile, the data gathered from the prenatal medical files showed no statistically significant difference in consultation attendance between women with planned and unplanned pregnancies. Thus, the professionals made claims about unplanned pregnancies that the statistical data did not support. The healthcare professionals have extensive knowledge on the institutional definition of family planning as provided by the United Nations and the World Health Organization, but they are also contributors to the discourse in which irresponsibility and disengagement are automatically associated with unplanned pregnancies. This affects the provider-patient dynamic and discourages women with unplanned pregnancies to share their experiences due to fears about judgment.

Providers' definitions of family planning. Most of the providers that shared their definitions of family planning explained the concept in similar ways. Eleven of the fourteen

providers described family planning as a conversation between partners in which both individuals decide to have a baby when emotionally and financially ready to provide for the child. The providers' definitions often resembled a self-interview process in which they stated the questions a person should ask themselves before having a child. Examples included 1) can I financially support a child and 2) is my partner reliable enough to have a child with? The similarities found in their conceptualizations point to the medicalized practice of family planning as part of their health education. The providers' commonly shared medical background is the reason why providers think about family planning in more analogous ways than the patients I interviewed. Thus, the disparities in conceptualizations are not between different providers, but more so between the providers and patients.

As I will demonstrate later in this chapter, many women do not share the medicalized and institutional definition of family planning like their providers have learned. This makes the categories of "planned" pregnancy and "unplanned" pregnancy inconsistent and inaccurate when attempting to capture the reality lived by the patients. Pre-conceived notions seen in the following section negatively impact the relationship between provider and patient. Without acknowledging the human reality of family planning amid medicalized terms, the provider fails to educate women and their families in an approachable and understanding manner. If providers do not address the gaps between themselves and patients, the words "planned" and "unplanned" will continue to inadequately provide insight on the realities of the women, and will thus fail to provide useful data on the needs of the Bom Retiro neighborhood.

Nurses and physicians: differences perceived between planned and unplanned pregnancies. Every nurse and physician I interviewed acknowledged differences in their interactions with women with planned pregnancies and women with unplanned pregnancies.

Several health professionals described women with unplanned pregnancies as more likely to experience negative emotions and have conflicts with their partners and family members. Most physicians and nurses focused on inadequate prenatal care when woman have unplanned pregnancies. Nurse Lana, a married Brazilian woman mentioned that unplanned pregnancies result in issues such as hiding the pregnancy from family, women becoming mothers before they are mature enough to handle a child, and constant judgment from friends and family. Similarly, Nurse Luisa, another married Brazilian woman stated unplanned pregnancies caused a greater amount of conflicts in the family, financial instability, and emotional challenges. Most healthcare professionals elaborated on issues with attendance and prenatal behaviors when women have unplanned pregnancies. For example, Nurse Lucas, a married Brazilian male, stated that women that do not plan their pregnancies miss their consults and exams more so than women with planned pregnancies. He claimed that unplanned pregnancies tend to not be wanted, and thus the women do not prioritize their prenatal care. Nurse Adriana (married Brazilian woman), Nurse Pedro (married Brazilian male), and Dr. Alessandro (single Brazilian male) all shared similar opinions on the prioritization of planned pregnancies.

However, through my data analysis I found that the providers' claims that unplanned pregnancies meant less adequate prenatal care (based on attendance) was nothing more than a stereotype. Women with unplanned pregnancies did not statistically miss more medical appointments than women with planned pregnancies (see Figure 4 below).[10] In fact, women with unplanned pregnancies had higher rates of appointment attendance than women with planned pregnancies. Every single provider and nurse I interviewed stated women with unplanned

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[10] I conducted my analyses on data I collected from the prenatal medical files of the registered pregnant patients at the time of my research. I explain the prenatal medical files and my analyses in the section "Pre-Natal Medical Files: Gaining a Greater Understanding of the Pregnant Female Patients."

pregnancies had a harder time following through with prenatal care, but this was not evident in the data I collected. The dissonance between the data and the claims show that the propagation of negative stereotypes is not just a patient issue, but rather a clinic-wide, and societal problem that creates a judgmental setting for women that did not plan their pregnancies. The negative discourse of irresponsibility discourages women from confiding in their professionals about their experience with family planning. This proves to be detrimental to the nine-month relationship that is presumably established between a provider and patient during a 40-week pregnancy. In the case of unplanned pregnancies, women that do not feel comfortable sharing their stories with their healthcare providers miss the opportunity of filling in educational gaps on pregnancy prevention and reproductive health. Without this knowledge, women fall into a perpetual cycle of misinformation and risk having more unplanned pregnancies in the future.

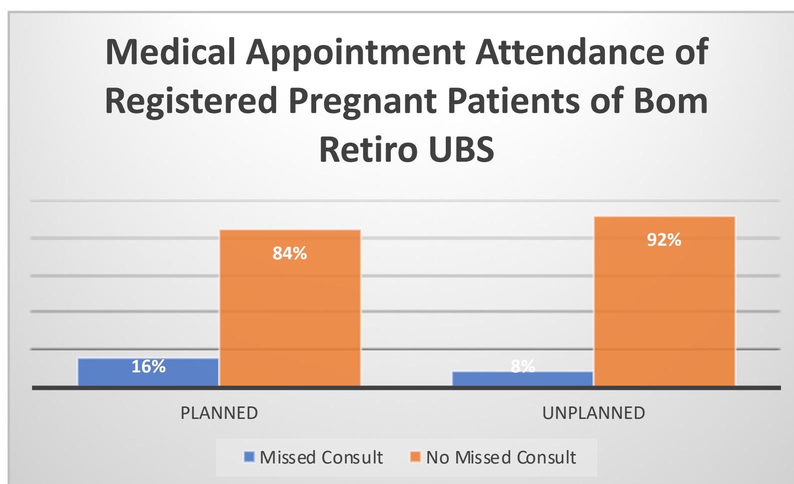

Figure 4. Medical Appointment Attendance of Registered Pregnant Patients of Bom Retiro UBS. The percentage of women with planned and unplanned pregnancies that have missed a prenatal care medical appointment.

Several of the physicians and nurses that spoke about differences in prenatal care brought up a greater male presence in planned pregnancies, but this was not true in my data. This demonstrates that claims about a greater male presence are a product of the discourse embedded

in family planning more than what the providers are seeing in the clinic. Three of the providers explicitly stated that male partners attend more medical appointments when the pregnancy is considered planned. However, my data showed the exact opposite. My statistical analyses made clear that women with planned pregnancies were more likely to be in marriages or stable unions than women with unplanned pregnancies. However, this cannot be interpreted as a greater male involvement throughout the pregnancy in a clinical sense. Throughout my research, I joined medical appointments physicians had with pregnant patients and noted whether these women came accompanied by anyone. If the women did come with someone, I recorded who that individual was. In my five weeks of research, only four men joined their pregnant partners of all 36 medical appointments in which I spoke with the women. All four of these men were with women that had reported their pregnancies as unplanned. The minimal male presence points to the fact that family planning and pregnancies are socially seen as women's issues and responsibilities. Additionally, the fact that all these pregnancies were unplanned demonstrates the inconsistencies between what is happening in the clinic and what providers claim they see in the clinic. Thus, providers are not always making objective claims and show to be susceptible to the discourse prevalent in the community.

My interview with Dr. Cesar (a single Brazilian male) made clear to me that providers, much like their patients, can also interchangeably use the words unplanned and undesired when speaking about family planning. A healthcare professional's medical education provides access to an institutional definition of family planning. However, their medical education does not exclude them as contributors to the language around family planning. When I asked Dr. Cesar to elaborate on the differences he perceived between planned and unplanned pregnancies, he explained to me that women that do not desire their child (instead of saying unplanned)

experience more rejection, do not take their supplements, and do not take their nutrition into consideration. Dr. Cesar claimed women that do plan their pregnancies go above and beyond to ensure the health of their baby. The interchanging between ideas about love, desire, and planning is obvious. I find this exchange problematic due to the negative connotations against unplanned pregnancies. Language is a powerful tool, and in the clinical setting, patients trust providers as a source of knowledge and expertise (Briggs, 2005). There is a vertical relationship in which the provider becomes more powerful than the patient due their ability to interpret the person's body (Briggs, 2005). Since patients deem the provider's interpretation as truth, the provider's words hold great weight in molding a patient's current perceptions of their bodies, and selves including family planning. This presents a situation in which physicians and nurses can either challenge current family planning discourse or maintain current stereotypes. The reality I noted in the clinic points to the latter for now, but recognition of this shortcoming can begin providers' efforts to challenge current notions.

Community agents. Five of the seven community agents I interviewed recognized a difference between planned and unplanned pregnancies in their line of work. The language these agents used to explain the disparities aligned with explanations I heard from the physicians and nurses. As I demonstrated in the previous subsection, my data did not support several claims against unplanned pregnancies, including missing more medical appointments and having less of a male presence. However, what stood out to me from these healthcare providers was that two community agents, both Brazilian women, were the only two providers to not recognize a difference between women with planned and unplanned pregnancies. For example, Susana, a divorced agent argued that the women cannot be generalized into planned and unplanned groups, but rather providers need to consider each woman's situation on a case-by-case basis. In most of

Susana's cases with pregnant women, regardless of whether planned or unplanned, prenatal care has been consistent. Susana elaborated on pregnancies as emotional processes in which a woman's feelings on love and desire can change throughout gestation. My observations of the community agents' work, along with these interview responses, later sparked my interest in utilizing community agents in future programming and legislation to change current attitudes about family planning.

However, in my interview with Monica, I noticed that even in the case of a provider not differentiating between planned and unplanned pregnancies' prenatal behaviors, there was still a divide between Brazilian and immigrant women. Thus, before community agents can be effectively used as the bridge between physicians and patients, they must also recognize the shortcomings of their own language. Monica, a single agent also stated differences in care did not exist between planned and unplanned pregnancies, but they did exist between Brazilian and immigrant women. Monica claimed immigrant women do not seek information about birth control as much as Brazilian women and once pregnant, do not understand the importance of prenatal care. Women from Bolivia and Paraguay were often portrayed as "Others" in the Bom Retiro clinic. As the "Others", these immigrant women were often associated with unplanned pregnancies given the negative associations on the word "unplanned." After collecting and analyzing the demographic data from prenatal medical files, I found Brazilians and immigrant women were just as likely to have an unplanned pregnancy. Thus, the data of the clinic illustrated a different reality than the professionals emphasized in their discourse. Ultimately, within the scope of my five weeks of research, I found claims made about immigrant women as a group of women that did plan their pregnancies as much or care for their prenatal health as

baseless statements that only wrongly divide the clinic into what is Brazilian as planned and responsible, and what is not Brazilian as unplanned, irresponsible, and problematic.

My time with the providers of the Bom Retiro UBS made evident that health professionals hold pre-conceived notions about planned and unplanned pregnancies. The two community agents that saw more similarities than differences between women with planned and unplanned pregnancies were a minority. The grand majority of community health agents, and more generally, health professionals associated unplanned pregnancies with fear, shock, and a lesser priority given to prenatal care. The problematic language around family planning is not unique to either providers or patients, but rather both contribute to the discourse heard and spread in the community. I argue the language around unplanned pregnancies is problematic for a community agent's link of work. As a bridge between the medicalized clinic and the realities of people's lives in Bom Retiro, community health agents serve as valuable tools in attempts to close the gap between provider and patient. As providers of information and services, there is a responsibility to break past stereotyping in the realm of family planning. Should the municipal government try to close the gap between providers and patients, family planning programs should take advantage of the community agents that are constantly exposed to the medical discourse of the clinic and see the realities their patients live. The municipal government should offer training to community agents to explain the family planning services in the clinic to members of the community and share information on planning a pregnancy in the factories and homes of Bom Retiro.

Pre-Natal Medical Files: Gaining a Greater Understanding of the Pregnant Female Patients

I conducted my research in the Bom Retiro neighborhood and clinic for five weeks. This is a limited time to interview women of the neighborhood. I decided to focus my efforts on

pregnant women of Bom Retiro because 1) I was fascinated by the dichotomy the Prefecture created between "planned" and "unplanned", 2) each medical team had a weekly three-hour time block dedicated to pregnant patients, meaning many opportunities to speak with women, and 3) these women were experiencing a facet of family planning with their pregnancies. I had the chance to talk to 36 women during medical appointments while pregnant or consults with their newborn children from the 154 pregnant women registered in the clinic. Women that do not have a high-risk pregnancy have one monthly medical appointment with either a nurse or doctor until the 32nd week of pregnancy. It is at this later point in the pregnancy that visits become more frequent with one visit with a doctor every two weeks until the 37th gestation week. After this point, the consults are on a weekly basis with the medical team's physician until the delivery of the baby. Thus, the opportunity to see all women interact with their providers was very limited within a five-week research timeframe.

The diversity of the neighborhood was obvious upon arrival in Bom Retiro, and I wanted to assess whether this same diversity was evident in the registered pregnant patients of the clinic. In other words, were there certain types of individuals having children in Bom Retiro? The prenatal medical files of all 154 women presented a unique and valuable opportunity to answer my question and gain a greater understanding of the women in Bom Retiro. The files allowed me to interpret data on the women's nationalities, ages, marital statuses, and race among other demographic points I analyze later in the chapter.

Obtaining access to the prenatal medical files. During my first week of research, while passing the registrar office, I noticed medical files grouped together with bright pink tape covering the top of the files. I asked Dr. Alessandro about the taped files that caught my attention, and he explained to me that the registrar labelled all pre-natal medical files with the

pink tape. While pregnant, all women registered in the clinic had two separate medical files, 1) the prenatal file and 2) the general file with all medical information except for their current pregnancy kept in their family's larger file. Given the personal information detailed in the files, I needed prior approval before looking at the files or collected information from the files. This is when I turned to Larissa, the head administrator of the UBS. Larissa knew all the inner workings of the clinic, and the healthcare providers referred to her as their boss. I approached Larissa in her office and explained my interest in the prenatal medical files. I assured Larissa that I would keep all identities private as I recorded the data. Larissa was incredibly supportive, and I began collecting data from the files the following day.

The first page of the prenatal files mainly covered basic demographic information. I decided to focus my attention on the age of the woman, the level of education completed, the woman's race, marital status, and nationality. I chose to collect this information to assess whether women with planned and unplanned pregnancies were significantly different in race, age, education level or other points mentioned above. The information collected on the second page was much more specific to the woman's current pregnancy. The data that stuck out most to me was what kind, if any, of contraception the woman was using at the time of the pregnancy. This page was then followed by a chart in which the provider would detail each of their consultations with the woman. The physician or nurse would write the date of the appointment, the weight of the patient, the measurements of the woman's abdomen area, and information on the heart beat if the pregnancy was over 20 weeks of gestation. The provider would also write down information about fecal, urine or blood exams needed if the patient was beginning the next three months (trimester) of her pregnancy.

Not every file had all this information available. In fact, most files included some demographic and pregnancy-related information, but not all boxes were covered. When I asked providers and staff in the registrar, the most frequent answer was just forgetfulness or overlooking some minor details. Due to this, I gathered all the information I could from each file onto a password-protected Excel sheet. The Excel sheet covered each woman's nationality, age, race, education level, marital status, whether their current pregnancy was "planned" or "unplanned", whether any contraception was being used at the time, and whether any consults had been missed throughout the pregnancy. In cases where the information was not available, I logged in "NA" onto my spreadsheet. I begin my analysis of these cases focusing on basic demographic information, regardless of whether the women reported their pregnancy as planned or unplanned.

Demographic Information of all Pregnant Women Registered in the Bom Retiro UBS

Nationality. In the Bom Retiro UBS, the majority of pregnant women were Brazilian, but only by a small margin. Figure 5 (below) demonstrates the percentage of women that identified as Brazilian, Paraguayan, Peruvian, Bolivian or did not state their nationality, "NA". The percentages reflect the diversity I found in the Bom Retiro neighborhood. 54% of pregnant women (82 women) were Brazilian while 41% of pregnant women (62 women) described themselves as immigrants from either Bolivia, Paraguay, or Peru. Twenty-one percent of all pregnant women reported being Bolivian, making them the largest immigrant population in my research. On a national scale, Paraguayans and Bolivians are tied as the third largest immigrant communities in Brazil as of 2017 (Wejsa & Lesser, 2018). There are roughly 48,000 documented Bolivian and Paraguayan documented migrants, respectively. However, in a country of over 200 million inhabitants, the Bolivian and Paraguayan communities make up a small percentage of the

national population. The large immigrant percentage in comparison to national percentages demonstrates that Bom Retiro was a special place to study how Brazilians and non-Brazilians interact in a Brazilian healthcare setting. My observations made evident that despite the diversity, the community was still divided between Brazilians and the "Others" that resided in the neighborhood.

As seen in Jessica's (the community agent) comments in my previous section, I often heard comments from providers and patients about differences between immigrant women and Brazilians, particularly in the women's levels of responsibility assumed when pregnant. I frequently heard that immigrant women were more likely to have unplanned pregnancies and Brazilian women were comparatively more likely to have planned pregnancies. I collected information on the nationality of the registered pregnant patients in the clinic to statistically test whether immigrant women actually had more unplanned pregnancies. I found immigrant women were not statistically more likely to have unplanned pregnancies. I discuss the implications of my findings in the following section further comparing planned and unplanned pregnancies. For the time being, I recognize the opportunity in Bom Retiro to see Brazilians and "non-Brazilians" interact in such proximity, including in the public clinical setting.

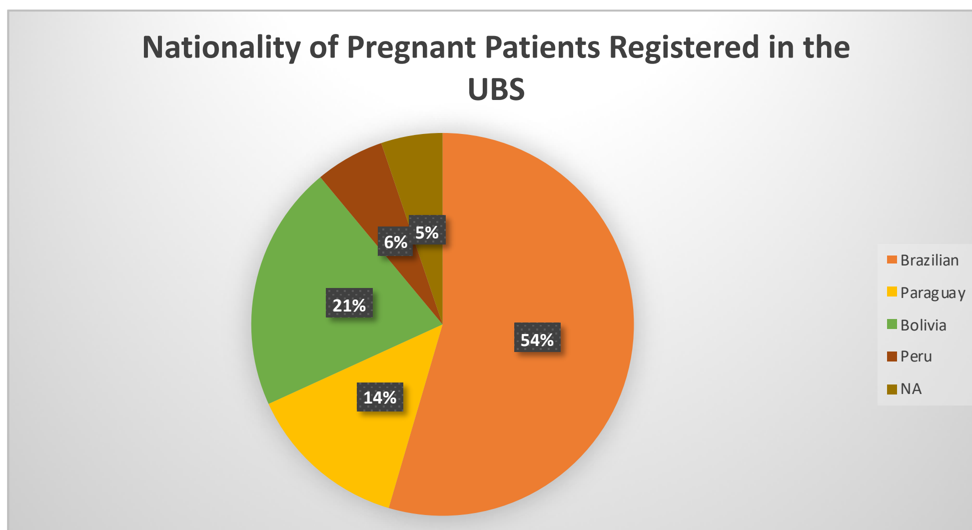

Figure 5. Nationality of the Pregnant Patients of the UBS. A percentage breakdown of the nationality reported of all 154 pregnant women registered for care in the Bom Retiro UBS.

Race. Figure 6 (below) illustrates the race all pregnant patients identified as for their medical file. Most women (58%) reported being *parda*. The IBGE, the Brazilian Institute of Geography and Statistics, defines *parda* as a person that is a racial mix of a black individual and another person of another color or race. Individuals in Brazil can self-report under the *parda* category as *mulata, cabocla, cafuza, mameluca, and mestiça*.[11] The second largest racial group that women stated was *branca* (white). However, there is a large difference in population size with 89 women that reported being *parda* versus the 24 women that said they were *branca*. According to the IBGE, the Brazilian Institute of Geography and Statistics, 51.4% of individuals residing in São Paulo state are *branco* while only 14.5% are *pardo* in a 2008 analysis.[12] Thus, in comparison to São Paulo state, the Bom Retiro neighborhood in São Paulo city has a greater *parda* presence. My time in Bom Retiro made evident that nationality had a much greater impact

[11] Diretoria de Pesquisas - DPE Coordenação de População e ... (n.d.). Retrieved from https://biblioteca.ibge.gov.br/visualizacao/instrumentos_de_coleta/doc3277.pdf

[12] IBGE, Diretoria de Pesquisas, Coordenação de População e Indicadores Sociais, Pesquisa das Características Étnico-raciais da População 2008.

on identity and the grouping of individuals than race in the neighborhood. In many of my conversations, providers and patients either alluded to or explicitly differentiated between Brazilian pregnancies and immigrant pregnancies. However, not a single provider or patient discussed differences between pregnancies of *branca* women and *parda* women. In the presence of a large, concentrated immigrant community, similarities between Brazilians seem more emphasized than their differences. There seemed to be a stronger need to form a national Brazilian identity in the presence of many individuals Brazilians consider foreign and different from their cultures and values.

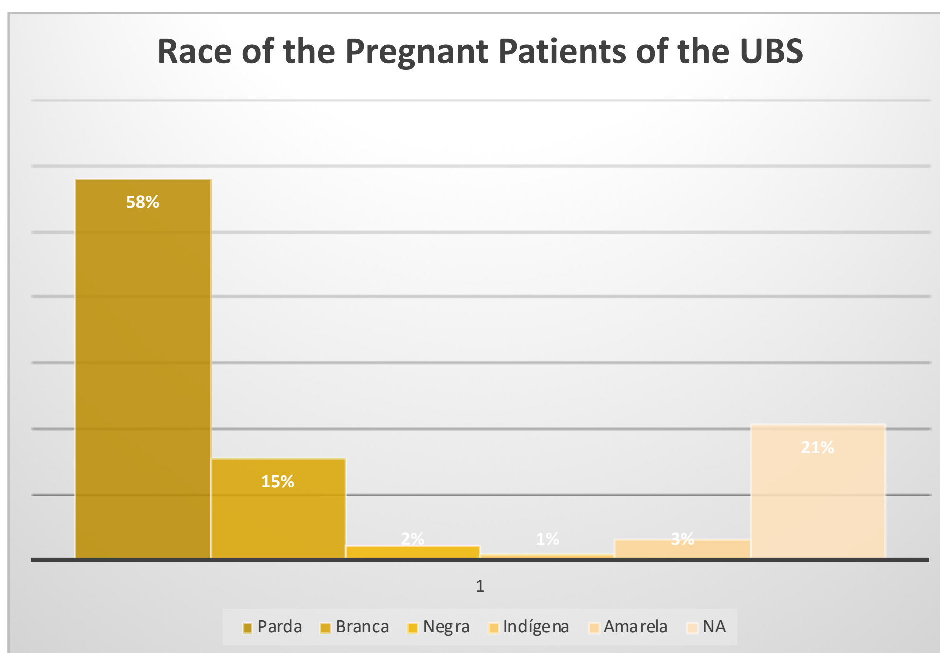

Figure 6. Race of the Pregnant Patients of the UBS. A percentage breakdown of the race reported of all 154 pregnant women registered for care in the Bom Retiro UBS.

Marital status. Figure 7 (below) demonstrates the relationship statuses of all pregnant women. To my surprise, more pregnant women were single (36 women) than legally married (23 women). Most women stated they were in a stable union, defined in the 1994 8,971 Act as the "union of persons either single, judicially separated, divorced or widowed, who have cohabited

for more than 5 years, or who have children in common".[13] Given relationship statuses are self-reported, I cannot assess solely from the responses on paper whether individuals are defining a stable union per these legal regulations. However, the large number of pregnant individuals that reported being in a stable union points to a separation from traditional family values in which married women have children and care for the family at home (Htun, 2003). Family units are seemingly more varied and complex in the neighborhood than simply the traditional definition of a family. Despite the small percentage of women that reported traditional marriages, I noted the traditional gender dynamics of male control over family planning and fertility are still largely dominant in Bom Retiro. I elaborate on gender dynamics in the neighborhood in the final section of this chapter.

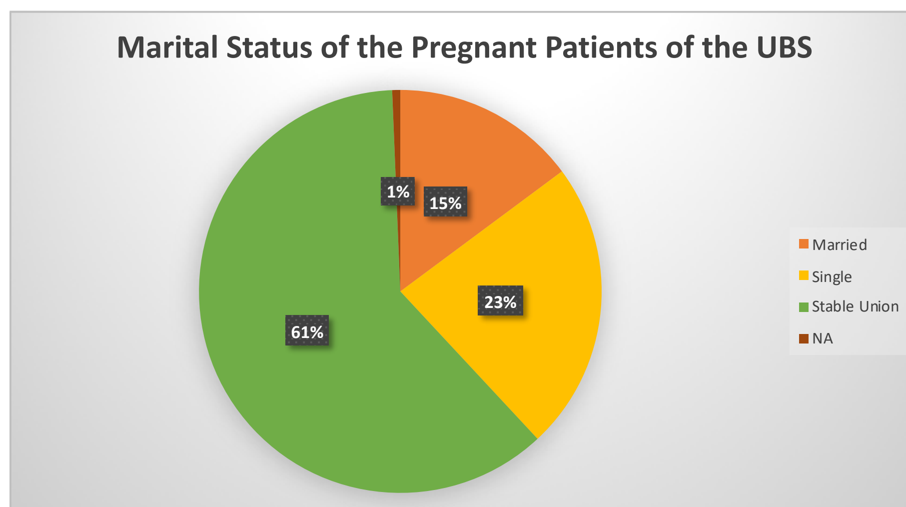

Figure 7. Marital Status of the Pregnant Patients of the UBS. A percentage breakdown of the relationship status reported of all 154 pregnant women registered for care in the Bom Retiro UBS.

[13]Report of the United Nations High Commissioner for Human Rights. (1997). New York: UN. https://www.ohchr.org/Documents/HRBodies/HRCouncil/ProtectionFamily/CivilSociety/ABA-ABLA-ABEP-Cfmea-CLAM-SPW%20(Joint%20submission).pdf

Education level completed. As seen in Figure 8 below, almost half of the registered pregnant women (49%) completed their high school education. A small percentage of women reported continuing onto their college education, with only 3% completing college and another 1% beginning, but not completing their studies. In comparison, the IBGE found that 16.9% of all Brazilian women 25 years or older completed their college education ("Estatísticas de Gênero", 2018). Thus, the pregnant women of the Bom Retiro neighborhood are completing high-level education at much lower rates. It is undeniable that this disparity can be attributed to the large immigrant community residing in Bom Retiro as well as the textile factory-work that dominates the workforce in the neighborhood. Thus, one can infer family planning discourse at the university-level is not influential in the education and daily lives of residents in Bom Retiro. The individuals residing in Bom Retiro are obtaining information on family planning through friends and family members. The data I collected on the education level of the women highlights the importance of addressing the language around family planning in the neighborhood. After all, most of the women utilize their close contacts and healthcare providers as their main sources of information for family planning and family values. As I previously explained, the language that healthcare professionals utilize is critical in shaping common knowledge and perceptions on family planning. In a neighborhood where most patients do not continue onto higher-level education and many did not complete high school, individuals are gaining their insight on family planning from conversations in the community. As leaders and educators, the providers' words carry great meaning and can educate communities where misinformation about contraception and pregnancies are constantly shared between residents.

One example of the importance of providers educating patients is a medical appointment I joined between Dr. Alessandro and a young Bolivian woman that had missed her ultrasound

appointment in a different clinic. The ultrasound images would have allowed Dr. Alessandro to gain greater insight on the baby's health. However, the young woman explained to Dr. Alessandro that she did not get her ultrasound done because she believed ultrasounds were harmful for the baby and can cause birth defects. Dr. Alessandro reassured the patient that having an ultrasound would not cause birth defects and would help them reach the healthiest pregnancy possible. During my interview with this woman, I asked her where she had heard that ultrasounds caused birth defects. She explained to me that she was worried after hearing comments about ultrasounds from the other women that work with her in a textile factory. This interaction between me, Dr. Alessandro, and the patient demonstrates that 1) women are obtaining misinformation from each in the community and 2) if patients feel comfortable enough to share their knowledge and experiences, providers and women can work together to fill the informational gaps on family planning. In the case of this young woman, she is now able to share the information she gained from Dr. Alessandro, a trusted professional given the "power" dynamic previously mentioned, and encourage better prenatal care amongst her friends and local community.

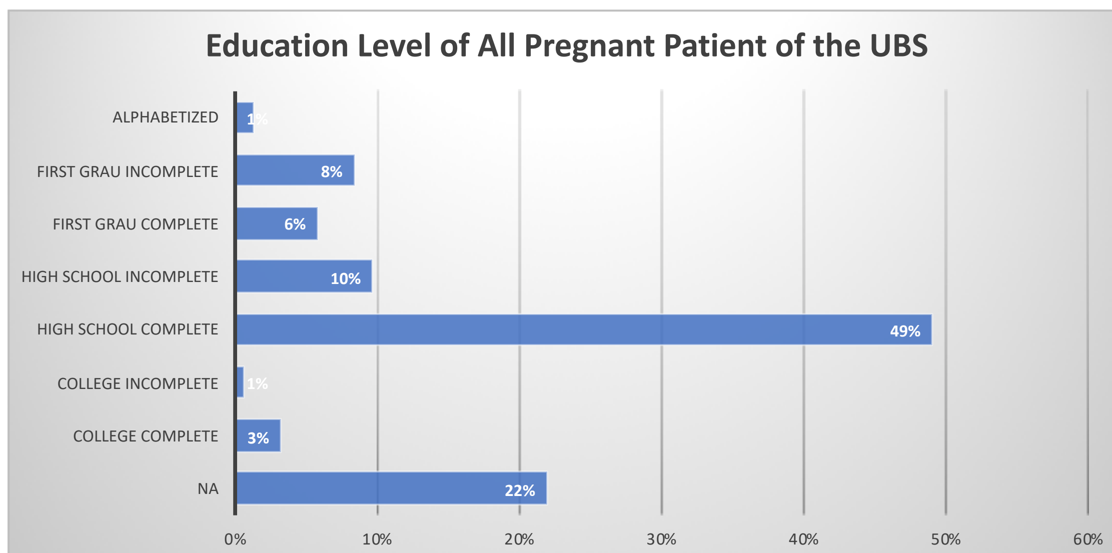

Figure 8. Education Level of All Pregnant Patients of the UBS. A percentage breakdown of the education level completed and left incomplete by the pregnant women registered in the Bom Retiro UBS.

"Planned" versus "unplanned" pregnancies and contraception use. Now, in regards to the current pregnancies of the 154 women, 122 files included whether a woman had planned or not planned her pregnancy. However, in five of these cases, the provider wrote down *planejado* (planned) on one page and *não planejado* (not planned) on another page of the same file. These five cases can be a result of error as physicians do not accurately report pregnancies as planned or unplanned. However, I argue the changing responses go beyond human error. These five cases highlight 1) a woman or a provider's definition of planned or unplanned can change throughout one's experience with family planning and 2) the two categories provided do not adequately describe the experiences of the individuals seeking care in the clinic. As I discuss data regarding planned and unplanned pregnancies, I refrain from considering data from these five cases. Out of the 117 labelled cases, 75 women (64.41% of labelled cases) categorized their pregnancies as unplanned while the remaining 42 women (35.59% of labelled cases) described their pregnancies as planned.

Not only did most women claim to not have planned their pregnancies, most women also said they did not use any form of contraception (see Figure 9 below). Over half of all registered women (51%) explicitly reported not using any form of birth control under the "No Use" category. Meanwhile, only 21% of all 154 women used any form of birth control at the time of their pregnancy. The CIA World Factbook states 80.2% of all women of reproductive age (15 to 49 years old) in Brazil in a marriage or in a stable union use some form of contraception.[14] However, only 16.9% of registered pregnant patients in the clinic in a marriage or stable union used some form of contraception. What happened in Bom Retiro? Why is such a disparity present in my data?

Many other women in stable unions or marriages may be successfully using contraceptive methods the clinic provides. Thus, that is why they have prevented pregnancy and are not a part of the data sample. However, 69% of all women with unplanned pregnancies were in a stable union or married, thus my sample is pointing to potentially lower contraception use in Bom Retiro. However, I need to research clinics in other regions of the country and gather data on more women to strongly claim that women in Bom Retiro use contraception at a lower rate. For the scope of my thesis, the physical access to contraception did not seem to be an issue. Various birth control methods did not seem difficult to obtain given that SUS provides the Pill, male and female condoms, and hormonal injections free of charge in the Bom Retiro clinic. Rather, the transmission of misinformation among women about contraceptive options, cultural expectations

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[14] CIA, C. (2014). CIA World Factbook. *Washington, DC: United States Central Intelligence Agency (CIA).*

placed on Brazilian and immigrant women, and a fear of judgment from a lack of knowledge all play a role in the low rates of contraception use.[15]

For example, one of the Bolivian women that I met with an unplanned pregnancy explained to me that she stopped using birth control pills after her friends had told her that the Pill would either make her a sex addict or make sex very uncomfortable by stopping her genital's natural lubrication. At this point, this woman stopped using her contraception and became pregnant shortly after. The misinformation on contraception and safe sexual practices can largely impact a woman's life, including the risk of having a child when attempting to avoid a pregnancy. The issue not only lies in the fact that that false information exists and that it is spread in the community, but women often do not feel comfortable talking about contraception and what they think they know about their options with their providers. In this case, this woman felt comfortable enough to share her story with me, another young, Hispanic woman who is not native to Brazil. However, this was not the case with her provider as she ultimately decided to listen to her friend's comments rather than reaching out to her physician, nurse, or community agent. Once again, the relationship between provider and patient is critical in avoiding situations of contraception misuse and addressing the misinformation in the discourse of the residents of Bom Retiro.

[15] I elaborate on misinformation, cultural expectations, and education in the following section of this chapter.

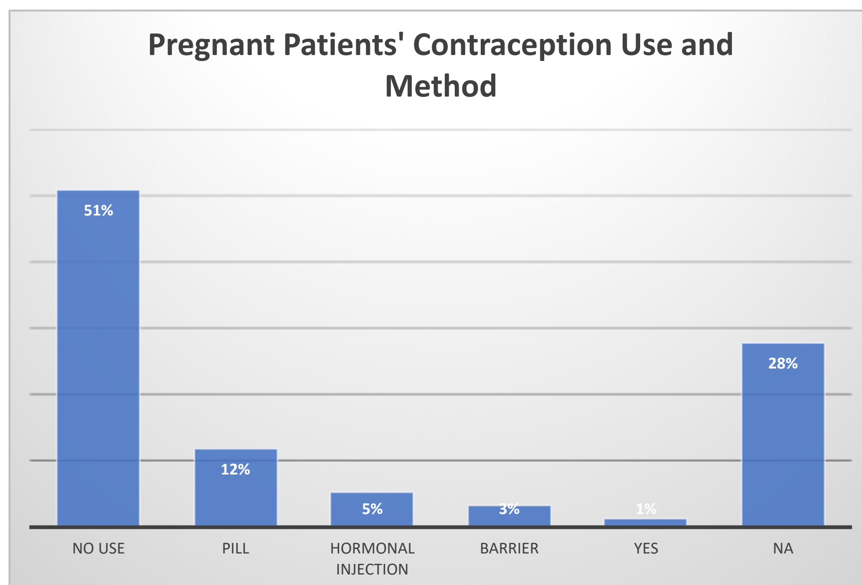

Figure 9. Contraception Use and Method of Pregnant Patients of the UBS. Percentage breakdown of contraception use at the time of pregnancy of all registered pregnant women in the Bom Retiro UBS.

Unplanned versus Planned: Are there Demographic Differences?

I now focus on whether there were significant differences on the demographic points mentioned above between women that planned their pregnancies and the women that did not plan their pregnancies. The goal of these analyses is to identify any factors that differentiated women that plan or do not plan their pregnancies. I took all the data from my Excel sheet and separated the information into two different data sets, "Planned" and "Unplanned" to run different tests of statistical significance.[16] After my analyses, I found women in the "Planned"

[16] I tested for significant differences between women with planned and unplanned pregnancies using Microsoft Excel's Data Analysis Tool pack. To test qualitative data for significance I used two different tests, the chi-squared test and the common odds ratio. To test quantitative data for significance I utilized the Two-Sample t-Test Assuming Equal Variance. The sources below explain the three statistical tests I used.
Cressie, N. A. C., & Whitford, H. J. (1986). How to use the two-sample t-test. *Biometrical Journal*, *28*(2), 131-148.
Greenwood, P. E., & Nikulin, M. S. (1996). *A guide to chi-squared testing* (Vol. 280). John Wiley & Sons.
Lipsitz, S. R., Laird, N. M., & Harrington, D. P. (1991). Generalized estimating equations for correlated binary data: using the odds ratio as a measure of association. *Biometrika*, *78*(1), 153-160.

and “Unplanned” categories were not significantly different from each other in all but one category, marital status. In a statistical sense, my data was mostly “insignificant”, but there is great cultural significance as I attempt to unpack the weight of the words unplanned and planned in the clinical setting. The words planned and unplanned were just labels that separated women that were far more similar than they were different. The labels of planned and unplanned will remain much more problematic than helpful until legislators and providers work together to encourage discussions on family planning and filling in educational gaps for both providers and patients.

Nationality. Of all the demographic information collected, nationality was of most interest to me. No other demographic point was emphasized in conversations with providers and patients as much as nationality. The words planned and unplanned often felt interchangeable with the words Brazilian and immigrant. It is a gross generalization to claim all providers and residents of the neighborhood stereotype immigrant pregnancies as more often unplanned and Brazilian pregnancies as more often planned. However, these comments arose frequently and need to be addressed, especially when the statistical data did not support such claims (see Figure 9). In fact, a smaller percentage of immigrant women described their pregnancies as unplanned than Brazilian women. When considering immigrant women per their nationality, Paraguayan women reported a higher percentage of planned pregnancies than unplanned pregnancies. Paraguayan women, and not Brazilian women, had the highest rate of planning their pregnancies. As was true of all other nationalities, most Paraguayan women with unplanned pregnancies reported not using any form of contraception at the time before their pregnancy. Thus, I cannot

argue that the higher planned pregnancy rate is solely due to a more effective use of contraception. Rather, I attribute the higher planned pregnancy rate to more Paraguayan women describing their pregnancy with greater regard to feelings love and desire than other immigrant women and Brazilians. I do not claim that all Paraguayan women defined their pregnancies in the same way, instead a greater number of Paraguayan women due to the cultural pressure in the Paraguayan immigrant community to feel deep love for a child.

Nationality was not a statistically significant factor that predicted whether a pregnancy was planned or not planned. Now, two principal questions arise from this data 1) do different conceptualizations of a planned pregnancy between Brazilian and immigrant women account for the data, and 2) if Brazilian and immigrant women are not significantly different in their rates of planning their pregnancies, why are such claims still so persistent in the clinic? In my research, I found women conceptualized family planning in numerous ways regardless of their nationality. Thus, a woman's status as Brazilian or immigrant did not determine their thoughts on family planning. Different conceptualizations may contribute to the percentages seen below, but my time with the women in the clinic made clear that women had varying conceptualizations about family planning regardless of their nationality. In regards to my second question, the data I collected and analyzed did not support the claims I heard and noted about differences in family planning between Brazilian and immigrant women. My data sample was limited to the 154 women that the UBS had registered as the pregnant patients. However, from my sample and daily observations I deduce a differentiation in the clinic between what is "Brazilian" and what falls under an "Other" category, namely immigrant residents of Bom Retiro.

The family planning stereotypes originate from negative attitudes towards the immigrant community in Bom Retiro. As seen in Maria's story at the end of my first chapter, in which nurse

Lana refused to use me as a translator for a Bolivian immigrant that had just learned she was pregnant, these attitudes against pregnant women can impact their healthcare and diminish the level of care providers offer to them. For immigrant women that did not plan their pregnancies, there was an intersectionality between the negative associations against immigrants and against unplanned pregnancies. I often heard individuals in the clinic refer to these women as "evidence" of the irresponsibility of immigrants in Brazil. Thus, these women suffered from an isolating discourse in the community that makes gestational care in a foreign country and foreign language even more difficult.

Percentage of Planned and Unplanned Pregnancies by Nationality		
Nationality	**Planned (%)**	**Unplanned (%)**
All Women	35.59	64.41
Brazil	31.25	68.75
Immigrant	38.77	61.22
Paraguay	60	40
Peru	14.29	85.71
Bolivia	33.33	66.67

Figure 10. Percentage of Planned and Unplanned Pregnancies by Nationality

Age. As Figure 11 shows, women that did not plan their pregnancies were not significantly older or younger than the women that did plan their pregnancies. Women with planned pregnancies had an average age of 26.45 years old while women with unplanned pregnancies had an average age of 24.67 years old. Women with unplanned pregnancies were on average younger, but my analysis demonstrated that younger women were not statistically more likely to have an unplanned pregnancy. However, there is cultural significance in my data, and

this is best seen in cases with pregnant teenagers. It came as a surprise to me that the youngest patient described her pregnancy as planned. I did not get a chance to speak with this patient, but I learned through her prenatal files that she was a Paraguayan 14-year-old that described her marital status as in a "stable union." Her profile reminded me of Valeria, another Paraguayan young woman that got pregnant at 15-years-old with who she now considers her stable partner. Valeria openly expressed the difficulties and pain she felt when discovering her pregnancy to me, and it is reasonable to assume another incredibly young mother would feel a similar way. Such a young woman that utilizes the word "planned" can be speaking about her pregnancy in such a way due to family pressures, but it is also a means to avoid judgment as best as possible. This last point is applicable to all the women rationalizing through their pregnancies. This case, along with Valeria's story, demonstrates that very young women are sexually involved and conversations about family planning need to occur from a young age. Healthcare providers are important in providing family planning information, especially when the Brazilian public school system does not include sex education as part of the required curriculum (da Silva, 2014).

Average Age of Pregnant Patients of the UBS		
Nationality and Planned/ Unplanned	**Average Age**	**Standard Deviation**
All Women	25.43	6.1
All Planned	26.45	6.4
All Unplanned	24.67	6.03

Figure 11. Average Age of Pregnant Patients of the UBS

Monthly Income. Of the 154 registered cases, only 81 prenatal medical files had information on the monthly family income in the woman's household. This is a limited sample to draw convincing conclusions from, but this data still highlighted the gap between an idealized

version of family planning and the actual human experience. Ten of the fourteen providers I interviewed mentioned financial stability as a crucial factor when planning a family. Interestingly, women with planned pregnancies reported lower monthly family incomes than women with unplanned pregnancies (see Figure 12). This difference was small and not statistically significant, but the lack of a significant difference also demonstrates the gap between an idealized theory of family planning and what occurs in Bom Retiro. One would expect higher incomes from families with planned pregnancies given the value placed on financial stability, but this is not the reality of the members of the community.

Average Monthly Family Income of Pregnant Patients of the UBS		
Nationality and Planned/ Unplanned	**Average Income (Reais)**	**Standard Deviation**
All Women	2223.46	1138.80
All Planned	2170.0	1048.38
All Unplanned	2326.81	1213.58

Figure 12. Average Monthly Family Income of Pregnant Patients of the UBS

Race. In regards to race, a greater percentage of women that did not plan their pregnancies (66%) were *parda* than women that planned their pregnancies (57%). An equal percentage of women reported were *branca* (see Figure 13). I found no significant difference between women that planned and did not plan their pregnancies based on their race. In other words, there was no association between being *parda* or *branca* for women with planned or unplanned pregnancies. A woman with an unplanned pregnancy was not more likely to be *parda* than a woman that planned her pregnancy. Race was also not mentioned in my interviews with patients or providers. The participants, whether provider or patient, in this health setting did not seem to distinguish or group individuals dependent on race. As I explained previously,

nationality was of much greater importance for the family planning and general medical discourse of the UBS. In the clinic, discussions about prenatal behaviors, including attending appointments and medical exams, and contraception use frequently revolved around distinctions between Brazilians and immigrants.

Individuals in Bom Retiro did not use race as a distinguishing factor when discussing family planning with me. This surprised me given the emphasis on race in Brazil in my academic career. Throughout my Emory career, I have learned about Brazil as a country that struggles with racial inequality at large. Thus, when first arriving to Bom Retiro I expected my conversations with providers and patients to include perceived differences between pregnancies of different races. However, this was not mentioned a single time in my five weeks of research. Ultimately, the lack of racial discourse and the divisiveness in the clinic between Brazilians and those considered "non-Brazilians" demonstrate that citizenship status and nationality are points that must be considered when researchers study healthcare in Brazil.

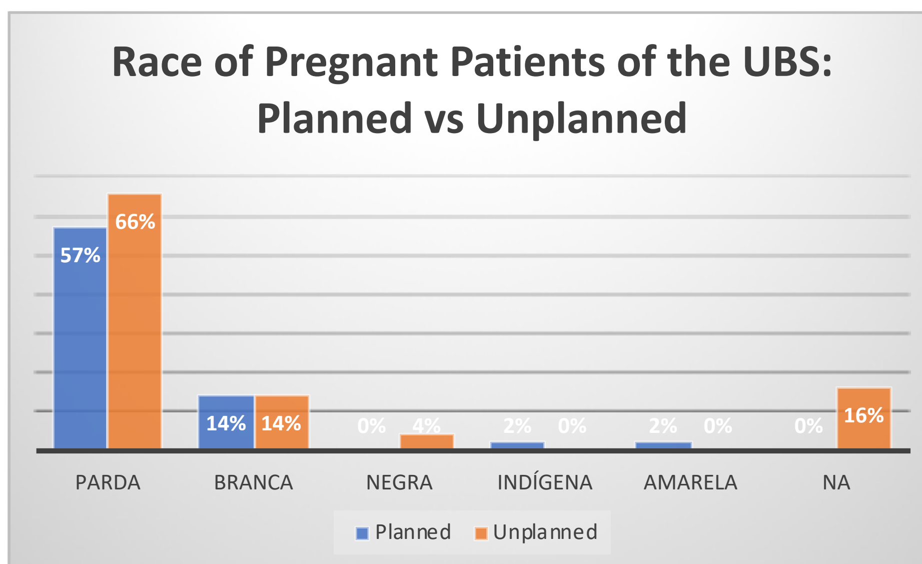

Figure 13. Race of Pregnant Patients of the UBS: Planned vs Unplanned

Marital status. The only significant difference I found between women that planned and did not plan their pregnancies was in their marital status. Overall, 93% of women with planned pregnancies described themselves as being either married or in a stable union. Meanwhile, 70% of women with unplanned pregnancies reported being either married or in a stable union. There was also a large difference in the percentage of women with planned pregnancies that stated being single (7%) than women with unplanned pregnancies (29%). The differences in percentage described above and seen in Figure 13 suggest that more women with planned pregnancies are having children with stable partners than women with unplanned partners. One would assume this translates into greater male involvement throughout the pregnancy and family planning in general in cases of planned pregnancies. However, I did not observe a difference in involvement from fathers depending on the planning status of the pregnancy. In fact, from all 36 women I interviewed during their medical appointments, only four male partners attended the consult. All four women accompanied by their partners described their pregnancies as unplanned rather than planned. Thus, my observations would point to the exact opposite than a planned pregnancy meaning greater male involvement through medical appointment attendance.

There are several factors that must be referred to in these observations. Firstly, given that many residents of Bom Retiro work in textile factories, male partners may not be able to attend to economically support their families. Thus, I cannot fully measure male involvement and participation through their attendance to a medical consult. Secondly, while there is a significant difference in the number of women reporting a stable union or marriage when planning their pregnancies and not planning their pregnancies, the terms themselves are also socially and legally nuanced. Women state their marital status, and all other demographic information, after confirming their pregnancy through a pregnancy test. Thus, it is impossible to know whether

women defined their marital status based on the legal definitions or their own social definitions of being married, in a stable union, or single prior to their pregnancies. A stable union is legally defined as two partners cohabiting for a minimum of five years.[17] However, women that have lived with the same partners for several years may also be identified as a stable union as opposed to being single. Additionally, women in Brazil may not be aware of the legal distinctions between the three marital statuses and may categorize per their own country's legal definitions or social norms. Despite these nuances, my statistical analyses suggest women with planned pregnancies are significantly more likely to be married or in a stable union than women with unplanned pregnancies.

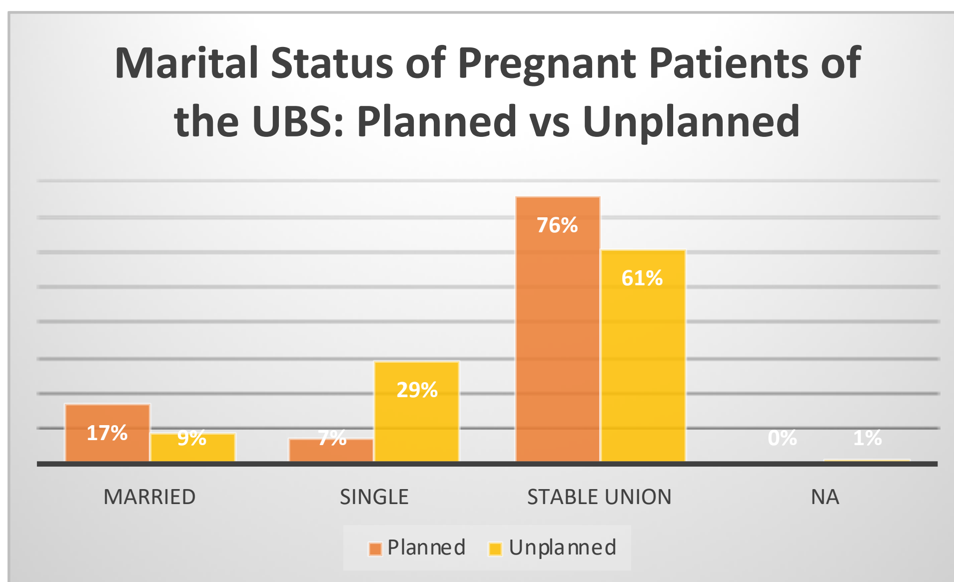

Figure 14. Marital Status of Pregnant Patients of the UBS: Planned vs Unplanned

Education level completed. Given that 49% of all registered women completed their high school education, I decided to test whether women with planned or unplanned pregnancies

[17] Report of the United Nations High Commissioner for Human Rights. (1997). New York: UN. https://www.ohchr.org/Documents/HRBodies/HRCouncil/ProtectionFamily/CivilSociety/ABA-ABLA-ABEP-Cfmea-CLAM-SPW%20(Joint%20submission).pdf

had significant differences in their percentages of completing high school. I found no such difference between the women when categorizing as "High School Complete" or "High School Incomplete". The "High School Complete" category included women that began and/or finished their college education. Meanwhile, the "High School Incomplete" category included women that may have only completed their primary education or were only literate. A larger percentage of women with unplanned pregnancies (51%) reported completing their high school education than women with panned pregnancies (45%). However, the difference is insignificant and women with planned pregnancies were not more likely to complete their high school education than women with unplanned pregnancies.

A woman that completes her high school education can read and understand educational materials on family planning and contraception. Thus, given that women with planned and unplanned pregnancies completed their high school education at similar levels, it cannot be assumed that a lack of comprehension of educational materials is responsible for unplanned pregnancies. Additionally, if women are completing their high school education at similar rates, one would assume women have completed similar lessons on reproductive health and family planning in public schools. However, the current state of sexual education in Brazilian public secondary schools leaves much to be desired. The Brazilian Ministry of Education and Culture includes sexual education in its National Curriculum Parameters what Denise Regina Quaresma da Silva describes as a cross-cutting theme (da Silva, 2014).[18] Meaning, sex education is implemented at the secondary education (high school) level at the discretion of educators as seen

[18] da Silva, D. R. Q. (2014). Sex education in the eyes of brazilian public school teachers. *Creative Education*, *5*(15), 1418.
Brasil (1997). Ministério de Educação e Cultura. Parâmetros Curriculares Nacionais. Brasília: Ministério de Educação e Cultura.

fit with other topics or subjects covered in class. Thus, the women in the clinic that attended and completed their high school education in a public school may have rarely discussed sex or family planning in the educational setting. Despite the lack of significant difference between women with planned and unplanned, the current structure of sexual education in Brazil must be addressed given the low rates of contraception use and high rates of unplanned pregnancies in Bom Retiro.

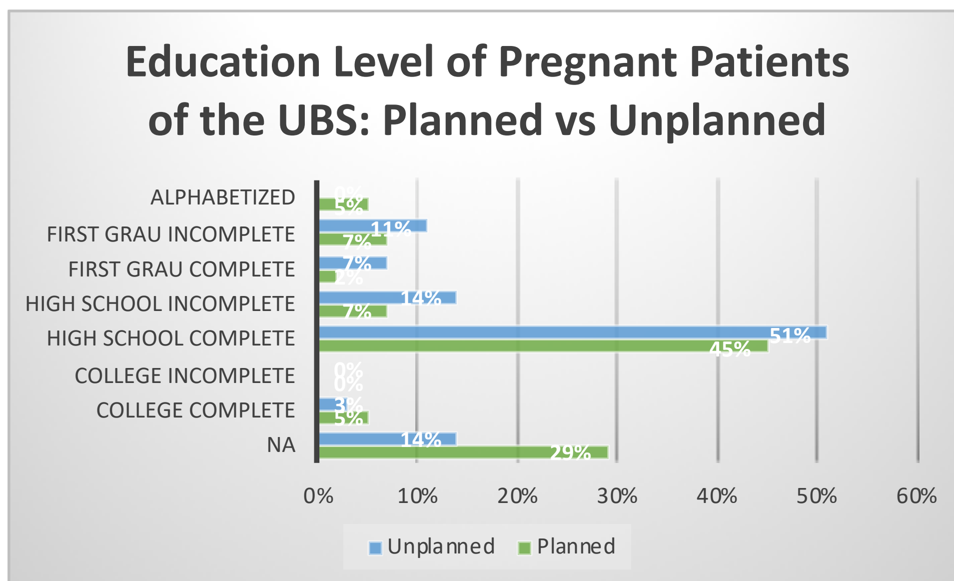

Figure 15. Education Level of Pregnant Patients of the UBS: Planned vs Unplanned

Contraception use. A greater percentage of women with unplanned pregnancies did not use contraception at the time of their pregnancy, but only 50% of women with planned pregnancies reported not using any form of birth control. Another 14% of women that planned their pregnancies also stated they were using some form of birth control during the time of their pregnancy (see Figure 16). To describe a pregnancy as planned while also using birth control is seemingly impossible when considering the act of attempting to have a child. This puts into question the definition of "planned" for the women identifying in this manner. I argue some women described their pregnancies as planned because of the known judgment against

unplanned pregnancies. These women did not plan to have a child, but they do not want their pregnancies to be associated with a lack of love or desire. During my observations of appointments, I noted many women in the clinic that defined their pregnancy as unplanned immediately followed their answers with an affirmation of love or desire for the child despite not planning the child. Thus, there are women that sense a need to justify the feelings they feel towards their pregnancies, and this is a result of current perceptions of not planning a child. These women that want to avoid judgment from friends, family, and their medical team are at risk to continue to incorrectly use their form of contraception and have another unplanned pregnancy. Thus, the problems with family planning shortcomings in the clinic persist.

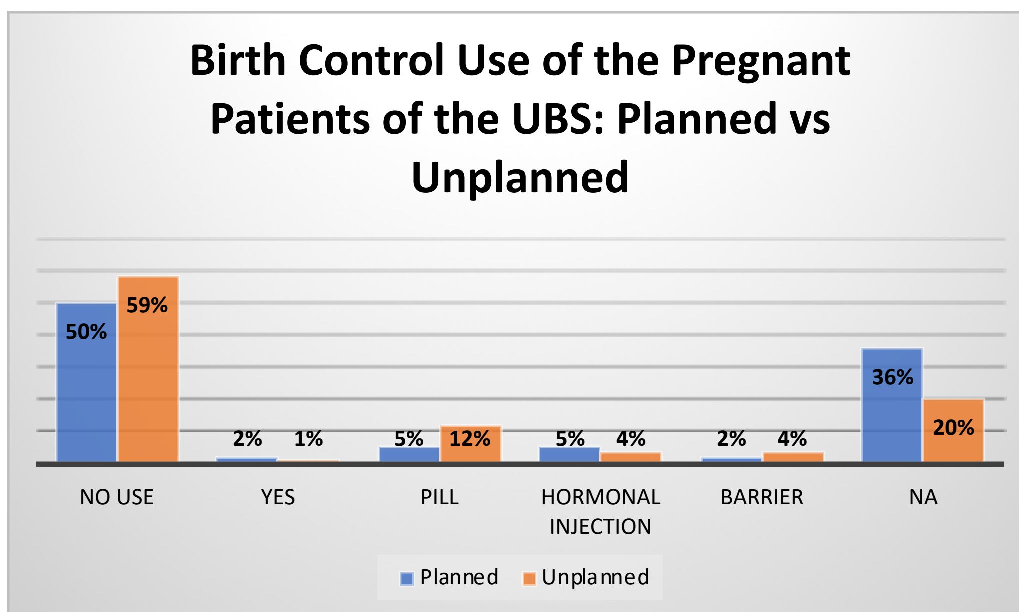

Figure 16. Birth Control Use of the Pregnant Patients of the UBS: Planned vs Unplanned

The Conceptualizations of Family Planning of Female Pregnant Patients of the Bom Retiro UBS

The data analyzed in the previous section demonstrates that women with planned and unplanned pregnancies of the Bom Retiro UBS were far more similar than different. Only one demographic point proved to be statistically significant in differentiating between planned and

unplanned pregnancies. Women with planned pregnancies were significantly more likely to be in stable relationships, reported as either a stable union or marriage, than women with unplanned pregnancies. The data I analyzed begins to unpack the difficulties in categorizing pregnancies. The lack of substantial differences between planned and unplanned pregnancies demonstrate that the negative connotations on unplanned pregnancies do not reflect the reality of Bom Retiro. The connotations are a product of the discourse shared and maintained in the community. The unique, and often emotional, stories women shared with me about family planning were far more complex than the *planejado* (planned) or *não planejado* (unplanned) a provider had written on their medical files.

I spoke with 36 women when their medical appointments with their providers came to an end to gain greater insight on their definitions of family planning and its ambiguities. I joined three physicians during their medical appointments with pregnant women seeking prenatal care. I also joined two nurses in puericulture appointments, consults for recently-born babies. All the appointments began in a similar fashion. The provider picked up the next medical file hanging on a bin on their door and called the patient's name. The patient, whether a pregnant woman or a woman with their recently-born child, entered the room and usually greeted me and the provider. The physician or nurse then introduced me, briefly explained my research interests, and asked if the patient felt comfortable with me joining and taking notes during the medical appointment. If the patient did not feel comfortable, I left the appointment and waited for the next patient to be seen. If the patient agreed to me staying, I observed and took notes throughout the consult about questions patients asked and anything striking about the interaction between the provider and patient. Once the appointment was over, I asked the women whether I could ask them some questions about their pregnancy and ideas about family planning.

I kept my conversations brief given the fifteen- minute time limit providers had for each of their appointments. I focused my questions on the planning status of their current pregnancy, their history of contraception use, and their conceptualizations of family planning. In this section I demonstrate that the women I interviewed did not all share the same ideas on family planning and what it truly meant to plan a pregnancy. I did find three recurring responses throughout the interviews: 1) women did not respond or explicitly stated they did not know about family planning, 2) women described family planning as a joint decision-making process between a partnership, and 3) women interchangeably used love, desire, and planning in their discourse on family planning.

Women that did not have a definition for family planning: acknowledging and confronting informational gaps when providing family planning services. How can women that explicitly stated not knowing what family planning meant label their pregnancies as planned or unplanned? One of the most surprising responses collected in my interviews was the frequency with which women stated that they did not have a definition for family planning. A quarter of the women I interviewed answered in this fashion. Several women sat silently after I asked for their definitions of family planning, and I reassured these women they did not have to answer the question. I focus my discussion on the women that explicitly stated not knowing what family planning meant to them. When I analyzed their demographic information, I noticed the women that answered this way were not significantly distinct when compared to all the registered pregnant patients at the time of my research. Most women reported being in stable unions, had an average age of 23.5 years old, and over half of these women did not use any

contraception at the time of their pregnancy.[19] The lack of a response was not unique to Brazilian women or immigrant women. There were four Brazilian women that answered this way and the remaining five women originated from Bolivia (three) and Paraguay (two).

Despite their lack of a response, all nine women answered whether their pregnancies were planned or unplanned. Five women had unplanned pregnancies, two women had planned pregnancies, and one woman reported her pregnancy was half-planned. The last woman's provider had categorized her pregnancy as unplanned on her medical file. I cannot generate a single explanation on how these women defined their pregnancies, but there are several possibilities I highlight. Some women immediately responded with long pauses or awkward gestures after I asked for their definition of family planning. This suggests discomfort with the topic due to either embarrassment, a desire to avoid talking about planning a pregnancy if the current pregnancy is causing stress, or simply not wanting to share an opinion or story.

Other women were more expressive about not knowing about family planning, as was the case when interviewing a 25-year-old Brazilian woman pregnant with her fourth child. When I asked her to define family planning, she confidently stated she did not know what family planning meant or how to plan a pregnancy given all four of her pregnancies were unplanned. However, by labelling her own pregnancy as unplanned, she is implicitly utilizing her own definition of planned and unplanned. Meanwhile, the woman that described her pregnancy as half-planned also demonstrates a self-constructed categorization of planned and unplanned. I argue women have their own spectrums on which they explain their personal experiences with family planning to themselves. Thus, women claiming that they do not know about family

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[19] As shown in Figure 10, the average age of all registered women in the Bom Retiro UBS was 25.43 years old.

planning are acknowledging the lack of a medicalized definition, but they are still conceptualizing their experiences with family planning in their own ways. These women may not even comprehend or identify their conceptualizations as part of family planning because they do not engage with such conversations with their providers.

The lack of a response from over a quarter of the women reflects a dissonance between the patients and their providers, ultimately pointing to the shortcomings of the current family planning services of the clinic. Family planning is a human experience and providers must encourage women to share their understandings of family planning as well as share definitions that organizations such as the United Nations have produced. Dr. Karen Hardee, a researcher of family planning and current Project Director at the Population Council in Washington D.C. states there is a global need for human rights-based family planning programs (Hardee et al., 2014). In her "Framework for Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights", family planning services are equitably distributed, affordable, and the patients' views are valued (Hardee et al., 2014). This last point is of great importance to encourage women to share their ideas and expand their knowledge of the services available to them.

A group of women claiming to not have a definition of family planning is evidence of a need for greater access to educational materials and resources. When physicians listen, value, and acknowledge women's perspectives, they will also reduce the gap between providers and patients. As seen in my first chapter, the formal, institutional definitions of family planning are associated with many positive outcomes for society including economic development. However, providers and legislators need to consider both the formal terms and the human experiences women have with such terms to create and provide effective family planning programs that expand a community's knowledge on planning a pregnancy and other facets of family planning.

Family planning as a conversation between partners: gender relations in the clinic. Another prominent theme in the discourse of the women I interviewed was the focus on family planning as a conversation between two partners to make decisions about family size. They conceptualized a couple as the most basic unit at which family planning occurs. Once again, most of the seven women were either in stable relationships or marriages, and their average age was even closer to the overall average at 25.14 years old. More women reported their pregnancies as planned, but the disparity is slim with only four planned pregnancies and three unplanned pregnancies. In comparison to the women that did not define family planning, there was a greater number of Brazilian women speaking about family planning in this fashion. Only two of the seven women that focused on the partnership were immigrant women, and both were Bolivian. This majority Brazilian group suggests ideas of family planning as a joint-decision are not as prevalent in the immigrant community of Bom Retiro. However, Brazil is not immune to the gender roles Latin-American cultures have instilled in the home and society. In its ideal form, to describe family planning as a conversation between partners suggests gender equality. One must consider the power dynamics in Brazilian and other Latin-American relationships. Family planning may require a conversation between partners, but my experience in the field demonstrated family planning and pregnancy prevention is still presented as a woman's, rather than a couple's, responsibility.

John Baldwin and Eros de Souza describe Brazil as a machista culture that reinforces a social hierarchy of men over women (Baldwin & de Souza, 2001). This machismo culture is intricately connected to another social phenomenon described as Marianismo, in reference to the Virgin Mary. Marianismo reinforces the image of women as good wives and mothers that are submissive to men in the household (Baldwin & de Souza, 2001). Arrazola and Rocha explain

that these gender roles are embedded in the private and public domains of Brazilian life. In regards to the private space, the home is presented as a feminine space in which women take ownership of household affairs, food acquisition, and child care-taking (Arrazola & Rocha, 1996). The sexual revolution of the 1960s and feminist movements of the 1970s challenged these notions of machismo and the private feminine sphere (Baldwin & de Souza, 2001). Cowan described the 1960s as a sexual revolution that swept through Brazil, through which sex became less taboo and women began consuming birth control at unprecedented rates (Cowan, 2016). The feminist movement of the 1970s also prompted changes in policies to shift away from the women's traditional role to one of greater flexibility and independence (Caldwell, 2017). In regards to healthcare, one of these policies was PAISM, a comprehensive approach to women's health that looked at women beyond their reproductive role as mothers (Diniz, 2012). However, throughout my time in Bom Retiro, I found machismo and the women's traditional role in family life were still influential in the neighborhood. Despite a historical movement away from materno-infantilism in Brazilian healthcare, family planning discourse frequently leaves the responsibility of family planning on women. Paradoxically, men often fixate on controlling the family size, yet women are responsible for preventing pregnancies when not wanted. Thus, women are the vehicles by which men gain control of family planning.

Contraception use was one of the greatest points for control in the power dynamic between men and women in family planning. Several of the women I spoke to had chosen to discontinue their contraceptive method because of their partner's desire to have a child. By not referring to their own desires to have a child, their responses point to the control one partner, most frequently the male, can have over decisions about prevention and fertility. For example, a 20-year-old Brazilian woman described her pregnancy as unplanned. When I asked her to

elaborate on her contraception use, she explained she had stopped taking the Pill because her husband wanted to have a child. In this case, the pregnancy was not categorized as planned because she was not desiring a pregnancy at the time. Her decision to stop taking birth control is rooted in her male partner's desires in having a child, not a mutual desire the partners have at this point in their lives. This is also illustrated in another patient's interview in which she described her pregnancy as half-planned given the fact that she had planned her pregnancy and her partner had not planned her pregnancy. Although this is a reversal of the common power dynamic, it still highlights the elements of control and power that challenge the notion that family planning is a conversation between two equally considered partners.

I also witnessed the prominent presence of these traditional gender norms in family planning in several interviews a special community agent conducted with couples seeking either a vasectomy or tubal ligation. The community agent interviewed two Brazilian couples for tubal ligations and one immigrant couple for a vasectomy. The immigrant male partner stated that he wanted to move forward with a vasectomy because he knew they were less invasive and less painful than tubal ligations. Meanwhile, both Brazilian couples wanted a tubal ligation. When the community agent asked for their reasoning despite longer recovery times and a greater amount of pain, the couples elaborated on the woman's role in assuming responsibility for pregnancy prevention. One of the men also explained the sense of masculinity associated with being able to fertilize a woman. These interviews are clear examples of the gender roles that remain dominant in the family planning discourse. Thus, the machismo and Marianismo Baldwin and de Souza described are still embedded in the language of family planning.

Within the realms of the clinic, I only saw four men accompany their partners to prenatal medical appointments in my entire five weeks of research in Bom Retiro. It must be noted that

individuals may have jobs in factories or within sales that do not allow for time off to attend these consults. Paternal investment can be shown in numerous ways outside of the UBS, and my research is limited in its understandings of paternal involvement in the home. However, at face value, the small amount of men present in the consults suggests that the responsibility of assuring a healthy pregnancy lies on women. Of the four men present in the consults, only two were engaged in conversation with the providers and asking questions about prenatal care. The two engaged men in the medical appointments reflect the disparity in responsibilities assumed between men and women in prenatal care, one of the components of family planning. Ultimately, family planning cannot be a conversation and decision between partners without recognizing and eradicating the unequal expectations and roles socially imposed on men and women.

Love and desire: the seemingly interchangeable nature of planning and loving in family planning discourse. Unpacking the family planning discourse in the clinic inevitably leads to ideas of love, wanting, and desire. Nine women focused on family planning as having a child when there is a strong desire and love for a future child. These women interchangeably used the words “planned”, “wanted”, and “loved” when elaborating on the experience of planning a pregnancy. The demographic information I collected demonstrates the average age of these women was 25.88 years old and all women were in stable relationships or marriages. Five women were Brazilian while the remaining four were immigrant women originating from Bolivia (two) and Paraguay (two). Thus, there was no strong distinction between Brazilian and immigrant women when uniting the concepts of planning with wanting, loving, and desiring.

Interestingly, all but one of these women defined their own pregnancies as unplanned. The women that focused on desire when discussing family planning were more likely to not have planned their own pregnancies. This suggests their pregnancies came at a time when they did not

desire a child, which may explain the emphasis on these terms. Given that family planning is a human experience, emotions such as love and desire are intricately related to pregnancy. However, interchangeably using love and planning further propagate the negative stereotypes on unplanned pregnancies. Pairing the words unplanned and unwanted contributes to the images of unplanned pregnancies as ones of neglect, disregard, and regret. Not all unplanned pregnancies are not loved or desired, and to group all women into large categories with strong emotionally charged words maintains the misconceptions surrounding the pregnancies labelled as unplanned.

The National Survey of Family Growth (NSFG) of the United States defines and separates the terms unintended, unwanted, and mistimed pregnancies in their research. A mistimed pregnancy is one in which the woman wanted a pregnancy, but not at the time of their pregnancy (Stanford et al., 2000). An unwanted pregnancy is one in which a woman did not want any more children for the rest of their life and is now pregnant (Stanford et al., 2000). Finally, an unintended pregnancy is a wider conceptual umbrella under which the NSFG includes mistimed and unwanted pregnancies. Unintended pregnancies are associated with higher risks of elective abortion, inadequate prenatal care, poor health behaviors, and problems in child development (Stanford et al., 2000). However, the NSFG has done little research on how these terms relate to a woman's life and the situations in which they find themselves when pregnant. Several of the women I interviewed made an effort to distinguish between mistiming their pregnancies and wanting their pregnancies. For example, a 27-year-old Paraguayan woman described her pregnancy as unplanned, but also mentioned wanting a child, just not at the moment of her pregnancy.

The dissociation between planning and wanting became even clearer to me after interviewing a 41-year-old Brazilian woman that consulted Dr. Alessandro after not hearing the

baby's heartbeat in her last ultrasound. Dr. Alessandro explained that she may be experiencing a spontaneous abortion, to which the woman responded with teary eyes, stating she would pray for the health of her child. If the terms unplanned and unwanted were truly interchangeable, such a reaction would be trivial, but not planning a pregnancy does not eradicate all possible feelings of love and desire a woman can have throughout her pregnancy. One cannot deny the words planned and unplanned illicit strong positive and negative emotions, and all positive feelings are often associated with planned pregnancies and all negative emotions with unplanned pregnancies. This is problematic and a disservice when attempting to achieve a more human approach to family planning services.

Miranda: sexual trauma in cases of planned pregnancies. Love and wanting are not the only emotions that can result from a pregnancy, providers must also take into consideration the negative emotions that can result from pregnancies women consider planned or unplanned. One of women I interviewed, named Miranda, surprised me with her response when I asked her to define family planning. Miranda immediately stated family planning meant sexual trauma. Dr. Stephen Joseph defines trauma in Psychology Today as a deeply disturbing or distressing experience (Joseph, 2012). Now, in Miranda's narrative, sexual trauma included loss and pain for both planned and unplanned pregnancies. Miranda's story highlights why interchangeably using "planning", "loving", and "desiring" is incorrect. The common family planning discourse I heard wrongly associated all negatives with the term unplanned and all positives with the term planned. In Miranda's case planning a pregnancy did not avoid feelings of rejection and fear, demonstrating family planning is an emotional experience that goes beyond the associations recognized in the language of providers and patients.

I met Miranda after a community agent brought her to the clinic in hopes of encouraging her to continue seeking medical care. Dr. Cesar explained to me that Miranda had a high-risk pregnancy and missed most of her consults. I joined the medical appointment between Dr. Cesar and Miranda, and noted she was quiet and reserved throughout their time together. Once the appointment was reaching its end, Dr. Cesar suggested Miranda should seek psychological care, to which Miranda agreed. Miranda expressed her concerns about her current pregnancy, stating she did not feel any desire for the child and did not want to deliver her child. This was the only medical appointment I joined in which I heard an explicit rejection of the pregnancy. It surprised me to hear Miranda's comments given that she described her pregnancy as planned to me. In fact, Miranda described all five of her pregnancies as planned, except for her first one. Miranda shared her painful story with me during the interview I conducted. Miranda's narrative highlighted the fact that planning a family is a human experience that can be emotionally tolling for the women living through these moments.

Throughout our interview, Miranda detailed the struggles she faced with each of her pregnancies and elaborated on a unique phenomenon she described as planning her pregnancies to the point of causing a premature delivery. According to her discourse, planning a pregnancy was emotionally powerful enough to affect a woman's body and physiological health. Miranda began her story with family planning with her first sexual experience with her partner, through which she became pregnant for the first time. Her partner began beating her while she was pregnant and abandoned her once their daughter was born.

Miranda's first pregnancy occurred right after her first sexual experience with her partner. Her partner began beating her while she was pregnant and abandoned her once their daughter was born. Her abusive relationship with her partner resulted in an initial rejection of her

daughter until she eventually opened-up to her baby. When attempting to have her second child, Miranda had two miscarriages, one of which happened at five months pregnant. Miranda vividly remembered seeing the mangled pieces of her baby being taken out of her body. Despite the gruesome memory, Miranda desperately wanted a second child. She remembered singing songs about having a baby boy throughout her pregnancy, but her second child passed away just three days after the delivery due to high blood pressure issues. As Miranda continued to speak about "planning" her child, she frequently mentioned the power of her desire and longing for more children. Miranda shared that she had wanted and planned for her third child so hard that she made the boy arrive early at 5 months old. She shared spending every day in the hospital with her child until he was large and strong enough to be sent home. Her fifth and final pregnancy was extremely challenging for her, she felt severe psychological stress at the thought of her child being born. This is her first time sincerely not wanting a baby since her first-born daughter. To my surprise, she described her most recent pregnancy as planned and did not attribute her trauma and distress to a state of being planned or unplanned.

Overall, my interviews with the women of Bom Retiro highlighted the need for more conversations between providers and patients to expand knowledge on family planning, challenging existing gender norms, and an acknowledgment of the emotionally charged words frequently used in family planning discourse. In Miranda's case, planning her pregnancy did not avoid pain or suffering. Her story is a strong and saddening example of the impact the emotions associated with family planning and pregnancies can have on a woman's life. Providers must consider the connotations of words commonly spoken in the clinic and challenge patients to think about the negative stereotypes maintained in their discourse. Given that family planning is a human experience, it is also an emotional experience. When caring for pregnant patients,

administering contraception, and providing educational materials in the clinical setting, one must remain conscious of the power of their words and the emotions they can evoke. Women that explicitly state that they do not know what family planning means may be unfamiliar with the institutional concept described by the United Nations and other international organizations, but they have conceptualizations of the experiences they are living when avoiding or attempting to get pregnant. Physicians, nurses, and community agents need to encourage women to share their experiences to connect the informational gaps between the term "family planning" that seems foreign and sophisticated to these women and the realities they live when having children. Without these conversations, patients and providers fall into a cycle that ultimately lead to more unplanned pregnancies and greater economic and social strains of these women that will greatly benefit from talking about family planning with their providers.

Conclusion

Throughout my thesis, I demonstrate that 1) there is a gap between how providers and patients conceptualize family planning, 2) this results in informational discrepancies and helps maintain negative stereotypes in discourse and 3) the government-established dichotomy between planned and unplanned pregnancies inadequately provides insight on the realities of the women of Bom Retiro. In my five weeks of research, I spoke with pregnant women in the clinic and realized they had their own unique stories about family planning including sexual trauma, the hardships of being an immigrant woman in a new country, and the judgment experienced as a young teenage mother. These experiences shaped how these women described their pregnancies and made evident to me that their realities were far more complex than "planned" or "unplanned" categories. Thus, women and their healthcare providers are using the same terms, planned and unplanned, but are often communicating disparate ideas with family planning.

The gap between providers and patients inhibits the exchange of information and disallows conversation that challenges stereotypes against unplanned pregnancies and immigrant women in current discourse. For example, providers often associated unplanned pregnancies with less adequate prenatal care and immigrant women with irresponsibility and unplanned pregnancies. However, my data analyses demonstrated these claims were not true and proved that providers also have stereotypes in the ways they think about family planning despite their medical training. These stereotypes and their resulting actions, such as Maria's case in which Lana refused to use a translator to "promote responsibility" discourages women from sharing their stories with their providers or describing their pregnancies as unplanned in the first place. This can lead women into a perpetual cycle of misinformation in which women continue to have unplanned pregnancies and misuse contraception. Providers need to recognize the gap and the

negative stereotypes in their discourse to improve their relationships with their patients, and ultimately improve family planning services in the clinic.

The municipality's current dichotomy of planned and unplanned pregnancies is not indicative of the reality seen in the clinic, as is clear from the fact that women with planned pregnancies and unplanned pregnancies were statistically far more similar than different. When I asked women to categorize their pregnancies, several women used words such as half-planned or planned by one partner and not the other. Meanwhile, other women attributed the planning of their pregnancies to God. In another five cases, pregnancies were described as both planned and unplanned in the same prenatal medical file. Even the women that did report their pregnancies as one or the other were not accurately represented through these categories. For example, there are women that described their pregnancies as planned to avoid the negative associations against unplanned pregnancies. This was made evident to me when only 50% of the women that described their pregnancies as planned reported not using contraception at the time of their pregnancy. Some of these cases could have resulted from a lack of knowledge or misinformation about birth control use, but I argue most of these cases occurred due to current perceptions on not planning one's pregnancy. It is evident that the current dichotomy does not address these complex dynamics and does not provide useful information about the women being served in the public clinics.

Now, I do not suggest the elimination of words such as planned and unplanned from our language when thinking about family planning. The compelling evidence in favor of family planning services make conversations about family planning at the State, providers, and individual levels an important aspect of care. Public health researchers attribute family planning intervention programs in underserved communities with greater economic opportunities for

women and their families, and reduced maternal and infantile mortality (Cleland, 2006; Ganatra, 2016). It is indisputable that successful family planning services improve the lives of millions of individuals that have gained access to contraception and education on pregnancy prevention and conception when desired (Cleland, 2006; Ewerling, 2018). Therefore, I do not argue that the solution to the existing gap between providers and patients is to eliminate the words planned and unplanned from our vocabulary. Additionally, replacing the current dichotomy with another set of categories, such as intended and unintended, would not remove the connotations made to one group versus the other. Rather, I argue that providers need to engage their patients in conversations that go beyond categorizing pregnancies. Medical files created by the State should include questions that encourage conversations, including whether a woman was using contraception at the time of her pregnancy, the frequency at which she utilized her birth control method, where she obtained information on her contraception, and if she was not using any contraception at the time, what was her reasoning for this decision. These are the types of questions that can provide insight on informational gaps that either the provider or patient may have. Providers may not be aware of some common misinformation spread in the community while patients may not be aware of their misuse of contraception if they do not feel comfortable enough to talk to their providers.

Legislators can optimize the success of their family planning services by training healthcare professionals and creating guides that help start conversations between providers and patients. I propose training community agents to encourage their patients to seek more information on family planning and talking to their physicians about planning pregnancies. To utilize categories such as planned or unplanned, the residents of Bom Retiro and their healthcare providers need to be better informed about what planning a pregnancy means to each other and

themselves. This does not mean ignoring every woman's personal experiences with family planning in favor of a more medicalized definition, but rather enhancing a woman's personal experience with information on pregnancy prevention and conception. Conversely, physicians and nurses enhance their views of family planning with greater consideration to the fact that their patients think about family planning in different ways than themselves.

One of the most striking components to me about public Brazilian healthcare was the providers' visits to factories in which the workers were largely immigrant men and women. Physicians, nurses, and community agents worked together during these visits to provide care to as many people working in the textile factories as possible. I propose a similar factory visit with community agents to present information on family planning alongside physicians and nurses. This way, large groups of individuals can be educated, especially immigrant populations that are most susceptible to negative attitudes in the clinic about irresponsibility and a lack of information. Given the fact that the bulk of reproductive responsibility lies on women, agents can plan initial visits specifically for the women working in these sites.

In regards to negative stereotypes against unplanned pregnancies, it is difficult to eradicate every resident's preconceived notions, but efforts to tackle some perceptions can begin in the clinical setting. Unplanned pregnancies can cause fear, shock, and conflicts in the lives of many women, but to stereotype all women as irresponsible throughout their pregnancies without addressing these connotations is wrong and problematic. Physicians and nurses need to recognize the power of their words in the clinical setting, and make a conscious effort to address these stereotypes with the women seeking gestational care. Women with unplanned pregnancies need to feel comfortable with the healthcare professionals they regularly interact with during their pregnancies. Patients and healthcare providers establish a nine-month relationship in which they

can work together to fill in informational gaps about family planning to avoid unplanned pregnancies in the future. Ultimately, these conversations will not only educate women in their next experiences with family planning, but will also educate healthcare professionals on better serving the women they see in the UBS.

Strengths, Limitations, and Future Directions

As a foreign, Spanish-speaking researcher in Brazil, I had strengths that provided unique insights, but also had limitations in the scope of my studies. I did not arrive to Brazil with the intention of developing a project that was so deeply connected to the stereotypes against immigrant women in the clinic. However, the fact that I am a young, Hispanic woman in a country that isn't my own and a native Spanish-speaker allowed me to connect with the immigrant women and hear more about the struggles they faced in the clinic. My identity allowed me to immerse myself in a sector of the clinic that other Brazilian, native Portuguese-speakers had not been able to relate to as well. Conversely, I faced the challenge of attempting to connect with Brazilian women while being a non-native Portuguese speaker who was still learning the local jargon. This made it challenging to formulate questions that would prompt women to address my main research questions. However, this was a challenge I overcame, and I was still able to engage both Brazilian and immigrant women in conversations about family planning.

My conversations and my data analyses covered various demographic points of the registered pregnant patients, including nationality and marital status, but there are still points that my research alone cannot answer. Time was a limitation to my research, and a second, longer stretch of time in Bom Retiro would strengthen my results. I took advantage of my five weeks and collected information on all the women seeking care during that time. However, I was not

able to interview all the registered patients. Additionally, I was only able to collect information on the one initial consult for the women that had just begun their prenatal care in my five weeks. A greater amount of time in the clinic, preferably more than nine months, would allow me to collect more data on appointment absences and statistically test whether women with unplanned pregnancies are more likely to miss their consults. I would also conduct research in primary health clinics (UBS) of other regions of Brazil, including the Northeast and South to compare Bom Retiro to the remainder of the country and understand conceptualizations of family planning on a national scale.

Some of the questions that my research cannot adequately answer include 1) the role of social class, 2) the role of religion, 3) whether the women of Bom Retiro use less contraception than the national average, and 4) the role of race beyond Bom Retiro. The women I spoke to in the clinic mostly shared the same occupation as either a seamstress or clothing salesperson in the neighborhood. Thus, my exposure to women in other fields and other social classes was extremely limited. Additionally, I did not speak to women that could afford private healthcare, and chose to not use the public health clinics. Thus, future research should consider private facilities as well as public clinics to assess whether women in higher socioeconomic classes also have a gap between themselves and their providers in their conceptualizations of family planning. Women in higher socioeconomic classes may have a greater understanding of the medicalized concept of family planning. However, I argue women also undergo unique experiences that alter their understandings of planning a pregnancy, regardless of their socioeconomic status.

In my time in Bom Retiro, my exposure to religion was limited to the women that described their pregnancies as planned by God. Future research should explore the role of

religious institutions in women's understandings of their bodies, pregnancies, and family planning. Did some of the women of Bom Retiro describe their pregnancies as planned because their religion looks down upon unplanned pregnancies? Based on my limited exposure, I believe more data would demonstrate that religious pressure does affect how some women describe their pregnancies. For now, my research shows that religion contributes to the inadequacy of the categorization of pregnancies as planned or unplanned. As seen in the case of women that claimed their pregnancies were planned by God, there is a discrepancy between women that believe God plans pregnancies and providers who believe romantic partners plan pregnancies. Thus, future research should explore the impact of religious materials, education, and sermons on the conceptualization of family planning.

Now, in my second chapter, I demonstrate that over half of all registered pregnant women reported not using any form of contraception at the time of their pregnancies. In fact, 51% of all pregnant women explicitly stated that they did not use any contraception. Meanwhile, the CIA World Factbook states 80.2% of all Brazilian women of reproductive age that are in a stable union or marriage use contraception. This disparity leads to the following questions: 1) do the women of Bom Retiro use contraception less frequently, and if so, why, 2) how did the CIA World Factbook collect this information, and 3) would the national percentage stay as high as 80% should other researchers conduct more work in clinics across the country? The current State-produced documents do not ask women about the frequency of contraception nor how accurately a woman should use birth control to classify herself as a user of contraception. Just like the dichotomy between planned and unplanned pregnancies, asking a woman whether she uses contraception is also a complex question that researchers need to unpack.

I also demonstrate in my second chapter that race was not mentioned in the family planning discourse of Bom Retiro. In the presence of the large immigrant community of the neighborhood, the similarities between Brazilians were much more emphasized than their differences. This surprised me given the prominence of race in discussions I have had throughout my academic career in Brazilian studies. Future research should address whether discourses in clinics across Brazil with smaller immigrant communities or greater racial diversity fixate more on race. Given my academic background in Brazilian studies, it would be interesting to note whether *parda* and *negra* women are associated with unplanned pregnancies and irresponsibility when immigrant communities are not as large as those in Bom Retiro.

Lastly, I propose community agents as the best healthcare professional to serve as a bridge between physicians and patients. However, future research should study who residents of Bom Retiro feel most comfortable confiding in and seeking information from in the clinic. This information can be collected via interviews with patients of the clinic and more observations of the conversations had during medical appointments and community agents' home visits. Additionally, future research should explore how and where women seek family planning information in their communities outside of the clinic, especially due to a lack of a nationally standardized reproductive health curriculum. This research on the dynamics between patient, providers, nurses, and community agents, and the community will aid in the development of effective family planning programs.

Appendix A

Common Questions for Female Patients during their Medical Appointments

One of the most valuable experiences throughout my time in Brazil was the opportunity to meet and discuss family planning with the women attending medical appointments in the clinic. I wanted to conduct my research in a dynamic and inclusive manner, and the conversations I had with these women made my goal possible. Most of my conversations occurred when I joined physicians and nurses during medical appointments with pregnant patients. I also spoke with some women that brought in their young babies and children for check-ups, called *puericultura* appointments. In both types of appointments, the physicians and nurses introduced me to the women and I asked whether they felt comfortable answering some questions for my research. Despite the time constraints per appointment, I aimed to make my interviews feel like conversations, and thus conducted semi-structured interviews. I knew the women may feel hesitant to share personal information about their pregnancies and contraception, and thus wanted the interview to feel as natural as possible. To do so, I created a set of standard questions and then continued to ask a few more questions that flowed naturally during the conversation.

As a native Spanish speaker, I offered to ask all questions in either Spanish or Portuguese to the women. I found my proficiency in Spanish to be immensely helpful when connecting to the immigrant women during their appointments. In fact, speaking in Spanish added a sense of comfort and confidentiality in cases where the physician or nurse in the room did not speak Portuguese. Through these conversations I gained first-hand accounts of immigrant women's experiences in a clinic in which the discourse from Brazilians often associated them with irresponsibility and unplanned pregnancies.

Questions I asked to women seeking prenatal care:

1. What is your name?
2. What is your age?
3. Where are you from?
4. What is your marital status?
5. Is this your first pregnancy? (If not, I asked the next question)
6. How many children do you have?
7. Was your current pregnancy planned or unplanned?

(If this is not the woman's first pregnancy, I asked the next two questions)

8. How many of your pregnancies do you consider planned?
9. How many of your pregnancies do you consider unplanned?
10. Did you use any form of contraception at the time of your current pregnancy?

(If the woman answered yes, I asked the next two questions)

11. What contraception method were you using?
12. Why did you choose that method?

(If the woman answered no, I asked the next question)

13. Is there a reason why you decided to not use contraception?

(If the woman had other children, I asked the next question)

14. Did you use any form of contraception at the time of any of your pregnancies?

(If the woman answered yes, I asked the next two questions)

15. What contraception method were you using?
16. Why did you choose that method?

(If the woman answered no, I asked the next question)

17. Is there a reason why you decided to not use contraception?
18. In your own words, what does it mean to have a planned pregnancy?
19. In your words, what is family planning?

Women attending the medical appointments of their young babies and children (*puericultura*):

1. What is your name?
2. What is your age?
3. Where are you from?
4. What is your marital status?
5. How many children do you have?
6. How many of your pregnancies do you consider planned?
7. How many of your pregnancies do you consider unplanned?
8. Did you use any form of contraception at the time of any of your pregnancies?

(If the woman answered yes, I asked the next two questions)

9. What contraception method were you using?
10. Why did you choose that method?

(If the woman answered no, I asked the next question)

11. Is there a reason why you decided to not use contraception?
12. In your own words, what does it mean to have a planned pregnancy?
13. In your own words, what is family planning?

Appendix B

Common Questions for Physicians, Nurses, and Community Agents of the Bom Retiro UBS

I interviewed the physicians, nurses, and community agents of Bom Retiro to 1) better understand their role within family planning services and 2) learn whether providers thought there were differences in care between women with planned pregnancies and women with unplanned pregnancies. When available, I conducted my interviews in a consultation room for more privacy. When not available, I conducted my interviews in a break room in the back of the clinic or in the hallway where patients waited for their appointments. I wanted my conversations to feel as natural as possible and thus conducted semi-structured interviews. To do this, I created a set of standard questions and allowed the provider to elaborate on the points they focused on in their initial responses. For example, if a provider mentioned differences between Brazilian women and immigrant women, I asked more questions about the differences they perceived between the nationalities.

Questions I asked to the healthcare providers:

1. What is your name?
2. What is your age?
3. Where are you from?
4. What is your marital status?
5. How many children do you have?
6. What type of health professional are you in the clinic? (Physician, nurse, or community agent)
7. What medical team do you work with?
8. How would you describe your role within the family planning services offered in the UBS? What kinds of interactions do you have with pregnant patients? Do you see them in their homes? Do you see them in medical appointments?
9. As a healthcare professional involved in family planning services, you work with women that planned their pregnancies and women that did not plan their pregnancies. Do you believe there is a difference in your work between women with planned pregnancies and women with unplanned pregnancies?

(If the provider answered yes to the above question, I planned to ask the next question. Most often, the providers elaborated on the differences they perceived without me asking them to do so)

10. Can you explain the differences you have noticed between women that planned their pregnancies and those that did not plan their pregnancies? Is there a difference in their prenatal care?
11. In your own words, what does it mean to have a planned pregnancy?
12. In your own words, what is family planning?
13. What are the most common questions you receive with pregnant patients?
14. What are the most common questions you receive about birth control?
15. What birth control methods do women most commonly ask about or ask for?
16. What concerns do women most commonly have when asking about a contraception method?
17. What are the most common misconceptions you hear from women in the clinic about family planning?

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