Power and the Pill: Mid-Life Women Negotiating Contraception

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Abstract

Contraception is often a taken-for-granted element of actively heterosexual women's lives. Yet while modern contraceptives have technically enhanced women's ability to control their fertility, the history of women's struggles to achieve this control shows the importance of understanding the social context within which women's contraceptive decisions are situated. Previous feminist studies of contraception in the UK have tended to concentrate either on aspects of medicine or on heterosexuality. Whilst both areas have highlighted the need to understand how power relationships structure women's contraceptive experiences, these two aspects have not been integrated adequately. There has also been a tendency to focus research on younger women, and mature women's ongoing use of contraception has generally been overlooked.

This thesis is based on qualitative interviews with twenty-two mid-life British women aged between 30 and 40, as well as observations at a family planning clinic. It demonstrates that only by giving full consideration to the extent and complexity of the power relationships surrounding contraception can an understanding of women's decisions and everyday practices be achieved. The concept of 'subjective power' is developed to explore how these women make strategic and creative use of circulating discourses, interact with disciplinary regimes, and situate themselves within multi-faceted webs of power relationships, such as in relation to the institutions of medicine, the media, and heterosexuality. The embodied nature of both the risk of pregnancy and the use of contraceptive technologies is argued to lead the women to assert a right to bodily autonomy. Yet this assertion conflicts with their expectation of equitable coupledom within heterosexuality and their routine consideration of men's preferences. In addition, this thesis will show that taking 'proper' responsibility for preventing pregnancy constructs women as respectable, yet may increase their risk of contracting sexually transmitted infections.

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No one I have met outside academia seems to have the faintest idea about what a PhD is. Whilst some may know of the technical aspects (the proposal, research, analysis and writing up etc), the living and breathing bit of doing a PhD is very difficult to explain to those who have not been intimately involved. It is an organic process within which anyone who touches your life has the possibility of sending your thoughts into a new direction. Although it would therefore be impossible to list everyone who has influenced the direction of my research, there are some particular groups of people without whom this project could never have come to fruition.

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Chapter 1

Introduction

Looking at contraception raises complex and heterogeneous questions about the ways in which it intersects and re/informs actively heterosexual women's lives. The social consequences and physical reality of pregnancy impact on almost all areas of women's lives. Hence seeking to exert control over their fertility has been, and remains, fundamental to the ordering of many women's lives. The development of modern contraception, and widespread general acceptance of its use, has had a major impact on British women. Despite contraception's unusual status in being available free on National Health Service (NHS) prescription, the social context structures women's ability to exercise agency in this area. In particular, feminist studies of contraception have highlighted how the institutionalised power of medicine and the gendered power relationships of heterosexuality affect women's ability to access and use contraception (Barrett and Harper 2000, Foster 1995, Gordon 1990, Hawkes 1995, Holland *et al* 1998, Thomas 1985).

Whilst these previous studies have shown the importance of understanding power relationships, the research to date has usually focused on only one aspect. Consequently, whilst women's everyday experiences are structured by both medicine and heterosexuality, research has not fully integrated the two. Moreover, previous research on contraception has tended to concentrate on younger women, yet actively heterosexual women are likely to use contraception repeatedly until the onset of the menopause in their forties or

fifties. Many women in their thirties change sexual partners; they may marry or remarry, separate or divorce. Whilst some women in this age group may want to have children, others do not. Consequently, contraception remains an important issue for mid-life women, despite the lack of attention given to them either by research or current health promotion policies. This study has sought to address these gaps.

Based on qualitative interviews with twenty-two women users of contraception in the UK, aged between 30 and 40, and observations made at a family planning clinic, this research has explored medicine and heterosexuality as complex interrelationships of power within which women's contraceptive experiences are situated. By asking the women to recount the different choices they made at different points in their lives, this thesis has produced a retrospective history of the women's 'contraceptive careers' (Thomas 1985). What emerges from the accounts is that whilst contraceptive choices construct, and are constructed by, power relationships, the interrelationships are always fluid, with the different components waxing and waning in importance.

The focus of this thesis is on women's everyday experiences of contraception, and how power relationships structure individual women's lives. The importance of understanding the broader social context has been shown by historical accounts which have drawn attention to women's desire and struggle to achieve control over their reproduction, particularly in relation to laws,

regulations and instruction by the church, state and medical profession. Often lacking precise details of how women felt and acted, historical accounts have had to infer the effects of such structural factors on individual women. Yet this history highlights that contemporary 'issues' often resonate with those of the past. Consequently I will begin this introduction with some brief details which will help to situate my contemporary study of contraceptive power relationships in its historical context. I will then give details of the structure of this thesis.

Historical Struggles over Contraception

Strategies for family limitation have a long history and one that is inseparable from the society in which they were practised. As many histories of contraception have made clear (see for example McLaren 1990, Gordon 1990, Riddle 1997), decisions over fertility emerge from and are intertwined with the wider social context, including marriage customs, economic factors, cultural prescriptions, and, of course, gender relationships. Moreover, the sanctions that were in force against birth control strategies often provide the main source of evidence of their use (McLaren 1990, Riddle 1997). It also has to be remembered that the division between abortion and contraception is a relatively recent occurrence. Historically, pregnancy was only confirmed after quickening during the second trimester; before this occurred, women had just failed to menstruate (McLaren 1990, Duden 1993, Riddle 1997). Indeed, many of the herbal remedies recommended to prevent conception were also used as

abortifacients, further obscuring an absolute distinct between the two. Three historical periods will be used here to emphasise the importance of situating contraception within and recognising it as a constituent of varying power relationships.

My earliest example illustrates how the use or non-use of contraception has been used as a marker between different populations. The early Christian church (AD100-600 approx.) adopted sexual control as a principal differential between itself and 'pagans' (McLaren 1990). It focused on the controlling of sexual urges, asserting that sexual intercourse should only occur for procreation within marriage, and condemned any other sexual act as unnatural and sinful. Contraception and abortion were prohibited and associated with evil. This early denunciation can clearly be understood as part of a political power struggle both between Christianity and other religions and within religions, as different Christian sects sought to differentiate themselves from each other. It was women who bore the brunt of the condemnation and ran the risk of excommunication, as contraception was linked to adultery, prostitution or other 'unnatural acts' (McLaren 1990). Yet there is evidence that many herbal-based contraceptive methods were in use at this time and were often successful (Riddle 1997). Hence, even in this early period we can see an indication of the complexity of the power relationships within which contraceptive decisions are embedded. The utilisation of contraception by the church as part of its wider political strategy also illustrates the importance that religious teachings have had, and continue to have, in producing ideologies of

contraception. In addition, it draws attention to the ways in which discursive constructions of female bodies and activities are used as markers of religious, national and other constructions of identity (see for example Yuval Davis 1997 or Gedalof 1999).

The next example looks at the link between the nineteenth century birth control movement and eugenic ideas, and the feminists' debates over contraception. During this period the 'population question' began to dominate debates over contraception, following Malthus' argument that population growth was a threat to social stability as it would outstrip society's ability to maintain itself (Weeks 1989). Gordon (1990) argues that Malthus' ideas continue to be important to contraceptive debates today, with assumed links between poverty, overpopulation, and moral failings leading to the poor being the targets of birth control campaigns. Following Malthus's ideas, organisations promoting birth control were set up, with the first emerging in 1876. However population statistics suggest that the middle classes had already adopted strategies for family limitation, before these public campaigns began (Weeks 1989, McLaren 1990).

Many Victorian middle-class feminists, however, objected to the use of the more technical 'methods' promoted at the time, and instead advocated 'voluntary motherhood' through periodic abstinence. Jackson (1994) argues that they saw contraceptive devices as a threat to female bodily autonomy because their use made it more difficult for women to refuse sexual

intercourse. Utilising discourses of moral purity in conjunction with women's rights, the call for male self-restraint was also aimed at providing some protection against sexually transmitted diseases, as it called for both a reduction in extra-marital sex and periodic abstinence within marriage. This debate highlights that contraception must be understood within the context of heterosexual power relationships. Ideas about contraception emerge from existing discourses of 'normal' heterosexual relations, but are also implicated in re/producing them. The nineteenth century opposition to contraceptive devices from some feminists illustrates their concerns with the position of women in the patriarchal family, yet their solution of chastity for men was also rooted in women's subordinate status.

The last historical example is the work of Marie Stopes, who is probably the best known British supporter of birth control. Stopes demanded that women should be able to enjoy sexual relationships, asserted women's right to control their fertility and opened the first birth control clinic in England in 1921 (McLaren 1990). Yet her campaigns were also explicitly eugenic, as she believed that providing contraception to women would be the most successful method of reducing the reproduction of 'degenerate stock'[1]. Stopes promoted a cervical cap as the preferred method of contraception, which required women to attend a clinic for fitting. She lobbied the medical profession for acceptance

[1] Marie Stopes was a Fellow of the Eugenics Society, and also formed the Society for Constructive Birth and Racial Progress. However, Cohen (1997) has argued that her clinical practice did not reflect her eugenic principles, as when dealing with individual cases her concern for women's personal well-being entailed her giving advice on overcoming infertility to 'dysgenic' women.

of contraception, and promoted the 'mother's clinic' as an ideal model for dispensing advice and methods. Thus, we can link Stopes' work directly to the beginning of the professionalisation of family planing (Leathard 1980).

These historical examples illustrate many different aspects of contraceptive power relationships. The attitudes of the early Christian Church show how religion and political struggles are related to ideologies of contraception, with prescriptive roles for women to follow, and that contraception can be used as a marker of difference. The link between contraception and eugenic ideas was established in the nineteenth century, and the provision of contraception today still has strong racial and class dimensions, which run alongside notions of 'good' and 'unfit' mothers. In some parts of the United States today, for example, women who agree to have long-term contraceptive implants may receive cash incentives, or probation rather than a custodial sentence (Kuo 1998). Whilst in Britain discrimination is often less visible, evidence suggests that women's access to contraception is still affected by their social and economic position (Foster 1995, Hawkes 1995).

Work by Stopes and others focuses our attention on heterosexual relationships and women's right to control their bodies. It also highlights the paradoxes involved in assigning responsibility for preventing conception. Methods such as the cervical cap, advocated by Stopes, give women greater control over contraception, but can also be considered to reduce male responsibility. Conversely, giving men an equal (or greater) responsibility for contraception

may give them power over women's bodies. This tension needs to be set within the power relationships of heterosexuality.

Stopes sought to establish family planning as socially acceptable, although at the time it was restricted to giving married couples a way to limit and space their families. Her advocation of the growth of clinics and appeals to the medical profession for approval and involvement can be understood as the beginning of contraception's professional legitimacy. The introduction of the contraceptive pill accelerated the shift during the twentieth-century with the concentration of access to contraception in medical hands increasing the possibility for both surveillance and control over women's sexual lives. This is probably the most significant historical legacy affecting British women's ability to access contraception today. Whilst religions, nationalism, and the state still play a part in the broad social context of contraception, they are not as prominent in British women's everyday contraceptive experiences as the institutions of medicine and heterosexuality.

In order to understand women's diverse and multifaceted experiences of contraception it is therefore necessary to consider both the role of medicine in the provision of contraception and the dynamics and complexity of different aspects of heterosexuality as an institution and practice. My focus in these areas will be on factors that affect women's individual agency, whilst retaining a recognition of wider systems of inequalities and discrimination. A central tenet of my analysis is that an understanding of the multifarious power

relationships surrounding contraception is constitutive of women's experiences. It is only by giving full consideration to the extent and complexity of power relationships that surround contraception, and the role that contraception has in power relationships, that an understanding of women's decisions and everyday practices can be achieved.

Structure of the Thesis

The traditional division of sociological research on experiences of contraception into either health or heterosexuality is also reflected in the structure of this thesis. Whilst I have used this division to increase analytical awareness, I wish to acknowledge its artificial nature. The day to day business of heterosexual relationships is of course a different experience to that of accessing contraception and the role medicine plays in that request, but the nature of contraception means these different and sometimes conflicting areas intersect and women find themselves in the middle. My definition of contraception encompasses any methods that are deliberately employed to restrict conception, and thus includes abstinence, extended lactation, and withdrawal as well as the use of barrier methods, sterilisation or hormonal methods.

I begin in chapter 2 by reviewing the existing literature on medicine and heterosexuality in relation to contraception. Examples of medical and popular understandings of contraception are used to illustrate how these differ from the writings of feminists. This chapter will show that although power relationships

have long been considered important to our understanding of women's experiences of contraception, few writers have really analysed these power relationships in detail. In chapter 3, existing feminist theories of power are examined for their ability to explain the complexity of contraceptive experiences. This will lead to my development of a conceptual framework which allows for the exploration of multiple deployments of power that inform and are informed by women's experiences of contraception. Following this examination of the literature, chapter 4 explores my methodology, sets out the initial research design and gives details of the fieldwork carried out. It also seeks to explore the way in which power relationships are also constituents of the research process. Thus the relationship between the researcher and researched, the academic conventions of a PhD, and the requirements of medical gatekeepers, alongside many other factors, all re/act to affect the design, process and outcome of the research.

The next three chapters present the fieldwork findings and explore different sites of contraceptive power relationships. Chapter 5 considers both medical consultations for contraception and other factors that influence the medical site of contraception, including notions of respectability and responsibility, within which women make their contraceptive decisions. It argues that contraception is an embodied technology that contributes to a gendered sense of knowledge, risk and responsibility. The next chapter looks specifically at emergency contraception, which became very topical during the course of my research. Its

change in status during my fieldwork, from a prescription-only to an over-the-counter medicine, led to particularly detailed accounts from the women I interviewed after the deregulation was announced, as well as giving me an opportunity to consider how the media coverage affected their opinions. The chapter will argue that whilst a symbolic difference between 'proper' contraception and the morning-after pill was reaffirmed by the media coverage, the women did not uncritically accept the dominant images constructed in the media coverage. Aspects of heterosexuality are explored in chapter 7, which shows that the use of contraception is an intricate part of heterosexual encounters, although it is rarely acknowledged as such. I consider the two-way relationship between contraception and sexual practices, and how men appear to be an absent presence within women's contraceptive decisions.

Chapter 8 seeks to weave together the different strands of contraceptive experiences explored in the chapters on medicine, the media and heterosexuality. Using the framework developed in chapter 3, it utilises the concept of subjective power to show the complex and multifarious nature of women's contraceptive decisions. It argues that whilst women manage their reproductive lives individually, the social context exerts multiple and often conflicting pressures on them. Despite the nominal right of British women to freely access contraception through the NHS, women's ability to make autonomous decisions is structured through broad disciplinary regimes and specific frameworks of meaning that can constrain or enable them.

Chapter 9 concludes the thesis and argues that understanding power relationships is central to understanding women's experiences of contraception. There are many interrelating discourses constructing meanings of contraceptive usage, and women make strategic and creative use of these discourses to strengthen their subjective power and justify their actions. I will argue that whilst contraception is usually in the background, it is the foundation on which many actively heterosexual women build their lives. Yet the promise of freedom and control that contraception implies is not that simple. Although modern contraceptive methods have enhanced women's ability to control their fertility, women's ability to access and use contraception continues to be re/formed and re/produced within power relationships.

Chapter 2

Contraception:

Encounters with medicine and heterosexuality

Introduction

As I will illustrate below, in popular and medical opinion contraception is often viewed as an unproblematic experience, at least for mature British women. Although there is acknowledgement that there are some problems, such as physical side effects, the benefits of using contraception are taken to be obvious. Contraception is deemed to be widely and freely available, and an area in which women have the ability to make autonomous decisions. In contrast to this image, feminist literature has often highlighted the problematic aspects of contraception. It has seen women's desire to achieve control over their reproductive lives in terms of social struggle, particularly in relation to laws, regulations and instruction by the church, state and medical profession. It has also theorised how the dynamics and complexity of heterosexuality as an institution and a practice position women as unequal to men. So is contraception today simply a 'lifestyle' choice for most women, or should we still consider it as situated within, and a constituent of, complex power relationships?

This chapter will start by briefly outlining two examples, one from a medical journal and the other a woman's magazine, which illustrate current medical and popular opinions on contraception. Next, it will examine the feminist

literature on the role of the medical profession, including the impact of the medicalisation of contraception, and how recent changes may be reversing this process. I will also consider how medicalisation allowed for surveillance by health professionals over women's bodies, and look at the health implications of contraceptive methods. Contraception has the benefits of allowing women some control over their fertility, but it also carries risks. In the final section, different theoretical positions on heterosexuality will be explored, focusing on the implications for understanding how heterosexuality re/forms and re/produces women's experience of contraception. This chapter will argue that in order to fully understand contraceptive experiences, we need to consider it as a complex constituent of women's social lives.

Medical and Popular Understandings of Contraception

Contraception seems to be a taken-for-granted aspect of (heterosexual) women's lives today. It is generally assumed that most women will use some form of contraception for the majority of their fertile years and that there will be something that suits every woman's needs. In this section, I will first consider an article from *The Lancet,* one of the leading British medical journals, which illustrates prevailing assumptions about the role of medicine in contraceptive practices. I will then compare this with an article from *Prima,* a women's lifestyle magazine, and highlight how, although there are some differences, it is in broad agreement with the medical assessment of contraception's place in (heterosexual) women's lives.

A review article recently published in *The Lancet* described the range of contraceptive methods currently available and some of the methods currently under development. The authors wrote:

> Giving women reproductive autonomy through comprehensive and up-to-date information about methods is vital for successful and long-term use of contraception… Supportive counselling helping individuals to select the right method for them encourages compliance and ensures safety and efficacy. (Kubba *et al* 2000:1913)

Despite the article's explicit mention of women's reproductive autonomy, the quotation reveals three implicit messages: that doctors are the experts and are there to guide women; that the main impediment to successful contraceptive practices is ignorance; and that education is therefore the solution to any contraceptive problem.

In other words, whilst women should be given a choice, the parameters of that choice remain in the hands of medical experts. Doctors *help* women make the *right* choice and the term *compliance* (although in common medical usage) accentuates the perception that whilst women should be treated as autonomous health consumers, they need to follow their doctor's advice.

The article highlights two main forms of ignorance: unawareness of the range of contraceptives available and incorrect use of specific methods chosen. The authors suggest that the contraceptive pill overshadows other methods, and whilst they do point out that providers are also implicated in this problem (presumably this is why they have provided a full review for doctors of the methods available), women's ignorance is considered the main problem. The

proposed solution to this ignorance is education; if only women listened properly to their doctors, they would not experience any problems with contraception. So whilst the article appears to follow a health consumer model, that women should choose their method of contraception, it maintains the assumption of professional expertise, in that it is the doctor's role to counsel women on the *right* method for them.

Whilst it is of course very important that women have access to information on the range, contraindications and health implications of contraception, as well as how to use the different methods, the idea that the main problem is ignorance and that education provides the whole solution needs further questioning. The notion that once presented with information about health, people will make the 'right' choices and comply with the advice given stems from rational choice models of health behaviour, which have been the bedrock of health education in Britain (see Gastaldo 1997 for a critique of this position). Some feminist literature also seems to converge with this view, with an added assumption that women's empowerment can be achieved through education (Howson 1998).

Similar discourses can also be seen within popular understandings of contraception. For instance, in an article entitled 'Change your love life for the better', a popular British women's magazine discusses some less widely used methods of contraception. It told its readers:

> If you have been using the same contraception for years, take a look at what's new. You could improve your health and sex life.
> (*Prima Magazine*, August 2001:78)

The layout and tone of the article exhibits methods of contraception as consumer product items, similar to make-up, DIY products, or food. The article begins by including a few endorsing comments from 'experts' (in this case a family planning doctor and the British Pregnancy Advisory Service), and then for each different method presents a small section with a description, list of advantages and disadvantages, and comment on its general availability. The implication is that women, as health consumers, can and should consider their method of contraception as part of their life-style. Indeed, like many other women's magazines, Prima provides an aspirational agenda for its readers, suggesting women should constantly be investing in and improving upon themselves, often through consumption (Ouellette 1999). This agenda includes women's entitlement to an enjoyable sex life, which is highlighted in the article's title. Interestingly, despite the acknowledgement that contraception is related to (hetero) sex, (and the main picture accompanying the article is of a man and woman together), the article does not discuss men's involvement in contraception. Moreover, whilst there is an acknowledgement that some contraceptives may be problematic (for example when mentioning side effects and reliability rates), the overall message is that women today are empowered contraceptive consumers.

We can see some similarities between the medical and popular understandings of contraceptive choices. Both see women as consumers, albeit more limited

in the medical model, and both see up-to-date information as a solution to contraceptive dilemmas. Both contain fleeting references to (hetero) sex, but neither article considers heterosexual relationships in detail. One main difference between the two is the role of medicine in contraceptive choice. Whereas in the medical journal the role of the doctor is paternalistic, in the women's magazine the doctor's surgery or family planning clinic is demoted to the status of retail outlet. In neither of these articles is contraception deemed to be a complex issue, nor one in which power relationships are central. This is a major departure from the feminist literature on reproductive health.

The Contradictory Face of Medicine

The medicalisation of contraception is an area that has received considerable attention from feminist researchers. As Oakley (1993a) has pointed out, one of the essential differences between the historical use of contraception and today's use is the widespread involvement and control by the medical profession that has led to considerable surveillance over women's lives. Moreover, the medical control of contraception must be considered within the dominant medical discourses that implicitly construe women's reproductive capabilities as evidence of their inferiority to men (Martin 1987, Turner 1995). Although classified as medicinal, contraception is used by 'healthy' women, in contrast to other products which aim to 'cure' or assist people who are ill. Furthermore, most forms of contraception, and especially ones that are based on hormones, have short or long term health implications for the women who are using them. In addition, the doctor's control over most forms of

contraception must be considered as part of the more general role that doctors have in the governance of women's bodies (Lupton 1994).

In this section, three aspects of the feminist critique will be focused on. First, the ability of the medical profession to exercise surveillance over key aspects of women's lives will be examined. This will entail considering how dominant discourses re/inform medical perceptions and the implications this has for women when accessing contraception. Next, the disciplinary effects that contraception has on the body will be considered, with particular reference to the side effects and health implications of different methods. Finally, the relationship between the prevention of sexually transmitted infections and fertility control will be examined.

Medical Surveillance and the 'Responsible' Woman

The medicalisation of contraception has led to considerable surveillance over women's lives. Within the doctor/patient exchange, the medical profession has long been considered in a position of power (Turner 1995). Although, as Doyal (1994) highlights, the National Health Service (NHS) guarantees women access to health care, women's subordinate structural position (both within the NHS and as service users) disadvantages them and has serious implications for their ability to access information and treatment. Yet, the doctor/patient relationship is more complex than a simple hierarchical power relationship of doctor over patient. For example, Foucault (1990) drew attention to the way that patients are complicit in the production of

power/knowledge through the clinical encounter, and it has also been suggested that patients are increasingly adopting a consumerist approach that challenges the doctor's authority (Haug and Levin 1983). Consequently, it is important to investigate the complexities of the doctor/patient power relationship, whilst acknowledging that as many methods of contraception are only available on prescription, doctors retain a position of authority.

Feminist researchers have highlighted that many doctors do not trust women to make the 'right' or 'rational' decision over contraception, and this perception informs and recasts the power relationship between women users and health providers (Foster 1995, Hawkes 1995). Although explicitly eugenic agendas are rarely referred to in Britain today, there is evidence that in relation to contraception women are judged on social rather than medical grounds. Such judgements are closely linked to ideas about the biological and social role of mothering, which produce norms about the 'right' and 'wrong' times to become mothers, and which women should avoid becoming pregnant (see for example Thomas 1985, Hawkes 1995 and Smart 1996a). Moreover, as Martin (1987) (amongst others) has illustrated, women's bodies are often constructed as irregular, temperamental and in need of regulation, and this discourse affects the way that all aspects of reproduction are perceived. Indeed, Howson (1998) has suggested that normative femininity requires acceptance of the medical gaze, and an 'embodied obligation' to accept compliance, although this does not imply that women always comply without questioning.

Women are often evaluated in relation to their perceived ability to be a 'good' mother (Smart 1996a), and this influences judgements on how likely they are to comply with the medical regimes of contraception prescribed and how important preventing pregnancy is seen by the doctor. Hawkes (1995) argues that health professionals divide women according to their own perceptions of 'responsibility' and 'irresponsibility', and certain groups of patients, such as young women, almost always fall into the 'irresponsible' side. Women perceived as 'irresponsible' are more likely to have methods of contraception recommended to them that do not rely on self-application for use, such as injections or an Intrauterine Device (IUD also know as the Coil) (Todd 1984, Foster 1995, Hawkes 1995).

Although contraception is currently under medical control, it is important to note that historically many doctors were reluctant to become involved in family planning. Leathard (1980) describes how contraceptive services in Britain developed separately from other medical services, and did not form part of the development of the NHS. Thomas's (1985) review of the *British Medical Journal* issues from the 1950s and 1960s shows that doctors were often divided as to whether they should be involved in contraception, particularly in cases where use was not medically necessary but was desired by women in order to choose if, and when, they wanted to have children. However, with the development of the contraceptive pill, which as a hormonal intervention could only be prescribed by a doctor; the NHS (Family Planning) Act 1967, which entitled women to NHS prescriptions for the pill; and the

beginning of payments to General Practitioners (GP) for family planning work, contraception moved into the everyday work of GP surgeries (Foster 1995). As Doyal (1997) points out, appointments for contraception entail a large proportion of a GP surgery's workload, with an average of 1406 visits per year per 10,000 women (the next highest reason to consult a GP is acute respiratory infections at 873 visits per annum).

Whilst most contraception has remained under the remit of medicine for the last thirty years, there are signs that this is now changing. Currently many GPs are reporting an overload of work (see for example Morrison and Smith 2000), and this may have contributed to the changing attitudes towards the status of contraception within medicine. At many surgeries nurse-practitioners now dispense contraceptive advice and supplies, and family-planning trained nurses are now responsible for more and more prescriptions. In January 2001, the Medicines Control Agency reclassified emergency hormonal contraception (the morning-after pill) as a pharmacy medicine, rather than a prescription-only one, albeit with a particular protocol for pharmacists to follow. Indeed it has even been suggested that the contraceptive pill itself could be reclassified, so that women can just collect it from a chemist shop (BBC 03/02/02). [2]

Support for these trends needs to be understood within the context of the professional discourses of each of the relevant health professions. While the

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[2] At the time of writing, it is unclear if or how, this suggestion would be taken up. Some media reports have suggested that women would not see their doctors at all (BBC 12/06/2001), and others that an initial visit would be made to a doctor, with repeat prescriptions available without contacting a GP (BBC 03/02/02).

nursing and pharmaceutical professions are currently striving to develop their status as health professionals (see for example Dent and Burtney 1997, Asghar *et al* 2002), doctors' organisations are complaining that their members are overburdened with work (Morrison and Smith 2000). Transferring the responsibility for contraception from doctors to other health professionals would appear to work in the interests of all three professional groups.

While the medical profession currently has control over most prescriptions for contraception, in its development and availability contraception is a commodity produced by pharmaceutical companies. However, it is not a commodity necessarily accessed only through adequate supply and ability to purchase. Since most forms of contraception are only available on prescription, their market appeal must be linked into the dominant perceptions of providers, as well as women users. Foster (1995) points out that whilst different brands of contraceptive pill are heavily advertised in medical journals, the marketing of other contraception methods is much less common, and this may reduce the likelihood of doctors recommending them. Moreover, as Wajcman (1991) discusses, power relationships are also implicated in the range of methods currently available, as decisions to research and develop contraceptive methods are made within specific gendered ideologies.

Although socially produced, the purpose of contraception is ostensibly biological, and it certainly has disciplinary effects on the body. In addition, the perception of women's bodies as disordered and irregular and in need of

control, combined with a 'rational' desire to control fertility, has in/formed both the design and prescription of contraception. Watkins (1998) points out that the early advertisements aimed at doctors stressed how the contraceptive pill 'regularised' women into a twenty-eight day cycle, and the contraceptive pill is still recommended for women who have erratic periods (see for example Rees 1995)[3]. Furthermore, the medical profession has sometimes perceived these concerns as more important than the iatrogenic effects of contraception (Foster 1995).

Contraceptive Risks to Health

The methods of contraception currently available vary considerably in their effectiveness, and many of them also have detrimental effects on women's health. Alongside the discomfort that many women endure in order to try to control their fertility, there are also serious and even life threatening conditions which are associated with contraception. These include the risk of thromboembolism, gallbladder disease, and benign liver tumours (Kaplan and Tong 1996)[4]. However, there is considerable evidence that doctors routinely dismiss or disregard the reports of adverse side-effects from women, and also fail in many cases to fully inform women of the long-term health risks and known side effects (see for example Pollack 1984, Foster 1995, Doyal 1995, Walsh 1997). Moreover, women's prolonged use of a particular method cannot

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[3] It has also been suggested that the original design of the contraceptive pill, with a 21/7 schedule and thus a withdrawal bleed, was based on a perceived psychological need rather than any biological need (Thomas and Ellerston 2000).

[4] Web Sites offer the most up to date information on the side effects and health implications of different methods of contraception. Two medical sources are http:// www.fpa.org.uk (aimed at women users) and http://www.reproline.jhu.edu (aimed at health professionals).

be taken as a sign that they positively endorse it, as many women feel that they have no realistic alternative to the method they are using, and so have to accept any unpleasant consequences associated it (Snow *et al* 1997).

Many reasons have been suggested to explain the lack of attention paid by the medical profession to the health problems associated with contraception. For example, Todd's (1984) research found that male doctors often dominated conversation with women patients about contraception and negated women's capacity to express their concerns. In addition, the power invested in medicine, and a medical discourse which constructs women as irrational and unreliable, gives credence to the idea that any problems women report are imagined or unconnected to their method of contraception (Foster 1995). Even when side effects are admitted, it is typically assumed that these are a minor inconvenience when compared to the benefits of control over fertility (Luker 1975, Foster 1995).

Hunt and Annandale (1990) have suggested that due to increasing awareness of the health risks associated with the pill, together with the expectation it generates that women should be able to control their fertility, growing numbers of women in Britain are now choosing to be sterilised by tubal ligation. Yet, the risks of the operation are not always explained to women. Turney (1993) suggests that the medical profession's reluctance to recognise the problems inherent in the operation stems from its recommendation world-wide as a 'solution' to the 'problem of population'. Conversely, women who

elect for sterilisation because they wish to remain childfree are often pathologised and face medical reluctance to meet their request (Campbell 1999). Campbell suggests that the difficulties childfree women encounter when requesting sterilisation illustrate how cultural expectations of motherhood shape the medical profession's judgements.

It is not just the dispensing part of medicine that is implicated in the minimisation of the health implications of contraception. For example, the Dalkon Shield was an IUD which was released onto the US market without adequate testing, and it caused at least twenty deaths and an unknown number of cases of morbidity and infertility before it was withdrawn (Gordon 1990, Grant 1992)[5]. Moreover, one of the doctors whose published work recommended using the Dalkon Shield as a safer alternative to the pill failed to acknowledge his financial connection to the Shield (Grant 1992). As awareness of the problem grew, the pharmaceutical company switched to selling the device in developing countries. After its forced withdrawal in the United States, the company sent notification of the problems only to foreign embassies rather than directly to its customers, so that it continued to be fitted in women long after the dangers were well known (Gordon 1990, Grant 1992). This example clearly illustrates how corporate interests are also implicated in the power relationships surrounding contraception, from what is considered

[5] Grant's (1992) study of the Dalkon Shield Case reports that 306,931 law suits (about 8% of users) were brought against the company before the end of the imposed time limit. The actual number of women injured by the Dalkon Shield worldwide is unknown.

viable to research and design, through to the ways that different groups of people are targeted in order to achieve a financial return.

The case of the Dalkon Shield and the ongoing debates as to the safety of the contraceptive pill illustrate many of the dilemmas explored by Beck (1992) in his concept of the risk society. Whilst it is clear that contraception in general often poses a risk to women's health, the exact nature, and severity, of the risk is usually unknown to women (and their doctors) when they are choosing between different methods. As Lupton (1999) points out, attitudes and reactions to both perceived risks and expert knowledge are shaped by various factors, including the extent to which the risk is familiar or voluntary, the perceived effectiveness of any alternative, and the individual's socio-economic position. Even if the data were known (which they rarely are) an individual's reaction to perceived risk cannot be seen as emerging merely from a rational calculation of potential costs and benefits, but is shaped by and embedded in complex social relationships.

Yet despite all the problems and risks of contraception, it must not be forgotten that the ability to control their fertility is of enormous importance to huge numbers of women, and has been a central tenet of feminist campaigns for women's rights. Whilst there have always been disagreements as to *how* women should be able to exert control (for example, the nineteenth century debate between campaigns to support women's right to refuse intercourse and those who promoted contraception), feminists have always recognised the

centrality of fertility control in women's lives. Greer (1985) describes how many women not just welcomed but demanded access to the contraceptive pill when it was first developed, as it was believed that it would enhance their sexual freedom. Moreover, the move to the adoption of the term 'reproductive rights' within the international policy context recognises the symbiotic relationship between women's human rights and reproductive health (Berer 2000). In Britain, the use of contraception has been normalised, and British women rarely consider how the ability to limit the number of pregnancies plays a significant role in most other aspects of their lives (Lowe 1998). Despite the importance of the health implications of using contraception, and the possibility for surveillance that it gives to the medical profession, contraception must be seen to bring crucial benefits to many women.

Meadows' (2001) study of communication about contraception investigated how women learnt about and discussed different methods including the transmission of information about side effects. She found that whilst the women she interviewed often denied having much conversation with partners, friends or family about contraception, the women could easily recall stories told to them and by them, about problems encountered. She concluded that whilst it could not be said that there were networks of women informing each other about the side effects of contraception, these stories formed part of the social context within which individual women made their decisions. Whilst Meadows' study usefully draws attention to how the sharing of experiences

informs women's contraceptive decisions, her study did not look at how this related to the many other factors involved.

Dual Protection

Consideration of the need to protect against sexually transmitted infections as well as pregnancy has a long history, and since the emergence of HIV/AIDS the call for dual protection has re-established itself. Yet, research had shown that whilst theoretically most women are aware of the need for dual protection, it is not systematically practised, and most heterosexuals in the UK consider the risk of contracting HIV/AIDS to be minimal (Patton 1994, Lewis 1997). Moreover, there has also been a tendency, reflected within health education material, to assume that younger people have a higher risk of infection as they are more likely to be sexually promiscuous. Yet, as Maxwell and Boyal (1995) point out, up to 1990 approximately 50% of reported cases of HIV/AIDS were of people over 30. Both the rising divorce rate and research into the non-monogamous behaviour of cohabiting and married couples complicates any assumption of lower risk for those over 30.

An important aspect of heterosexual relationships that is particularly relevant to the utilisation of safe sex is that of 'trust'. Trust is needed to both create and sustain relationships, and the basing of heterosexual relationships on a concept of trust can have particular consequences for the utilisation of safer sex practices (Willig 1997, Maxwell and Boyal 1995, Woodstock and Koo 1999). If one partner suggests condom use, for example, this can imply that the

relationship is not monogamous, and thus undermine the foundation on which the relationship has been built. Indeed, Patton (1994) suggests that abandoning safer-sex practices may actually signal the development of both trust and commitment in heterosexual relationships.

Moreover, it has been argued that it is not just the insinuation of non-monogamous behaviour that is signalled by an insistence on safer sex practices. Miles' (1993) research found that the association of HIV/AIDS with 'deviant' populations means that a suggestion that protection may be needed implies a range of negative attributes for both partners. It suggests that at least one partner has engaged in high risk and 'deviant' behaviours and may also undermine the 'respectability' of the other partner for associating with them. Furthermore, since barrier methods were dismissed for many years as unreliable by health professionals, who were seeking to encourage the use of hormonal contraception, this has left the current promotion of condom use to prevent the spread of infection on shaky foundations (Thomas 1985, Foster 1995). These issues surrounding the problems of practising safer sex highlight the need to look closer at the gendered power relationships of heterosexuality in order to understand women's contraceptive experiences.

Contraception and Heterosexualities

It may be obvious that contraceptive experiences are embedded within heterosexual practices, but heterosexuality itself is affected by contraception. Although power relationships have been central to feminists in developing

understandings of social relationships between women and men, historically 'gender' has been the lens used rather than 'heterosexuality'. Yet there have also been debates among feminists about how heterosex is involved in the construction and maintenance of gendered relations of power and how we should define heterosexuality.

In this section, I will first explore how the relationship between gender and heterosexuality has been explained by feminists, before examining theories that highlight the complexity of heterosexuality. I will then consider the implications that 'normalised' heterosexuality has for women when considering contraceptive methods, and how contraception is embedded within heterosexual power dynamics. As disclosed in my analysis of popular discourses and early reactions to the contraceptive pill, contraception has often been considered as the route to sexual freedom for women. Feminist literature indicates, however, that there are many complicating factors.

Heterosexual Complications

Although feminists have long been concerned with the relationship between women and men, Jackson (1999) argues that feminist literature has often privileged gender as the social division that requires analysing, rather than 'heterosexuality'. Although many writers either implicitly or explicitly merge the two concepts together, Jackson (1999) argues that retaining a distinction between gender and (hetero)sexuality allows us to consider how the two

frameworks are interrelated, without positing sexuality as the most fundamental positioning of women.

Jeffreys (1996), however takes a different view, and considers gender to be a product of heterosexuality. Jeffreys argues that heterosexual desire is the eroticism of domination and submission, and this duality requires a division of gender, hence the differences between 'masculinity' and 'femininity'. Jeffreys argues that lesbian or gay sexual practices which are based on an unequal power relationship (such as butch/femme role-playing or sado-masochism) should also be considered as reproducing and reinforcing heterosexuality. For Jeffreys, power relationships are re/produced through the institutionalisation of unequal sexual practices.

Whilst I agree with Jeffreys that many of the institutions of heterosexuality re/construct the power relationship of masculinity and femininity, I do not think it is particularly insightful to see all hierarchical sexual practices as merely mimicking heterosexuality. Not only does it obscure the complexity of how different sexual identities are positioned (for example, how gay men may gain advantages from being men yet be disadvantaged by not being heterosexual), it also conflates considerations of sexual practices with sexual identities and institutions (Wilton 1996).

Like Jeffreys, Wilton (1996) recommends the concepts be merged. She suggests the term 'heteropolarity' be used to recognise the essential opposition of the two genders within heterosexuality, and wider society. Ingraham (1996)

has also stressed the dependence of gender on heterosexuality, although she has argued that rather than privileging gender, we should analyse society from the viewpoint of a 'denaturalised' heterosexuality, which could problematise both heterosexual structures and institutions and the gendered division of labour. Ingraham writes:

> Gender… is the asymmetrical stratification of the sexes in relation to the historically varying institutions of patriarchal heterosexuality. Reframing gender as heterogender foregrounds the relation between heterosexuality and gender (1996:169).

However, although discourses of heterosexuality do impact on almost all areas of social life, heterosexuality is not the only discourse to have an effect, and it is also shaped by other social markers, such as class, 'race', or religion (Smart 1996b). Skeggs (1997), for example, in empirical research with working class women, found that they were marginalised by heterosexual discourses linked to the historical depiction of both Black and White working class women as sexually deviant and dangerous. In order to distance themselves from this positioning, some of her informants invested in 'respectability', and disassociated themselves from other sexual identities. Despite recognising their marginalised positioning within discourses and the inequality in many of their sexual encounters with men, the women refused to be rendered powerless. Nevertheless, the resistances and investments that are available to them were limited and shaped by wider societal power relationships. Skeggs' research highlights the complexity of the relationship between gender and heterosexuality, and thus whilst it is important to recognise the relationship

between the two concepts, I, like Jackson (1999), remain convinced that we need to consider them separately.

Jackson (1999) and Smart (1996b) have also argued that it is often the absence of clear definition, plus the converging of the discourses of heterosexuality with those of gender, that has led to confusion about the utility of 'heterosexuality' as an analytical concept. For example, the term heterosexuality can refer to an aspect of social structure, a sexual identity, or sexual practices (Richardson 1996, Smart 1996b, Jackson 1999). Although the dominant discourses of heterosexuality re/produce social conventions, expectations and everyday practices as institutions and laws, assuming heterosexuality's generality and uniformity, we should not assume the social structures, sexual identities and sex practices of 'heterosexuality' always coincide. The perception of heterosexuality as a 'normal' and 'natural' integrated whole has contributed to its reproduction and the lack of attention given to it; therefore deconstructing it helps to challenge its hegemony (Rich 1981, Richardson 1996, Jackson 1999).

However, even if we conceptualise for variations in heterosexuality, we still need to consider that sexuality is an ongoing embodied process (Jackson 1999). As Jackson has argued, our embodied sexuality develops throughout our lives; through a process of 'active learning' (1999:25) individuals manage their desires and develop and reflect from sexual discourses at large as well as on personal sexual encounters. Consequently, sexuality is constantly

re/constructed and re/enacted within sexual relationships as well as within individuals' wider social lives. Thus (hetero)sexuality cannot be considered as 'natural', as opposed to the social construction of 'gender', but is re/produced through culturally and historically specific inscriptions (Butler 1990, Jackson 1999).

As well as merging gender and heterosexuality, there has also been a tendency within feminist literature to ignore the pleasure that many women experience from heterosex and to concentrate on women's sexual victimisation. Segal (1994) and others argue that the development of the 'women-as-victims' model has left heterosexuality overlooked as an area of women's struggle, power, and agency. The model of men as oppressors and women as oppressed has tended to be dominant in studies of sexual violence (see for example Cameron and Frazer 1987 or Dworkin 1988). It is imperative to recognise that violence, or the threat of violence, is a real and far too common experience for women. Indeed it has also led to the call by some feminists for women to give up having any sexual relationships with men, as the only way for women to gain power (for example the Leeds Revolutionary Feminist Group 1981). However, as Jackson (1999) has pointed out, this argument fails to distinguish between heterosexual institutions, experiences, and practices and tends to reinforce conceptualisations of women as inevitably and unavoidably becoming passive victims in their relationships with men. She argues that there is nothing innate within heterosexual sex that positions women as unequal, rather it is the social context of gendered power relations that give heterosex its meanings. For

Jackson, gender is the organising framework for heterosexuality, and it is the social practices of gender that inscribe the anatomical differences between men and women as meaningful.

Constructions of Heterosexuality and Effects on Contraceptive Practices

Smart has argued that whilst heterosexual sex is usually considered to be men penetrating women, if we consider other types of penetration and also the wide variation in sexual practices, 'it becomes unclear what is specifically heterosexual about heterosexual practice at all' (1996b:237). Although this argument is both authoritative and potentially transformative, currently within the institution of heterosexuality, vaginal intercourse is still considered to be the crucial element of sex (McPhilips *et al* 2001). This is a reason for contraception often being considered as a necessity. Moreover, the discourse of 'real sex' also affects the way that women can communicate their sexual desires (Meadows 1997) and is inscribed in safer sex literature promoting condoms rather than non-penetrative sexual practices (see for example Lewis 1997, Griffen 1998). Griffen (1998) has further argued that much of the safer-sex literature has identified women's empowerment with the ability to use condoms, further inscribing existing notions of penetration and male sexual performance as predominant.

The emphasis on intercourse and male sexual fulfilment evident in the safer-sex literature assumes constructions of male sexuality as active and female passive (see for example Smart 1994). Holland *et al* (1998) found evidence

that early heterosexual encounters tended to replicate this discourse, at the expense of young women's enjoyment. However, as young women grew in sexual confidence, although this discourse remained a central feature, they were more likely to consider their own sexual needs. Nevertheless, even if they succeeded in establishing an empowered sexual relationship, this would not automatically be replicated with any future sexual partner (Holland *et al* 1998), suggesting that female sexual power still eludes institutionalisation.

Ideas of 'uncontrollable' male sexuality continue to re/inforce women's responsibility for contraception. Intrinsic to the development and promotion of methods of contraception is the assumption that women are more likely to use them because of their risk of pregnancy, but also that they are sexually passive and therefore more rational. This can be seen in an emphasis on the development of female controlled methods of contraception, as well as literature encouraging women to carry condoms. Women are held to be accountable for male irrationality over their sexual desires (Smart 1994).

Yet, paradoxically, women's sexuality is simultaneously constructed as potentially 'chaotic' and 'uncontrollable', in a re/construction of the medical perception of women's disordered bodies. Moreover, it is the construction of a 'dangerous' female sexuality that leads to medical fears of the (ab)use of methods, such as an overdependence on the morning-after pill (Barratt and Harper 2000) or non-compliance with precise disciplinary regimes of specific contraceptive methods (Luker 1975). Women may also be deemed 'irrational'

and to need specific medical interventions, such as longer term methods like the IUD or injections, in order to remove the 'responsibility' from both themselves and their sexual partners. Consequently the competing discourses of 'passive' and 'dangerous' female sexuality are both constructed through and reinforced by contraceptive practices.

As Pollack (1985) points out, heterosexual sexual practices are expected to be both 'spontaneous' and 'intense' and methods such as the pill, which separate the sexual encounter from the act of contraception, appear to fit better with this dominant model. This type of method also upholds a model of female sexual passivity, by allowing women to be prepared but not necessarily expecting sex, and thus make it easier for women to be extemporaneous but not to risk pregnancy. To use barrier methods or withdrawal a more strategic set of sexual practices has to be employed, and they also require discussion and agreement between partners. Holland *et al* (1990) found evidence of this; many of the young women they interviewed were reluctant to buy and carry condoms, as they felt it could have a negative impact on their sexual reputations. This is further evidence of the way in which the utilisation of contraception is both inscribed by constructions of 'normalised' heterosexuality and at the same time re/produces these power relationships.

According to Giddens (1992), it was the separation of reproduction from heterosex that allowed the development of 'heterosexuality' to occur[6]. He argues that contraception has given sexuality its 'autonomy', and this has contributed to social changes which permit the emergence of 'pure relationships' as the emotional foundation of long-term relationships, including marriage. Although there is considerable evidence that there have been changes in the meaning of heterosexual relationships, for example the growth of serial monogamy in place of marriage for life, Giddens' optimism regarding the egalitarian nature of current relationships, and his presumption that modern contraception is an unproblematic experience for women, suggest that he has not fully considered feminist research in such areas. Furthermore, as Jamieson (1999) argues, perceptions of the 'pure relationship' have elevated the need for emotion work within heterosexual relationships, to create and sustain an impression of intimacy. Jamieson posits that rather than a transformation of gendered inequalities, the concept of the 'pure relationship' utilises and re/produces a therapeutic discourse that individualises personal problems at the expense of sociological understanding of power in relationships.

Women have gained more control over their fertility through modern developments in non-coital related methods of contraception, although currently they cannot unilaterally protect themselves against sexually

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[6] Gidden's (1992) argument seems to assume that technological innovations in contraception, such as the contraceptive pill, are an important element in these developments. Yet no direct link has been established between the development of contraceptive technology and fertility rates (McLaren 1999).

transmitted infections. Moreover, as Petchesky (1986) points out, sexual intercourse with men has always been a health hazard for women. Pregnancy, abortion, sexually transmitted infections and contraception can all be detrimental to women's health, and although women would obviously welcome a reduction in the health risks, the potential control over their fertility that modern contraception offers cannot be denied. Pollack (1984) has suggested that whilst women have gained 'responsibility', this has been offset by a decline in male 'responsibility', and thus women are now solely accountable for any 'failures'. Ringheim (1999) has argued that attempts should be made to increase men's share of responsibility as she sees the imbalance as symptomatic of gender inequality. However, if men are encouraged to be more involved in decisions over fertility this may reinforce rather than decrease inequality, since it has the potential to allow men to be able to exert control over women's bodies. Moreover, this assumption does not consider how women's experiences of contraception are both embedded in and re/enact such a complex range of power relationships, formed through the discourses and institutions of medicine and heterosexuality that I have outlined above, because simply including the responsibility of men does not confront these wider ideologies or their purchase on individual couples.

Conclusion

Contemporary popular and medical opinion see contraception as an unproblematic necessity that (heterosexual) women are easily empowered to access and use. Both locate contraception within a form of the consumerist

model within which women can be guided by experts to make the 'right' choice. This image contrasts sharply with feminist literature that has argued that women's experiences of contraception have always been re/formed and re/produced in relation to wider social relationships. Feminist literature has been sensitive to the medicalisation of contraception as a gradual extension of medical governance over women's bodies. Moreover, both the use and non-use of contraception has been shown to pose risks to heterosexually active women's health, including the risk of pregnancy, side affects, and sexually transmitted infections. Whilst certain risks have been downplayed by health professionals or corporate interests (for example the side effects of contraception), others have been minimised by women themselves (such as the risk of sexually transmitted infections).

This chapter has argued that just as contraceptive practices are embedded within heterosexuality, heterosexuality is in turn constructed through contraceptive practices. Contemporary discourses of heterosexual sex still portray men as the active participants and women as passive, with an emphasis on vaginal intercourse as 'real sex'. These constructions may re/inforce women's responsibility for contraception, as the 'rational' partner who can be relied on in relation to men's uncontrollable sexual urges, thus women's responsibility for and use of contraception reinforces certain discourses of heterosexuality. Yet, paradoxically, women's responsibility for contraception can also be construed as evidence of an ' active' sexuality, and construct them as deviant.

A crucial difference between popular and medical literature and feminist analysis is the attention given to power relationships. Whilst the consumerist model employed in popular opinion precludes such questions, feminists have argued that power relationships, such as between doctors and patients or heterosexual partners, are at the centre of women's contraception experiences. Although feminist literature on both reproductive health and heterosexuality has considered contraception, currently research has not fully integrated these two aspects adequately. I suggest that it is only by giving full consideration to the extent and complexity of all the power relationships that surround contraception that an understanding of women's decisions and everyday practices can be achieved. This chapter has outlined the complexity of contraception, its liminal position within medicine and heterosexuality, and the need to understand the power relationships within which it is located. The next chapter will focus more closely on conceptualisations of power and show that an understanding of power will allow an exploration of the range and diversity of the constraints and capacities which re/construct women's experience of contraception.

Chapter 3

Power: A Contested Concept

Introduction

As their starting point is gender inequality, feminists have often paid particular attention to explanations of power. As the last chapter illustrated, the feminist literature on medicine and heterosexuality has often focused on the control of women's bodies as the root or manifestation of the power relationships between men and women, and feminist theories have provided a range of concepts to explain how power operates to construct and maintain social inequalities. In this chapter I will consider different feminist conceptualisations of power in terms of their capacity to deal with the complexity of women's experiences of contraception in relation to medicine and as a constituent of heterosexuality.

Feminist theories have often needed to adapt or develop more general sociological models of power, or in some cases to repudiate them, in order to explain gender inequalities. Consequently, feminist explanations deal with many of the same dilemmas raised in sociological literature, such as the tension between structure and agency. Early second-wave feminists saw structural factors as the predominate cause of women's powerless position, and many drew from Marxist models in which structures were seen to reproduce themselves and constrain individuals' lives despite the nominal freedom they had. However, conceptualisations that focus on structures often imply that

individuals are like puppets, and the ability to exercise agency is demoted. Whilst the debate between the relative importance of agency and structure continues, Foucault's work, focusing on the productive capacity of power in promoting ideals and norms in society, has also been significant to feminist theories of power. For Foucault, power is relational in that it is an effect of relationships between groups or individuals. Consequently, whilst structures are implicated in the deployment of power, they can not be said to hold power over individuals.

This chapter will begin by considering the concept of patriarchy and how it was used to explain both women's position within heterosexual relationships and their treatment by the medical profession. I will then consider feminist appropriations of Foucault and how his theories have been used to explain aspects of medicine and sexuality. Next I use a feminist empirical study to assess the usefulness of rational choice theory, and consider how far these studies can explain the complexity of women's experiences of contraception. I will argue that although many of these feminist theories shed light on specific aspects of women's contraceptive experiences, in their current form they cannot do justice to its complexity. In the final section, I will outline my model of power, one which draws from two existing theories to produce an integrated model that recognises both structural and relational aspects of power.

Feminist Theories of Patriarchy

For many feminist writers in the 1970s and 1980s, patriarchy was the structural system of male domination, enabling men as a group (and in many cases individual men) to wield power over women. Power is considered as a possession in this tradition, accumulated by men as a social class, and used to subjugate women. Although originally defined as universal and monolithic, distinctions have increasingly been made between different forms of patriarchy. For example, Walby (1997) not only distinguishes between public and private patriarchy, but also argues for the need to consider how other social divisions (such as class and 'race') transform the form of patriarchal oppression.

(Hetero)Sexuality and Patriarchy

Whilst (hetero)sexuality has long been a subject of feminist theorising, Jackson (1999) argues that in early 'second-wave' feminism the focus was more on the outcomes of heterosexual practices and institutions and it took some time for heterosexuality to emerge as an object of theory. For example, feminists challenged the silence surrounding issues such as rape (such as Brownmiller 1975) and domestic violence (for example, Moore 1979), and often focused on marriage as an oppressive institution, rather than foregrounding 'heterosexuality'. It was the end of the 1970s before widespread critiques of heterosexuality began to emerge, many of them from a lesbian feminist position. Rich's (1981) article outlining the concept of compulsory heterosexuality was particularly significant in drawing attention to the way

society was structured through normalised patriarchal heterosexuality. For Rich, male power is institutionalised and operates through the denial and curtailment of women's affiliation with other women. Moreover, Rich argued that whilst women had throughout history supported other women against male excesses, a more explicit move towards the lesbian continuum could be a source of female power. Unlike other radical feminist groups (such as the Leeds Revolutionary Feminists 1981), Rich did not call for women to end heterosexual relationships, but her concept of power is similar, in that male dominance is constructed as structural and systematic, giving men power, including sexual rights, over women.

Other radical feminists also sought to explain how male sex rights over women's sexuality were critical in enforcing women's subordination. MacKinnon (1982) argued that an understanding of sexual oppression was essential and compared it to Marxist theories of the appropriation of labour under capitalism. Whilst Marxist theories identified the means of production as a single source of power, McKinnon argued that the control and ownership of women's sexuality was the source of patriarchal power:

> The substantive principle governing the authentic politics of women's personal lives is pervasive powerlessness to men, expressed and reconstituted daily *as* sexuality. To say that the personal is political means that gender as a division of power is discoverable and verifiable through women's intimate experiences of sexual objectification, which is definitive of and synonymous with women's lives as gender female (1982:535).

Thus for MacKinnon, (hetero)sexuality is both the source of and mechanism through which men retain power over women, and by studying sexual oppression we can begin to understand the extent of male power.

Patriarchal Domination in Medicine

Many early second-wave feminist studies of medicine also found the concept of patriarchy useful in exploring the way women were treated. They drew attention to the gendered nature of medicine in which doctors were almost exclusively men, and the implications this had for women as both patients and workers (such as nurses) within medicine (for example see Ehrenreich and English 1979, Foster 1995 or Witz 1992). Histories of medical diagnosis and treatment of women were collected and used to document the power that male doctors systematically exerted to make women conform to doctor's own perceptions of acceptable behaviour, particularly in the areas of reproductive health and sexuality (Ehrenreich and English 1979, Foster 1995).

Many feminist accounts highlighted that (male) doctors did not just define and control medical encounters, but routinely patronised women, dismissed their symptoms, and infantalised them (see for example Pollack 1984; Oakley 1993a). In the area of childbirth, for example, Oakley (1976) traced how pregnancy became medicalised in Britain, moving the control of childbirth from 'wisewomen' to male doctors during the nineteenth and twentieth centuries. Women were increasingly encouraged (or coerced) into hospitals to give birth, despite a higher risk of puerperal fever in the early years. Once in

hospital, interventions such as episiotomies, the use of forceps, and caesarean sections increased, alongside the routinisation of unnecessary procedures such as the shaving of pubic hair and the giving of enemas. It was through using the concept of patriarchy that feminist researchers could make important links between the significant power that many (male) doctors have routinely exerted over women's bodies, the design and implementation of treatment on a presumption of women's subordinate status, and the oppression and inequality women suffer in other areas of their lives.

The Problem with Patriarchy

Whilst the concept of patriarchy was usefully employed by second-wave feminists to draw attention to women's usually subordinate status, it oversimplifies complex relationships. Although doctors do retain considerable authority over medical practice, the model of patriarchal medicine does not fully represent the power relations in which both doctors and patients are located. For example, doctors retain the right to recommend or refuse certain treatments, but they themselves are subject to controls and limitations on their practice. For instance, within Britain, NHS doctors can only prescribe from a range of treatments approved by their health authority, and authorised by bodies such as the Medicine Control Agency. Professional associations, such as the British Medical Association (BMA), also act to shape the boundaries of normative practice, and the pharmaceutical industry develops and markets particular treatments from which doctors make their choices. Moreover, patients themselves are becoming more vocal and some challenge, and

sometimes overturn, decisions made by doctors (Lupton 1994). In addition, as men's monopoly of medicine decreased it became clearer that doctor's power does not stem entirely from their 'maleness'.

Lupton (1994) further argues that although the professionalisation of doctors gave them the legal-rational authority to exercise power over their patients, this does not fully explain doctor/patient interaction. Lupton (1994) describes how both functionalist accounts (such as Parsons 1951) and political economy perspectives (e.g. Freidson, described in Lupton 1994) have both highlighted medical dominance, although they disagree on its nature. Within the functionalist perspectives, doctors have a legitimate right to exercise power, and it is in society's interests for them to do so. In contrast, political economy perspectives construe doctors and patients as having competing interests such that conflict is inevitable. Such perspectives highlight the role of the state in legitimating the power of the medical profession, and the way corporate and middle-class interests are effectively allowed to socially control people of lower class positions, both as workers and users of health care. They often further highlight that the current definitions used by medicine individualises illness, and removes attention from the social and economic determinants of health and the iatrogenic effects of medicine.

It is the complexity of power relationships that is also an issue within theories of patriarchal heterosexuality. Despite their importance in raising awareness of the social construction of heterosexuality as a gendered relationship, its

institutionalisation (such as through marriage) and the extent of sexual violence, theories of patriarchal heterosexuality remain limited in their explanatory value. As Cooper (1995) has pointed out, whilst it is important to recognise domination and inequality, models of power which see the oppressed as totally lacking in power do not explain the complexity of power relationships. She argues that if only one group is recognised as having access to power, the ways that oppressed people exercise agency or resistance within systems of hegemony or domination is rendered invisible. Moreover, this approach also implies there is a hierarchy of groups within society, from the powerful to the powerless, and this cannot adequately recognise complicated identities that emerge from individuals' positioning within different hierarchies such as those of social class, 'race', or gender. For example, models of patriarchy that proclaim men as the oppressors and women as the oppressed, provide little room to explore how white women may have access to more power than black men (hooks 1990). Cooper (1995) also points out that by seeing power as the control of one group by another, we can also overlook the effect of power relations on all groups. While institutions of heterosexuality often position women as subordinate to men, they also have disciplinary effects on men.

Feminist Appropriations of Foucault

Foucault's theory of power moves us away from seeing power as a possession of a particular group, and focuses attention on power as a process that is often productive, rather than merely restrictive or prohibitive. For Foucault:

> Power exists only as exercised by some on others, only when it is put into action, even though, of course, it is inscribed in a field of sparse available possibilities underpinned by permanent structures. (...) It operates on the field of possibilities in which the behaviour of active subjects is able to inscribe itself. It is a set of actions on possible actions; it incites, it induces, it seduces, it makes easier or more difficult; it releases or contrives, makes more probable or less; in the extreme, it constrains or forbids absolutely, but it is always a way of acting upon one or more active subjects by virtue of their acting or being capable of action (2000:340-1).

Power is thus a process within relationships, whether between individuals, social groups or institutions, and whilst it can involve sanctions, more often it generates specific ways of thinking and acting. Foucault stated that the body, and sexuality in particular, are sites for the operation of power, and that the nineteenth century saw the introduction of 'biopower', whereby new technologies of surveillance produced 'docile bodies'. Whilst Foucault's work has been criticised for his lack of attention to the use of force and the power of the state, it does draw attention to the micro-operation of power and the complex and myriad ways that power is exercised (Ramazanoglu 1993).

Sexuality and Biopower

Foucault maintained that power and knowledge are inseparable, and that discourses surrounding the body both produce and maintain ideas about sexuality. However, although there are dominant discourses, the ideas they contain are constantly challenged by other, subordinate discourses. Consequently, resistance is a constant feature of power relationships. Moreover, it is not possible to eradicate power; resistances merely destabilise

or subvert power relations to the point when they become absorbed into the dominant discourse (McNay 1992).

Many feminists (for example Harstock 1990) have been critical of Foucault's writings. They often highlight Foucault's lack of attention to gender relations and the downplaying of the structural basis of power. However, it is widely accepted that his development of the concept of discourse and the effect of the disciplinary gaze make a strong contribution to feminist understandings of society (Ramazanoglu 1993). They allow an exploration of the impersonal operation of power through discourse, which is beyond and outside the interests and activities of any particular person or their gender. In particular, Foucault's concept of a productive biopower makes it possible to see the sexed body as both an instrument and effect of modern disciplinary power (McNay 1992). Although the body has a corporeal existence, sexuality can be understood as a 'historical construct', resulting from specific management regimes aimed at disciplining individual bodies and regulating the wider population (Foucault 1990).

Alongside the argument that Foucault underestimated the structural basis of power, such as the exercise of force and domination (Cooper 1995), he has also been censured for his apparent demoting of agency (McNay 1992). In his defence, McNay has argued that although his concept of 'docile bodies' is important, in his later work Foucault began to develop his ideas about the 'practices of the self', whereby individuals make autonomous decisions which

relate to but do not simply reflect the disclipinary effects of discourses. McNay argues that criticising the lack of agency in Foucault's theory is unjustified, and that his ideas on individual autonomy can be related to his notion of ever-present resistance. McNay further argues that although in origin gender blind, we can utilise Foucault's concept of practices of the self to understand how gender identity is both formed through discourse and an active process undertaken by individuals.

By utilising Foucault's concept of power, it is possible to overcome essentialising notions of the power relationships between women and men. Thus while male domination of women may often be associated with or physically sited on women's bodies, no 'natural' differences between the sexes have to be invoked (McNay 1992). A Foucauldian approach also allows an understanding of the way notions of sexed bodies and sexual differences are formed through discourses that justify and normalise gender inequalities. However, whilst the emphasis on discourse usefully highlights the social construction of sexuality, it can also decentre the corporeality of bodies. Access to and usage of contraception is shaped by and through the social context. It is an embodied technology, and has material effects on women's lives. Consequently it is necessary to ensure that whilst the importance of discourses in shaping contraceptive experiences is emphasised, this is not done at the expense of material and structural factors.

Foucauldian Explanations of Medicine

Foucault has had a significant influence on medical sociology and his work has been used to explore areas such as power/knowledge, disease categories, and medical surveillance and governmentality (Turner 1995). For example, Harding (1997) explores hormone replacement therapy (HRT) as a technology of power and argues that the competing discourses of medicine and feminist writing on HRT both construct the postmenopausal woman as a body at risk. Harding's study shows how the medical discourse assumes that surveillance through medical consultations is normal for menopausal women, and that HRT can overcome the 'limitations' of female physiology at this point in time. Yet paradoxically, although critical of the medicalisation of the menopause, feminist writing often also constructs postmenopausual women's bodies as at risk through their advocation of a 'healthly lifestyle' and emphasis on self-help through education (Harding 1997).

Thus whilst the feminist political project of empowerment through education (Harding 1997, Howson 1998) is a competing discourse to that of medicine, it also produces norms and values and is thus an instrument of governmentality. Foucauldian analysis allows exploration of how the female body is constructed within and through a range of health discourses, including feminist ones, and highlights the technologies of surveillance which produce power/knowledge. Moreover, in contrast to earlier views, which position an essential female body which can be freed from patriarchal medicine, it sees women's experiences of the body as constituted through discourses and everyday practices (Lupton

1994). This emphasis on the role of practice in power relationships has been developed further by other theorists.

EverydayPractices

The importance of everyday practice in reproducing power relationships has been raised by both Bourdieu (1998) and de Certeau (1988). For Bourdieu (1998), the embodiment of class affects cultural capital, and thus may limit or enhance individuals' social positioning through symbolic power. The concept of practice draws attention to the way autonomous individual actions are taken within structural situations. De Certeau (1988) in particular highlighted the importance of understanding the social context when considering the ability to adopt practices and he argues that there is a difference between 'strategic' and 'tactical' practices. He maintains that while 'strategies' are adopted by those whose institutional locations enable them to legitimate their enterprises, 'tactics' are the only tools available to the 'other', who have to seize opportunities 'on the wing' (1988: xix). Tactical options have to be continually negotiated or utilised and illustrate that individuals can manipulate situations or events not controlled by them to their advantage. Using de Certeau, it could be argued that doctors use strategies and patients can only have tactics. However, I would argue that this division over simplifies the contrast between doctors and patients. Whilst doctors do retain control over prescriptions or other medical treatment, their actions are also constrained and enabled by other factors. Moreover, women could have both an institutional location by virtue of being white, middle-class and married, yet be located as the 'other',

through contracting a sexually transmitted infection. Consequently, I do not think that this distinction can be usefully employed within this study, and the term strategies will be employed to describe both legitimated actions and those that have to be continually re-negotiated.

It is only by exploring women's everyday relationships to contraception in depth that we can understand how their individual decisions are shaped by the social context. For many women, the use of contraception is now so routine that, although they are making specific choices, they do not necessarily consider the decisions they make as an active process, but one that is predetermined by their taken for granted right to control their fertility and attitudes towards the current range of methods available (Lowe 1998). A focus on the way everyday contraceptive practices are moulded by the social context allows for an acknowledgement of the constraints surrounding women's lives but at the same time gives recognition to the agency they may exercise in making particular decisions in what they regard as their own best interests. Consequently, what is required is a model of power relations that can recognise the complexity and varying strengths of influences on women's decisions, the importance of everyday practices and strategies, and the extent of women's agency.

Rational choices?

The idea that women users of contraception adopt certain strategies in order to pursue desired outcomes should not be seen as an endorsement of rational

choice theory. Luker's (1975) study of contraceptive risk-taking is a classic example of the application of rational choice theory to contraception. Luker argues that although medical professionals assume that women who do not wish to become pregnant should always use contraception, they fail to consider all of the 'costs' and 'benefits' of this decision for women. Unlike some other proponents of rational choice theory, Luker argues that her definition of rational action includes 'less-than-fully conscious decisions' (1975:79), which makes it relevant to contraceptive use and non-use. She accepts that most women do not carry out an explicit cost/benefit assessment before they decide to take contraceptive risks, but rather weigh up different and often uncertain factors, such as their assessment of the likelihood of a pregnancy occurring, and any possible health implications from using contraception. Thus, Luker argues that for some women taking contraceptive risks is a more rational action than using contraception.

Whilst Luker's study accepts the complexity of contraceptive decisions, and recognises the different priorities medical professionals and women often have, she does not consider the shaping or constraining of decisions in terms of power. For example, Luker admits that family planning clinics have institutional practices that deter some women, but sees these as merely technical difficulties which could readily be changed, for instance by shifting from appointment to drop-in services (1975:150). She also argues that services should take steps to include men, as this would encourage mutual decision-

making (1975:151), without considering that couples may not be equal even within long-term relationships.

Luker's study highlights some of the problems that the application of rational choice theory has more generally. As Archer and Tritter (2000) argue, rational choice theory is based upon a notion of individual decision making that cannot fully account for structural factors. Whilst some of the women whom Luker interviewed might have been able to make different decisions if, for example, contraceptive services had been more freely available or safer alternatives developed, others would not have been able to change their actions as they could not deploy sufficient power to do so.

Despite these limitations, Luker's research (and rational choice theory more generally) does draw attention to the way particular contraceptive decisions can involve weighing up of risks and benefits, intricately related to a specific moment of time and space in each woman's life. Whilst it focuses on the women's individual decisions, it also draws attention to how assumptions of what is 'rational' permeate institutions such as medicine and form part of health professionals' judgements of women's decisions. However, whilst it may furnish some useful tools, its utilitarian reduction of complex lives into a simplistic calculation, and the lack of attention to the social nature of decision-making, mean that it cannot fully explain social action (Beckford 2000).

Powerful Heterosexuality?

One of the most recent feminist conceptualisations of power has emerged from Holland *et al's* (1998) study of young woman and heterosexuality. Holland *et al* have developed a sophisticated model which encompasses five interrelating 'layers/levels' of heterosexual power: language; agency; institutions; embodied practices; and variability through time and space. It incorporates power as productive and relational but argues that within the current social context men do have power over women (1998:24). Using this model to analyse their data, they argue that male domination is institutionalised and they conceptualise heterosexuality not as a duality but as masculinity. They argue that because male dominance is so entrenched, an autonomous female sexual identity rarely emerges:

> Heterosexuality is not, as it appears to be, masculinity-and-femininity in opposition: it *is* masculinity. Within this masculine heterosexuality, women's desires and the possibility of female resistance are potentially unruly forces to be disciplined and controlled, if necessary by force.
> (1998:11. emphasis in original)

According to Holland *et al,* male power is re/inforced through cultural 'norms' of heterosexuality. Male sexual needs are privileged, and both women and men are susceptible to the sexual disciplinary power of the 'male-in-the-head', whereby the double standard of sexual behaviour and wider discourses of heterosexuality are internalised. They argue that although individuals do challenge the privileged position of masculinity, their resistances can often be accommodated within the discourses rather than subverting the power

relations of heterosexuality itself. This is consistent with Hollway's (1984) analysis of how the emerging 'permissive discourse' built on rather than disrupted other heterosexual discourses leaving the gendered positions largely intact.

Holland *et al's* development of the concept of the 'male-in-the-head' usefully illustrates the importance of self-surveillance in the maintenance of normalised heterosexuality. It also recognises agency within social structures, in highlighting how young women are active in their acceptance of the constraints. However, whilst their concept of power draws attention to the complexity of power relationships and the normalisation of male sexual desires within a naturalised heterosexuality, it still rests on the notion of power normally located with young men and thus a corresponding need to empower young women. This undermines their assertion of young women as full active subjects. In addition, despite their detailed model of heterosexual power, their conclusions imply a monolithic concept which does not seem to reflect their data. The young women they interviewed can be seen to both benefit and lose from conforming with the 'male-in-the-head'. Acceptance of the 'male-in-the–head' does reflect a weaker position and an all too common inability to assert their own sexual desires, as Holland *et al* rightly point out, but conforming to societal norms like normative femininity can also bring the benefit of acceptance within a peer group.

Holland *et al's* study considers empowerment to be a process for young women, and they set out four points on a continuum to pinpoint the extent to which different young women were empowered within heterosexual relationships. The authors defined these stages based on their assessment of the ability of the young women to practice safer sex. The study seems to automatically equate the non-use of safer sex practices with a disempowered position, without fully exploring how the different levels of power they identified, such as institutionalised heterosexual norms and embodied practices, may contribute to any decision about safer sex practices. The promotion of heterosexual discourses that discourage safer sex will of course contribute to negotiation (if any) around safer sex by young women. However, whilst I might agree with Holland *et al* on the need for safer sex practices, to automatically assume that women's failure to insist on safer sex equals a disempowered position, without exploring to what extent safer sex practices were a priority for the young women, overlooks the complexity of power relationships and also downplays women's agency.

In order to understand women's contraceptive experiences we have to be able to understand the complexity of power relationships which shape and reflect the institutional context without overlooking the extent to which individuals exercise agency. Any specific contraceptive decision is embedded within a myriad of social factors; contraception is not just a point of intersection between medicine and heterosexuality as institutions, but re/forms and re/produces both heterosexual partnerships and doctor/patient relationships.

The choice of using or not using contraception can also affect other areas of women's lives, including education and employment, and often figures within transitional life-course decisions. Within my study a key measurement of deployment of power will be the level of self-determination felt by the women. How far were the women able to make autonomous decisions in what they considered to be their own best interest about whether to access and utilise contraception; and, if they were able to do so, what factors influence their chosen contraceptive method? By using self-determination as a measure, I hope to ensure that the women's ability to exercise agency will be assessed by their capacity to reach their own goals rather than goals declared as necessary by others. In order to achieve this level of analysis, a complex model of power is required.

Subjective power within a Polysemic Model

My model of power synthesises concepts developed by Cooper (1995) to explore sexuality and the state, and Layder (1997)'s theory of social domains, in order to analyse the agency that individual women can exercise over contraception and the power relations with which they have to contend. It allows for an exploration of the connections between women's individual circumstances and the wider social context. The model will open up for scrutiny whether and how the women draw from and subvert discourses and resources circulating within society to gain and preserve control over their reproductive lives, engaging with their unequal positioning within both hegemonic heterosexuality and the doctor/patient relationship.

For Cooper, power is 'an ongoing process' (1995:25) which is 'polysemous' in its nature. It operates through the generation of effects, and can be both productive and involve domination. Thus gender inequality is an effect of the multiple deployment of power through different social forms, rather than being solely rooted in the social norms ascribed to male and female bodies. This gives the advantage of highlighting the impersonal and productive elements of power, and does not assume that individuals have *a priori* interests that are denied them by powerful groups; that all interests are constituted through the social context. Layder also considers power to be a 'multi-form phenomenon' (1997:174), but suggests that we need to consider the link between power and emotion, particularly within individual agency. He argues that interpersonal behaviour is both shaped by and shapes power relationships, alongside other factors such as discursive or institutionalised norms.

In order to build up my model of power I will first outline in more detail each of the concepts developed by Cooper and Layder, with examples that might be relevant to a study of contraceptive experiences. Although the concepts within each model will be summarised separately, it must be remembered that this is just to facilitate the analysis, and in reality they are closely intertwined and interdependent. I will start by outlining Cooper's (1995) four modes of power (ideology, force, discipline and resources), and her three concepts for locating the operation of power (technologies, sites and effects). I will then consider their relationship to three concepts in Layder's social domain theory (situated

activity, social settings and contextual resources). After that I will discuss Layder's (1997) remaining concepts of emotion and psychobiography, and introduce the concept of subjective power.

In the final section, I will show how I have used these concepts to develop a model of power that can be used to explore and understand the complexities of women's lives. Building on the successive insights of feminist theory, it aims to overcome some of their limitations. Drawing from the earlier studies of patriarchal power, it will take into consideration the structural elements of women's unequal positioning, but rather than seeing power as a possession, will consider power as emerging from relationships. It will draw from feminist appropriations of Foucault and consider power/knowledge in the constructions of discourse, but will also highlight the embodied and material effects of power. I will expand on the interdependent relationships between the modes of power and their orchestration and it will be argued that whilst an individual's subjective power is drawn from the different modes of power, it is also variously affected by the site and type of encounter that individuals are involved in.

Cooper's Concepts for Analysing Power Relationships

Ideology

The first of Cooper's modes is ideology, which she describes as the 'range of interpretative frameworks and meanings through which social relations, practices and society generally are constituted and understood' (1995:21).

Many people's expectations about heterosexuality can be understood as being governed by this mode of power. For example, the unquestioning acceptance of heterosexuality as 'normal', as well as the cultural reinforcement of normative ideas of feminine and masculine behaviour portrayed by the media, can be understood as exercising ideological power, which facilitates or limits individuals' wish or ability to exercise agency.

The ideological mode of power could also be used to explain how discourses of 'acceptable motherhood' might influence women's contraceptive decisions. Not only is there still societal pressure for women to have children, they are also supposed to have an acceptable number, at an acceptable age (see Smart 1996a). Moreover, a pregnancy is still more socially acceptable within marriage or at least a long-term heterosexual partnership than outside it (unless of course the woman is deemed to be too young or too old). Although the prevalence and importance of ideas about 'motherhood' will vary, they still have to be contended with when women are making contraceptive decisions.

Other factors that could be governed by the ideological mode of power are the medical model of contraception, and the hegemonic status of the pill. Circulating discourses that prioritise the prevention of unplanned pregnancy and/or associate the prevention of sexually transmitted infections with deviant populations may also be linked to the ideological mode of power. Religious teachings on contraception, and their affect on women, are also within the ideological mode of power. Both in cases where women accept religious

dictates or where they have consciously rejected them. In either case, as with the above examples, women have to make their decisions either by accepting, manipulating or contesting ideas and discourses that circulate within society.

The concept of ideology draws attention to the circulating ideas and discourses which help to shape the social context as a facet of power. It allows consideration of how women perceive their role, rights and responsibilities within the wider societal framework of 'normalised' heterosexuality and a medical model of contraception. Moreover, it can be used to examine which of these circulating narratives can be said to empower women, or which women can appropriate to empower themselves, as well as when the narratives act to limit women's perception of the choices available to them.

Force

The second mode of power, force, refers to the actual or threatened use of physical or psychological violence to compel or coerce an individual to act in certain ways. As Cooper (1995) points out, although many Foucauldian relational models of power reject the continuing importance of force, it is still important to recognise that in some situations individuals simply cannot act autonomously, as the potential for them to make a choice has been taken away. As research on domestic violence and rape has shown, many heterosexual relationships are the sites of sexual violence inflicted on women, and it is especially important to recognise how force can shape women's lives (see for example, Kelly 1988, or Hester *et al* 1996).

Force can be understood to remove some or all of an individual's capacity for subjective power. Whilst it is obvious that extreme force will have a severely limiting effect on the ability of women to act autonomously, this concept could also be useful in identifying situations when women exercise agency in specific ways because of an actual or perceived threat of force. For example, this mode of power may lead to women acting in secrecy, to avoid confrontation within a heterosexual partnership. In some situations, it may lead women to make decisions based more on fear of the risk of violence than their own concerns about contraception. Other areas of conflict, apart from heterosexual relationships, may also influence women's contraceptive decisions. For example, when they were younger, women's concerns about severe parental opposition may also fall into this category.

Discipline

Discipline is the third of Cooper's modes of power, and she defines this as 'spatial and temporal mechanisms through which social interactions, institutions and bodies are ordered' (1995:22). She argues that it is through sexual disciplinary power that 'normalised' heterosexual practices are reproduced. The laws and regulations that re/produce and regulate heterosexuality as an institution can be understood as exercising disciplinary power. For example, marriage is still supported as the preferred arrangement for heterosexual couples, and the social security and tax systems still re/inforce women's dependant status on men they are living with (Segal 1999).

The medical control of reproduction also exerts disciplinary power. The contraceptive encounter subjects women to the surveillance of the medical profession. Moreover, because, in some cases, women and their bodies are perceived by doctors as being undisciplined, reported side effects or failures of contraception may be attributed not to the contraception itself but to a failure on the part of the women (Todd 1984, Foster 1995).

Each method of contraception can be understood as having a specific disciplinary effect on women's bodies, and positions women differently within the power relationships of heterosexuality and medicine. For example, the contraceptive pill gives women control over their fertility but requires them to take a daily dose of hormones within a set period of time, and they can only access the pill by submitting themselves to the disciplinary regimes of the medical profession. Moreover, the pill alone offers no protection against sexually transmitted infections. In contrast, using condoms frees women from medical surveillance, yet they are then dependent on male co-operation in protecting themselves against pregnancy and/or sexually transmitted infections in each and every episode of penetrative sex. Consequently, when making decisions about contraception women have to consider both the disciplinary effects that each method has over their bodies as well as the level of agency that it will allow them to exercise.

Resources

The final mode of power is resources, since Cooper (1995) considers the ability to access and deploy material advantages as a potential form of power. This mode does not just refer to wealth or access to other assets, but encompasses a wider definition, for example by including cultural capital. How women are socially positioned within society, including their class, ethnicity, or age, will have an effect on their ability to negotiate access to contraception from the medical profession, which will in turn have an impact on the power that they are able to exercise within heterosexual relationships.

For example, because in Britain most forms of contraception are available without charge through the National Health Service, women's financial position should not affect their ability to access contraception. However, it is likely that the levels of cultural capital women are able to deploy will have an affect on their ability to access forms of contraception that are not affirmed by their doctors as being the most suitable. Moreover, women who do not speak English as their first language may encounter barriers to their choice in contraception, for example, through not being able to negotiate with medical professionals, or by racist assumptions about their levels of comprehension, or other racial stereotyping (Douglas 1998).

The resources mode of power also allows us to take into consideration how individual women are positioned within their heterosexual partnerships. For example, women who are financially dependent on men may feel less able to exercise power over contraception, particularly if they consider that there may

be a conflict between their own preferred options and those of their male partner(s). Moreover, the level of resources that women are able to draw on will probably vary according to the type of heterosexual partnership. Women in long-term partnerships may feel, rightly or wrongly, that they have sufficient security to utilise a less effective form of contraception, since, should a pregnancy occur, a partner would share his resources in supporting a child. Conversely, some women who have sexual intercourse in short-term relationships may feel that a higher level of protection is required as they may only have their own resources to draw from should a pregnancy occur.

Technologies, Sites and Effects

As well as these four modes of power, Cooper (1995) identifies three further concepts necessary to analyse the way in which power relations operate. The first of these concepts she describes as 'historically specific technologies'. Cooper maintains that it is through these technologies that power's productive capacities are exercised. She gives examples such as cultural norms, the law, surveillance, and wealth as technologies related to the different modes of power.

Technologies can be understood as the modus operandi of power in people's lives. The concept describes the ways in which discourses, patterns of inequality, and other practices shape social perceptions and circumstances. For example, the media's re/construction of gender relations informs idealised notions of heterosexuality, which may then have an impact on the perceived

range of cultural practices available to individuals who are positioned within specific class, 'race', and sexual identities. Thus discourses of heterosexuality can be understood as shaping the technologies of power which operate through the dissemination of the ideologies throughout society.

Another 'technology' of power has developed through the medical control of contraception. Medicalisation has meant that most women will be asked to discuss contraception with their doctors at some point (even if only to inform them that they do not want any method prescribed). This is just one of the areas in which women are subjected to the surveillance of the medical profession over their reproductive lives. Moreover the form of health care in Britain, with free supplies and national distribution of contraception, means that accessing contraception cannot be taken as a measure of empowerment in the same way as it might have been historically in Britain or for women today living overseas. We cannot measure power simply by considering different degrees of access to contraception because nominally all British women have the same free access[7]. It is only by considering the complexity of power relationships that we can begin to understand how women remain both constrained and enabled despite this formal freedom.

The manifestation of a particular technology is also interrelated with Cooper's second concept, the sites that power operates in. These are particular locations with their own forms of governmentality. Within the field of contraception,

[7] Young women may experience problems accessing contraception, particularly if they are under the age of consent, but providing they are considered 'competent' access is available.

the GP surgery and the family planning clinic are examples of sites of power. For Cooper, sites are not just geographic or institutional but can also be systemic, such as welfare systems and the wider organisation of the NHS.

The final concept that Cooper outlines is the effects of power. The effects of power can either be planned outcomes or unintended events, and it is likely that all power relationships will have some form of effect. Moreover, the effects may have consequences for further resisting or subverting the deployment of power, either within that particular power relationship, or within others associated with it, or even one not directly linked except through external circumstances. For example, if a woman could not persuade a doctor to prescribe a particular form of contraception, this may have an effect both on any future doctor/patient relationship and on the women's position within any heterosexual relationship. Another example is the Gillick Case[8], which produced uncertainty in the public sphere over the legitimacy of prescribing contraception to young women. It had the effect not only of making doctors wary of prescribing but also reduced the numbers of teenage girls asking for contraceptive advice (Holly 1989).

By allowing for the development of analytical consideration of both the intended and unintended consequences of particular actions, Cooper's concept of the operation of power through effects could also be insightful when

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[8] Victoria Gillick took her local health authority to court to prove that it was illegal for doctors to prescribe contraception to girls under sixteen without seeking parental consent. After lengthy proceedings, including judgements both for and against the plaintiff, the action was rejected by the House of Lords (See Brahams 1987).

considering heterosexuality. For example, in relation to contraception, we could use this category to understand the changes that a pregnancy (whether intended or unplanned) may have on the power relations of a particular heterosexual relationship.

As Cooper points out, using a relational and productive approach to power allows us to consider 'power as an ongoing process' (1995:25). Heterosexual partnerships, like most intimate relationships, are not static, but have a variable or maybe even erratic character (and, as previously discussed, heterosexuality itself is an unstable category). The doctor/patient relationship too is far more complex than the patriarchal models of the powerful dominating the powerless allow for. Power relationships are continually generated and thus have a dynamic character. It is only by considering the complexity and variability of power relationships, and how this affects the complex processes of negotiation and contestation over contraception, that a greater understanding of women's experiences will be achieved.

Cooper maintains that although her model of power might appear to be concentrating on structural factors, this is because the 'access', 'quality' and 'character' of power is shaped by the current inequalities of society. However, she argues that:

> Human and institutional actors have the capacity to recreate or transform the social forms through which power operates... social struggles are not only about gaining access to power but also about changing its character and relative efficacy (1995:24).

Cooper's model of power does appear to offer the ability to recognise women's agency whilst retaining a focus on the structural constraints surrounding their lives. However, as her model was developed in order to explore the complex relationship between sexuality and the state, and in particular the ways that sexual minorities have struggled to produce social change, there are areas that it does not adequately address. One of the few drawbacks is that Cooper has not developed a concept for the power that each individual has access too. Whilst it is clear that individual lives take place within her different modes of power, there is no conceptual framework for how these are assimilated and deployed within an individual's everyday encounters. In addition, Cooper's model does not discuss the role of emotion within power relationships. It is in these particular areas that the strength of Layder's theory lies.

Layder's concepts for analysing power

Layder's theory sets out four social domains through which he argues we can understand social life. Some of his concepts are similar to Cooper's, others conflate some of her concepts, but Layder also uses concepts which allow for the examination of power relationships in face-to-face encounters in much more depth. In this section I will briefly outline Layder's concepts and indicate how they relate to Cooper's model.

Contextual Resources.

Layder describes his concept of contextual resources as the 'possession, distribution or ownership of cultural, material and authoritative resources

throughout the whole social system' (Layder 1997:4). He argues that rather than just being measured by access to material goods, contextual resources also take account of the discourses and inequalities perpetuated through cultural practices, such as images in mass media.

Layder's concept does not distinguish between the possession of or access to particular resources and how they are deployed within power relationships, and thus it combines Cooper's description of resources as a mode of power and the technologies through which power operates. Yet Layder stresses the need to recognise the 'cultural and discursive forms' of domination and the ways that they are transmitted through language and culture, for example by signs and signifiers. He asserts that this domain relates to much more than the unequal distribution of material resources, as it includes the discourses and practices that underpin societal inequalities. Therefore, this concept can also be linked to Cooper's ideological mode of power. Consequently, although Layder's domain of contextual resources remains important, I feel that Cooper's more precise of definitions of ideological mode and resources mode together with the technologies of power will take precedence in this instance.

Situated Activity and Social Settings

Whereas Cooper only details 'sites' as the location of specific power technologies, Layder utilises the two concepts of 'situated activity' and 'social settings' in order to account for the particularity of social encounters within specific organisational locations. Situated activity is, for Layder, a 'face-to-

face' social encounter which occurs within a specific social setting, for example a home, hospital, or street. Although social settings have a geographic location, Layder stresses that they also have a usual organisational form, which will both affect and be affected by the situated activities that take place in them. This is one of the areas where Layder's focus on the individual enriches the possibilities for analytical awareness, over Cooper's model that is focused more on social groups. The form of the particular sites of power, and the intensity of the relationship to the modes of power, will also vary. For example, the organisational form of a specific family planning clinic will influence the power relationships of the people who come in contact with it. Yet although this encounter occurs within a particular geographic site, it in turn is shaped by other factors such as the public face of family planning, the wider organisation of the NHS, and ideas about contraceptive cultural norms.

We can utilise these concepts in order to investigate the social encounters between women, male partners and health professionals to a greater depth. Many of women's deliberations over contraception will take place in the home. But by identifying women's negotiations within heterosexual encounters as a specific situated activity, in addition to considering how accessing contraception is a clinical encounter in a particular social setting, we can take into consideration both individual factors and the practices which enable and constrain them.

Psychobiography

Layder's final social domain is psychobiography, which he defines as the development of the individual within wider society, the way that the social context affects the individual over time. Psychobiography is the domain considering the intersection between psychological and sociological constituents. For Layder, it is important to recognise biographical individuality; how personal history, character and attitudes are inseparable from and inform all experiences. These will also have an effect on how individuals re/act to the power relationships that they find themselves in. Psychobiography refers to how individuals see themselves in relation to the world, their individuality within the social context. Although dominant discourses impose real constraints on their lives, individuals are usually conscious actors who can in many situations challenge, disregard, subvert, or comply with societal conventions or laws. It is within the domain of psychobiography that individuals reflect on their lives within society and the struggle to resist or subvert may emerge.

Although their use of safer sex practices as a determinant is problematic, Holland *et al* (1998) highlight how young women managed to empower themselves through reflecting on their experiences within heterosexual relationships, and they draw an important distinction between two levels of empowerment. The first level they call 'intellectual empowerment,' which is when the young women in their sample identified changes that they wanted to make to increase their control over their own sexuality and sexual

relationships in the future. The second level they called 'experiential empowerment', which refers to when women were actually able to carry out their intentions.

Although both of these levels can be related to Layder's psychobiographical domain, the concept of 'intellectual empowerment' has particular resonance. Holland *et al's* (1998) data illustrate how important it is for young women to recognise their inequality and lack of control in relationships, as the first step towards empowerment. Even if they are not in a position to make the changes they intend within that or subsequent heterosexual relationships, they are at least aware of their subjugated position. Moreover, it appears that in mid-life some women may have achieved 'experiential empowerment'. Although her research did not specifically address the way that it was achieved, Meadows (1997) found that the mid-life women she interviewed were confident about control over their sexuality and sexual relationships, and she suggests that this may have been gained through their life experiences. The distinction between intellectual and experiential empowerment is insightful, and by recognising women's deliberations within the psychobiographic domain, we can more fully integrate their understanding of specific encounters with the broader social context.

By utilising Layder's concept of the psychobiographic domain, we can thus investigate how women reflect on their life experiences and social positioning, and the likelihood that in turn these reflections may lead to empowerment in

future heterosexual relationships. It allows us to consider the areas in which individual's consciously mediate between their aspirations and intentions and the constraints imposed by wider society. It is in utilising this concept that we can see the reflexivity of individuals, how they understand their own position as neither fully autonomous nor completely culturally constrained, but exercise agency within the social world.

Emotion

In addition to his four social domains, Layder draws attention to emotion as an important feature of society that he argues is closely linked to power:

> Most forms and instances of power bear a complementary relation to emotion in social life. Sometimes emotion is the object of power plays and strategies… At other times emotion is simply an accompaniment to the effects of power… In yet other instances emotion itself may be a constitutive feature of power (1997:17).

Although Layder's linking of power and emotion could, I believe, be an important concept for this research, as emotion is often an inherent part of heterosexual relations, he does not really elaborate the links between emotion and power that he has proposed. Yet, the importance of emotion within everyday life should not be overlooked. In the context of heterosexual relations 'love' is clearly an 'active force' in how individuals 'account for and organize things emotionally' (Crossley 1998:21); including often serving as a justification for women to have sexual intercourse with men (Holland *et al* 1998, Jackson 1999). In many cases for women to admit to sex with men without an emotional attachment risks being labelled deviant. Indeed, as many

writers have suggested (for example Lees 1993, Skeggs 1997, Holland *et al* 1998) the division between the 'respectable' and the 'unrespectable', the madonna/whore dichotomy, not only affects the type of behaviour that women feel they can engage in but also the power relationships of heterosexuality itself.

Another example of the centrality of emotion to the power relations of heterosexuality is the notion of emotion work. Hochschild (1983) suggested the term 'emotion work' to describe the ways that individuals, and in particular women, manage their feelings in order to fit with conventional 'feeling rules' within society. Duncombe and Marston (1998) suggest that in long-term heterosexual couples, women help to maintain the relationship by carrying out emotion work on their partners as well as themselves in order to maintain the image of a happy couple. They suggest that whilst men do engage in emotion work, it appears to take place primarily 'in their heads', and is more likely to involve the suppression of their emotions. This model of women's emotional responsibility for managing day-to-day heterosexual coupledom, contrasted with men's self-absorbed emotion work, appears to me to resonate with the model of heterosexuality put forward by Holland *et al* (1998). They have argued that the young women's actions are informed by a 'male-in-the-head', which monitors their behaviour against a masculine model of heterosexuality. Furthermore, although the young men they interviewed also considered their actions against a hegemonic model of masculinity, they had no contrasting

'female-in-the-head' which pressed them to consider how things felt from young women's point of view.

Bartky (1990) has also considered the emotion work that women carry out within heterosexual relationships. She has argued that women do not simply collude with male power over them, but that their response is related to the effects of hegemonic masculinity on both men and women. Bartky suggests that whilst women recognise that men as a class have power, they also see the way that 'their man' is hurt by masculinity. Consequently, part of women's emotional labour within heterosexual relationships is to 'tend the wounds' of their man that have been inflicted by hegemonic masculinity. Moreover, this takes priority for the women, and thus renders them less likely to challenge their own position within that heterosexual relationship, as to do so would compound the wounds their men have already suffered.

The above studies suggest that the power of emotion in relationships is likely to have an important bearing on women's position. They illustrate how women's responsibility for emotion work may lead them to acquiescence with men's preferences, rather than to pursue their own. Yet alongside women's work in managing heterosexuality emotionally, there also exists their normative caring responsibility for any children. Both the emotion management of heterosexuality and the normative caring role of the mother may affect women's choices over contraception.

Subjective Power

For Layder, the need to incorporate emotion and an individual's psychobiography, alongside the other complex elements of power, mean that we have to consider 'subjective power'. The concept of 'subjective power' recognises the specificity of the individual and their capacity for agency, but acknowledges how this is re/formed through social forces. Whilst subjective power represents the ability of an individual to deploy power, it also acknowledges that such ability is constantly being re/produced through a symbiotic relationship between the social context and individuality. Moreover, as an individual's 'subjective power' is formed through their relationship with other social processes, it will also vary between different encounters. Consequently, people's ability to act autonomously or to change the situations that they are in varies enormously, not just between individuals but also for the same individual in different social sites and situations.

By combining the theoretical aspects developed by Cooper and Layder, the concept of subjective power acknowledges the omnipresence of power relationships without losing sight of individuality. It recognises that structures can constrain and enable individuals, but simultaneously highlights their agency. It acknowledges that individuals may weigh up costs and benefits without reducing their decisions to mechanical measures of rational calculation, and retains an emphasis on the social context within which individual's decisions are embedded. It allows us to consider how individuals draw from and utilise the discourses and resources available to them, but also

how these types of societal factors have shaped their ability to do so. The concept of subjective power acknowledges how individual's lives are constituted through complex and variable power relationships, and acknowledges the way that other modes of power shape but do not determine an individual's ability to act.

Layder's theory incorporates the specific 'inner power' of the individual into a way of explaining the importance of structures in determining the outcomes of face-to-face encounters. He also argues that psychobiography is a main component in subjective power, considering the historically formed specificity of the individual. Yet although he argues that subjective power is re/produced through psychobiography, emotion and structural elements, he does not note specifically how this might happen. Nor does he apply his understanding to any specific empirical situation.

This thesis aims to develop the concept of subjective power to explore the capacity of individuals to deploy power, in particular times and spaces, whilst acknowledging how this is formed through the modes of power. The concept of 'subjective power' will be employed to recognise the different levels of agency that women are able to exercise over contraception, and examine how these are related to other factors in their lives. It allows us to recognise how the wider social context affects an individual's ability to make autonomous decisions, and that power is just one aspect of complex social processes. An individual's subjective power can be understood as being drawn from the

different modes of power, which will sometimes reinforce each other, but can also conflict. For example, the discourses of 'good mothering', which prescribe appropriate times and circumstances for women to have children, may conflict with medical regimes of acceptable contraception. Women might be certain that they do not want any risk of pregnancy, yet doctors may be unwilling to provide a tubal ligation (Bartlett 1994, Campbell 1999). The 'passive' role assigned to women within hegemonic heterosexuality may conflict with women being able to carry and suggest the use of condoms to protect against the risk of sexually transmitted infections (Holland *et al* 1998).

Examples such as these highlight the complexity of women's ability to negotiate contraception within power relationships with medical professionals as well as within heterosexual encounters. In order to be able to make, and act on, autonomous decisions, women need to consider themselves in relation to wider society. They have to draw from or reject the circulating discourses with society, and either comply with or contest the power relationships re/inforced through the modes of power in which they are situated. This process may be reflexive, or women may manipulate them more or less self-consciously. Conversely, contraception is ideally suited for substantiating this model of power. The two distinct but related domains, medicine and heterosexuality, make available resources and discourses which actors can deploy in relation to one another.

The concept of subjective power can be used to refer to women's deployment of power within a particular time and space, in specific circumstances and relationships. It is not a static entity, nor can it be said to be a property of any individual or social group. It is organised through wider society and allows groups or individuals to draw from its attributes. Individuals may be fully conscious of their subjective power in any given situation, and this will give strength to their actions. However, subjective power may also shape their decisions in less visible ways as it re/produces norms and values which can prescribe boundaries of available choices. Women sometimes may have a strong position, perhaps because of their circumstances or because they are conforming to a dominant discourse, but levels of subjective power are transient by nature, and cannot necessarily be relied upon in respect to other decisions. Moreover, the deployment of power will have outcomes that may not have been foreseen.

Hence, my model of power utilises Layder's concept of subjective power in order to represent the extent that individual women can exercise agency within power relationships, how they as individual subjects deploy power within the social context. The level of subjective power that is available to women is based on and interrelated to the four modes of power (ideology, force, discipline, and resources) outlined by Cooper's model. All four modes of power are likely to have interdependent effects on the level of women's subjective power both within heterosexual encounters and doctor/patient relationships. They operate through technologies within sites of power, the

locations in which situated activity takes place within social settings. All these power apparatuses then react through emotion with an individual's psychobiography to produce a level of subjective power. The deployment of this power will have an effect that can then influence any or all of the modes or technologies of power. This model succeeds in conveying the circular process of power, as levels of subjective power will fluctuate as women move through their lives, and their circumstances change.

Conclusion

In this chapter I have looked closely at some of the dilemmas raised by theories of power and the complexity of the doctor/patient relationship and heterosexuality. I considered how theories of patriarchal domination and rational/legal power relied on a sharp division between the powerful and powerless that failed to explain the complexity of women's positioning. In comparison, whilst Foucauldian models of power could be used to explore the productive side of power relationships, they often overlooked the ubiquity of social inequalities based on class, 'race' or gender. Consequently, in order to understand women's experiences of contraception, we need to be able to simultaneously consider both their positioning within the wider social context and the extent to which individuals can exercise agency.

The model of power I have developed within this chapter seeks to be able understand power as polysemic, and to be able to explain how women draw from and subvert discourses and resources within society to manage their

reproductive lives. It uses the concept of subjective power to explain how women deploy power within a particular time and space both within doctor/patient relationships and heterosexual encounters. Subjective power is not a possession, but a way of analysing individual agency within the social context in order to achieve certain outcomes. It is re/formed and re/produced through other modes of power, and is a dynamic and transient variable. It is only by considering the complexity of power relationships that an understanding of women's contraceptive experiences can be achieved. Whilst this model of power has informed the analysis of the research, in the following chapters I will describe the methodology and the findings of the research, before applying the model of power to the women's accounts.

Chapter 4

Investigating Contraceptive Experiences

Introduction

If power is understood as an 'ongoing process' (Cooper 1995:25), then it must be considered throughout all aspects of the research. However, although many feminists have identified power relations within fieldwork as an issue in their reflections on questions of inequality, reflexivity, and 'othering', commentators on methodology do not always define 'power' and instead rely on a general assumed understanding with the reader. On occasions different, even competing, theoretical approaches to power can be detected within the same account, which may detract from its coherence in explaining methodological dilemmas.

Wolf (1996), for example, argues that feminists need to pay attention to the complexity of power relationships inherent in the research process. She argues that an aim of feminist research should be to eliminate inequality or to 'subvert' power hierarchies within the research process. This suggests that power is a possession of the individual researcher, who should choose either to use less power or to 'give' power to informants, rather than understanding power as an omnipresent aspect of all socially structured relationships, including the structures of knowledge production. Wolf's account, like many others, sees the 'elimination' or 'reduction' of power as central to avoiding exploitation, but focusing only on the 'power' of the researcher is an

oversimplification. Not only does it fail to fully reflect the complexity of power relationships between the researcher and the researched, it also ignores how the researcher and the researched are always enmeshed in a variety of other power relationships that impinge on the fieldwork process.

This chapter begins with the 'story' of my research, outlining decisions about the research design, the methods and the access arrangements, as well as giving brief details about the women participants and the places that interviews and observations were carried out in. Following feminist conventions, rather than a 'hygienic account' (Wise and Stanley 1993:155), I will explain how the process of the research affected the ongoing project and the adaptations that occurred. In the next section, I will reflect in more detail on the issues arising from the interviews and observations, and the implications that these have for the findings of this project. Finally, I will discuss in more depth subjective power within the research process and the implications it has for the ontological and epistemological nature of my thesis.

Initial Research Design

This thesis was designed to identify and investigate the complex power relationships in which women's choices and decisions over contraception are enmeshed. From the outset I decided to concentrate on women aged between 30 and 40, since most research of this kind has been with younger women. For my MA dissertation I had carried out an exploratory study in this area, which alerted me to the complexity of women's decisions, but which I did not have

time to explore (Lowe 1998). I felt that a deeper understanding of women's contraception experiences could contribute both to medical sociology and to the analysis of heterosexuality. The research had the possibility of tangible benefits for women in producing evidence for health practitioners, as well as developing academic knowledge.

My initial premise was that women's subjective power is an essential determinant of their ability to access and make use of contraception, and that contraceptive decisions are made in relation to, and impact on, other aspects of women's lives and thus also affect their subjective power. I was hoping to develop a complex and comprehensive model of power in order to analyse the complex interrelationships. In order to substantiate the theoretical underpinning of the research and to understand the complexity of subjective power, I felt that detailed accounts of women's experiences would be needed. Therefore the aim of the research methods became to elicit personal accounts from a broad range of women.

In-depth interviews are the most suitable way to explore the details of women's contraceptive decisions, the subjective power relationships in which they are embedded, and their impact on what Thomas (1985) calls 'contraceptive careers'. By allowing people to define the issues that they see as the most relevant, in-depth interviews do not limit research to the predetermined questions found in more formal questionnaires (see Ribbens 1989, Burgess 1993). Basing the interviews on broad topic areas would offer

the flexibility to explore the uniqueness of women's accounts, whilst retaining a form of structure from which to compare accounts. I planned to interview approximately twenty-five women in total.

Although some forms of contraception are generally available, for example, condoms can be bought in supermarkets or from vending machines, many methods can only be accessed through the medical profession. Indeed, even the term contraception is now associated mainly with prescribed methods such as the pill, and methods such as withdrawal or periodic abstinence are often no longer associated with the term. Moreover, the medical profession is encouraged to raise the issue of contraception regularly with women when they attend for other reasons, such as cervical screening (Rowlands and Carter 1997). This surveillance may compel women to give details of their sexuality and/or sexual relationships, in order to justify their current use or non-use of contraception. Consequently, I decided that accessing women through the medical profession would be an appropriate route particularly as it also allowed for the possibility of observing contraceptive encounters. It was hoped that being able to observe and then discuss the consultation with the women would allow a greater understanding of the deployment of subjective power in the interactions between the health professionals and women. The drawbacks to this approach included being considered as a part of the medical surveillance that I was studying, and excluding women not registered within the NHS, but I felt that the benefits of this approach outweighed its disadvantages.

In order to contact a broad range of women, two different routes of access were chosen. Women were to be contacted through a local GP practice and through a family planning clinic. These sites were chosen as they represent the two most common avenues for women to obtain prescriptions or supplies of contraception, and I also wanted to explore how the preferences of the women for one site or another re/informed their levels of subjective power. Although the women using the family planning clinic services were likely to be current users of prescribed contraception, I hoped that recruitment through the GP surgery would elicit accounts from women not currently using a prescription method. Since I planned to request a detailed contraceptive history from each woman interviewed, it was also envisaged that other routes to access contraception could be considered, such as post-natal consultations within maternity hospitals. Having decided to access the women through two different medical facilities, I then had to gain access. This involved seeking formal approval from the local medical ethics committee as well as negotiating access with each site.

Gaining Ethical Approval

Seeking medical ethics committee approval is often a long and drawn out affair. At the time of application, each health authority could set its own requirements as to the level of detail and the type of documentation required. All have certain criteria about the way that patients can be approached, and strict requirements concerning the level of information that must be given to patients as part of the procedure for obtaining informed consent. These aspects

have informed both the planning and the research process, and are evidence of how other power relationships impinge on the research process.

In the area of the West Midlands where I sought to carry out my research, the medical ethics committee provide an application pack giving guidance about the information needed. I was required to submit a written research proposal giving details of the research aims, rationale and methods proposed, including access, selection and the number, sex and age range of participants. Details of any risks to the researched had to be included, especially in terms of how confidentiality would be maintained. Copies of patient information leaflets, consent forms, and approach letters had to be submitted, along with letters from both research sites and my supervisors confirming their support for the research. The application had to be submitted at least three weeks before an ethics committee meeting, which were held six times a year.

Writing my application to the ethics committee clearly illustrated the different approaches to research taken by 'medical science' and 'medical sociology'. It was apparent that the guidelines for ethical approval were written with 'medical science' researchers in mind, and that their primary concern was of physical risks to patients resulting from clinical trials or alterations to treatments or procedures. The documentation was adamant that informed consent should be obtained, and stated that the preferred method was through the issue and discussion of a patient information leaflet, with arrangements for participants whose first language is not English. Yet, in contrast to most

sociological or feminist methodology texts, there was no mention of the level of disclosure necessary to gain informed consent, nor acknowledgement of the way that the ongoing nature of research often changes the project aims. As Burgess reminds us:

> All research is to some extent secret, as researchers do not know everything they wish to investigate at the beginning of a study, a situation which makes informed consent difficult (1993:199).

Furthermore, many of the issues I would expect to discuss under a broad heading of 'ethics', such as the relationship between the researcher and researched, and the interpretation and representation of the participant's accounts, were absent from the ethics committee's documented concerns. Indeed, describing my proposed research in an 'objective' fashion in order to meet their requirements, and excluding from the document so many issues that feminists have identified as important, seemed in many respects to be a very unethical way to obtain ethical approval!

Nevertheless, I submitted my application to the committee at the end of June 2000, for consideration at the July 2000 committee meeting. This was followed with what seemed like an incredibly long wait, although it was only until the middle of August, when I received approval in principle subject to two amendments to the consent forms and three further points of clarification. However, although full ethical approval was given at the end of August 2000, this was only one of the committees that my research had to be approved by. Once I had received written confirmation of the approval of the ethics committee, I then had to apply to the Research and Development Committee

of the family planning clinic's NHS Trust. Whilst I had been assured that this was just a 'formality', it still took over two months (and numerous telephone calls) for official approval to come through.

Access and Approach through the GP Surgery

Before ethical approval could be sought, it was necessary to gain outline approval from staff at the proposed research sites. Whilst considering the best way to approach local GP surgeries, I approached a colleague in the University's Centre for Primary Health Care Studies. She was able to introduce me to a surgery within reasonable travelling distance which had demographic variability in terms of their patient list. Her advice and help on my approach to both the surgery and the women participants was invaluable in getting the fieldwork started. The GP surgery is located on the eastern edge of a West Midlands city and covers an area that includes both social and private housing association estates, as well as some villages. The range of housing within the practice boundary suggested that it was likely that there would be a range of social classes using the surgery, and the staff informed me that they had patients from several different ethnic backgrounds.

I initially considered seeking permission to 'sit in' on appointments. However, the surgery does not run a specific clinic for contraception, so women use the general appointment system to discuss methods of contraception with health professionals and obtain prescriptions or supplies. This meant that the staff would not know who would be attending the surgery to discuss or obtain

contraception until the actual appointment. Another possibility was to approach women in the waiting area but I felt that this would be inappropriate on both ethical and practical grounds. Not only would it be extremely time-consuming but it would also be difficult to ensure confidentiality. Moreover, some women may be attending due to a serious illness, or even to seek advice on fertility problems, and in such cases a request to discuss contraception might well cause distress. Therefore, after considering these issues and in discussion with the practice, I concluded that the most suitable approach was to contact women by post to ask them if they would participate in the research, whether or not they were currently using any method of contraception. A letter asking about contraceptive decisions might still have been inappropriate for some women, but it was sensitively worded, and the women only needed to respond if they wished to participate. I hoped that this approach would cause a minimum amount of distress.

Along with the letter from the surgery, the women were sent a patient information leaflet and a postcard with a postage-paid reply envelope to enable them to contact me directly to arrange an interview, either in their home or at another suitable venue, depending on preference. The surgery had approximately 700 female patients in the 30 to 40 age group on its register and the initial plan was to contact 60 women randomly selected from this list. This would enable contact to be made with a broader range of women than those recently given prescriptions for contraception, for example, women who have been sterilised, use 'natural' methods of contraception, or who are not currently

aiming to control their fertility or protect against sexually transmitted infections.

Following the initial random selection of sixty names, it had been agreed that surgery staff would vet them to check that no patients who were terminally ill or who had recently suffered a bereavement were approached. However this check had consequences that I had not foreseen. On talking to the medical secretaries, it appeared that they had also removed other women from the list, on the basis that they were 'alcoholics' or 'not nice'. Although this intervention affected the sample, because the letters were coming from the surgery I was not in a position to have control over this process. Moreover, since it was likely to be the reception staff who would bear the brunt of any complaints about being approached, I had to be sensitive to their situation. Therefore, although I stressed that this vetting was not necessary on my behalf, I did not insist that the women excluded on these grounds were reinstated on the list.

Whilst I hoped that women with a variety of personal circumstances and class, ethnic and religious backgrounds would respond, previous research has illustrated that an approach by letter may alienate some potential informants. For instance, Glucksmann (1994) found that formal written assurances of confidentiality made some respondents reluctant to take part in her oral history study of women's labour, as it suggested 'that there might be something to hide' (1994:161). Whilst for some headed University paper gave reassurance as to her credibility, for others it was too 'official'. Since Glucksmann aimed to

contact women who had been employed on assembly lines, most of the women she contacted were probably from working-class backgrounds and the different reactions she encountered reflect the complexity of power relations between working-class people and state institutions.

In her study of mature students, Edwards' (1990) found that Black women in particular were angry at being approached by letter, and that for them the association of the researcher with a higher education establishment did not imply credibility, but reinforced their scepticism about being given a fair hearing. Edwards was given their addresses by the higher education establishments that they attended without their consent, and they considered this to be another instance of the institutional racism that they struggled against on a daily basis. The organised complaints and the many refusals to take part, despite a written apology by Edwards, illustrate the women were not powerless, despite their marginalised position.

Notwithstanding such problems, and that postal requests in general have a low response rate (Newell 1993), I was optimistic that an approach letter directly from the surgery, that aimed to be sensitive to recipients with different experiences, would be successful. However, only six replies were received from the initial batch of sixty letters. After these interviews had been pursued and completed, another seventy letters were sent, Since seven of these elicited replies, the response rate was exactly ten percent. Of the thirteen women who responded, eleven were subsequently interviewed. One woman declined when

I contacted her to arrange the interview, as she thought it was going to be a questionnaire (although full details were given in the approach letter). Another agreed to be interviewed at a later date as she was currently very busy, but having rung her on two further occasions, when she still did not have time, I left it up to her to contact me, and she did not. Whilst the total of eleven was slightly less than my initial target of fourteen, this route was successful in recruiting women who were not currently using prescribed contraception; at the time of interview only three of these women were using prescribed methods

Access and Approach in the Family Planning Clinic

The staff at the urban family planning clinic I approached were very supportive of my research, despite being in a period of transition. Between my initial approach and the beginning of my fieldwork it had been decided to site another service in the same building as the clinic. This meant that not only would the clinic have considerably less room, but their patients would need to queue up at the other reception area before being let through a security door to reach the clinic's reception desk. It was clear that at the time of my observations the staff were very apprehensive that many women would be deterred from using the service due to the physical rearrangements and reduction of space allocated to the clinic. Since my fieldwork period ended just as the changes to the clinic were being introduced, this thesis has not been able to address how the new arrangements have affected women users or staff. Although I would have liked to have returned to the clinic after the changes

had taken place, the management team felt that the staff needed to adjust to their rearranged environment and procedures without a researcher present.

The clinic ran ten family planning sessions a week, with four morning, three afternoon, and three evening sessions, one of which was specifically for women under twenty. As the reception staff write down in the appointment book each woman's date of birth, it was possible to know in advance which sessions were due to be attended by women in my target 30-40 years age group. This varied from none to six women booked in some sessions, although not all the women actually arrived for their appointments. There was some variation, but in general it seemed that more mid-life women used the afternoon sessions. However, this pattern may just have been a reflection of the afternoon sessions having more appointments available than some of the others. In total, I attended twenty sessions, which were split into four mornings, eleven afternoons, and five evenings.

Rather than a random sample from the patient list, all appropriately aged women were asked to participate as they arrived for their appointment. As it was normal practice for the reception staff to hand a woman her medical notes to take up to the waiting room, it was felt that the patient information leaflet could be paper-clipped to the front, and the nurse or doctor would inform me if consent was given. Since at that time the clinic reception desk was situated down the corridor from the waiting area where I was based, this ensured that the women did not feel coerced by my presence to participate in the research,

but had time to consider it. It was made clear to all the women that their treatment at the clinic would be unaffected by their decision. However, when the clinic staff saw the ethics committee approved patient information leaflet, they felt that it was too complicated for some of the women who attended. They asked if I could design a simpler form, inclusive of a space to give consent. This posed a dilemma, as any changes to consent forms or patient information leaflet should be approved by the medical ethics committee, a process that would have delayed my fieldwork. In consultation with the clinic staff, I decided that the best way to proceed was to design a simpler form, to be attached to the notes, but then hand the women the original form immediately if they agreed to take part. Although this seemed to overload the women with paperwork, I felt that it allowed for a simplified initial approach as well as meeting the requirements of the ethics committee.

Although all the clinic staff should have been informed about my research and the procedures adopted, on occasions it went wrong for various reasons. One of the hurdles was that different staff worked different sessions, so I was still having to introduce myself and my research in the third and fourth week of my fieldwork. Occasionally, the reception staff would forget to attach a form to a woman's notes. I found that the best way to tactfully remind them was to check the timing of the appointments of women in my target age group with the reception staff just before a session began. The family planning nurses were very helpful, and indeed sometimes, if they had not been given the details at reception, the nurses would ask women directly if they would

consider taking part. More problematic was introducing myself to some of the clinic doctors, most of whom only did one session a week, often arriving just as their session started. Apart from the nurse-only clinics, the patient list was divided between a nurse and a doctor, with some women occasionally being referred to a doctor after seeing a nurse. Whilst the nurses never forgot to let me know once consent had been given, on several occasions the doctors did not inform me and so I was unable to make contact with the woman concerned. As few of the doctors were interested in a detailed explanation of my research, I imagine that these incidents were oversights rather than expressions of disapproval at the aims of my research.

Once the women agreed to take part in the research, I asked them if I could observe during their consultations in the clinic. Afterwards I tried to arrange a date and time for the interview. Again, I offered the women the option of being interviewed at home or at another venue. Out of a total of fifty-seven women approached, twenty-one women agreed for me to observe their consultation, although only eleven of these women were subsequently interviewed. Two of the ten women who declined to be interviewed stated at the outset that they only consented for me to observe the consultation. Five women agreed initially only to decline the interview after the consultation had been observed and the other three agreed to be interviewed but were not at home when I arrived and either declined when I rang them or no firm interview arrangement could be made after three attempts. I believe that some of these problems were due to the timing of my fieldwork in November and

December. As it got closer to Christmas, it became more difficult for the women to spare the time to be interviewed, so I asked the women if I could contact them in the New Year. Although this worked in some cases, I believe that some of the eventual declines could be attributed to the length of time between the initial agreement and the interview date.

Fieldwork Processes

Self-Selected Samples

I had hoped that I would be able to interview a range of women with different personal circumstances and of different class, ethnic, and religious backgrounds. However, despite care being taken to ensure that there was diversity in the women approached, the women who agreed to be interviewed proved to be quite a homogeneous group. (More detailed biographical details of the women can be found in Appendix 1.) In total, eighteen of the twenty-two women interviewed stated that they were white English or British, two that they were white Irish, one woman that she was Taiwanese and one that she was Turkish. By self-definition, five women were middle-class, thirteen were working-class and four stated that they came from a working-class background but their current occupation or income meant that they could be considered as middle-class now. Five women were Catholic, three stated that they were Church of England, there was a Buddhist, a Taoist, a Muslim and a Baptist, whilst the other ten stated that they had no religion. Twenty of the women had children, and all of them had been pregnant at some point in their lives.

At the time of interview, thirteen of the women were married and one was cohabiting. Two of the women described themselves as in long-term relationships (but not cohabiting) and two stated that they had just started new relationships. Two women were currently separated from their husbands, although one of these was working towards reconciliation, one woman was a widow and one described herself as single. This snapshot picture does not reflect the complexity of the women's lives, as it does not take into account the range of past relationships that they had been in, and so for the analysis the women's contraceptive experiences were compared on the basis of their circumstances at the time of each method choice rather than their status at the time of interview.

As well as representing a sample consisting of mainly white working-class married women, another factor emerged which connected many of the women. In total, seventeen of them had a connection to either higher education or the health services, including nine out of the eleven replies to the postal requests. Sometimes this connection was direct, as for a doctor's receptionist, two Master's degree students, and a medical sales representative, whilst for others it was through a husband's occupation. In two of the interviews the women revealed that they were hoping to commence nursing training. Both the education and health services sectors are major employers of women, particularly in the area in which I was based due to the numbers employed at local universities. However, investment in either one or both of these sectors may have been a factor for the women who agreed to participate.

Although I felt that my sample did not fully reflect the diversity of class and ethnic backgrounds that I had hoped for, I felt that continuing with the same recruitment strategy would not have led to any significant enlargement of the representativeness of the sample. Moreover, to attach to the original plan a more targeted recruitment strategy, such as through community groups, would have required further approval by the medical ethics committee. This would not have been possible within the timeframe of PhD research. In my original plan, I had envisaged interviewing twenty-five women. I had completed twenty-two interviews, eleven from each site and felt that this provided me with sufficient material to work with. The level of generalisations that can be made from small qualitative research projects are often limited, but as Fielding states, 'the compensation for this is the depth of understanding gained (...) which can be a rich source of ideas for further work' (1993:169).

Interview Arrangements

The interview schedule (see Appendix 2) consisted of mainly open-ended questions in order to produce in-depth accounts from the women (Ribbens 1989). After it was written I carried out two pilot interviews and made some amendments[9] The questions asked the women to describe their contraceptive history; for example, which methods they have used, why those particular methods had been chosen and how they experienced them. In addition they were encouraged to explain how the decisions that they made related to their

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[9] I reorganised the topic areas, rephrased some questions and included a checklist to triangulate with the contraceptive methods mentioned during the contraceptive history section.

lives, relationships, and also their interaction with medical professionals. As the Personal Narratives Group (1989) have argued, listening to life history stories allows us to understand the logic of individual courses of action in relation to social constraints, and to see individuals as both objects and subjects within the social world. A 'conversational' style in the interviews was used to allow the women to discuss the issues within their own 'frames of reference' (Burgess 1993), and, as Burgess suggests, I often used the same language as the women when phrasing questions in order to increase understanding of their explanations.

Twenty of the interviews took place in the woman's own home, one in a café (at the woman's own suggestion) and one in a private room at the University. The topic of contraception can be a sensitive issue, and I was asking women to give details of a very personal area of their lives. I stressed to the women that pseudonyms would be used in all research reports and gave assurances of anonymity and confidentiality. All the women gave permission for the interviews to be tape-recorded. Only one woman expressed any concern about these issues, and her worries stemmed from her position as a secondary school teacher whose pupils may go on to attend my university. However, once reassured that no one else could have access to any recording, and that her real name and address could not be linked to any transcript, she was happy for the interview to proceed.

Interview Processes

The interviews revealed that for the women respondents the research was a process rather than being just a time-limited segment of their lives. Several of the women mentioned that the request for an interview had made them think about their current choices of contraception. For example, Katy reported that she had recently restarted discussing a vasectomy with her husband, 'it's only been in the last week or two, I suppose because knowing that you're coming and thinking about it'. Similarly, at the end of the interview, Patricia told me that whilst she did not have any questions, the interview 'has made me think about a few things that's all… Because your opinions in your mind aren't always as straight-forward as you think they are'. The interviews can be seen as an account of how the women understood their contraceptive careers at that point in time, but it should be recognised that they were contoured by the research process itself. The request to take part, the wording of the patient information leaflet, the focus of my questions, and my public demeanour all had an effect on both what the women told me and what they perceived I was interested in.

The majority of the women seemed to be comfortable with the interview situation and appeared relaxed. Having agreed to participate, they were likely to be generally at ease in discussing the subject areas (Goode 2000). Moreover, in any research in which people volunteer their time, the sample is likely to consist of amenable participants, who have agreed to participate perhaps because they like to help others out or see a potentially positive

outcome from the research. The women may also have had a particular experience with contraception that they felt warranted research, although their accounts did not seem to be extraordinary. My findings will have been shaped by this recruitment process, but this was inevitable. Seeking informed consent will always result in a sample of predisposed respondents, and it is not possible to accurately assess whether non-respondents' experiences are similar.

Yet despite their general ease with the interview situation, at times, there were problems with language, when women either struggled to find the words to describe their experiences or related them in accounts littered with pronouns and allusions. (This aspect will be discussed in more detail in chapter 7.) It was also obvious that some of the women were uncomfortable when I tried to ask questions about the risks of sexually transmitted infections, and unwilling to discuss it in any detail other than stressing that this had 'never been an issue' (Christine) for them. Although I had realised that this was going to be a challenging area, broaching this topic proved to be more difficult than I had anticipated. In some of the interviews I chose to miss out some of my questions around the risks of infection because I felt that to pursue the discussion could turn what was obvious discomfort into distress. Whilst this meant that on this topic there was far less material produced, I felt that any other course of action would have put the rest of the interview at risk and pursuing it was unfair to the women who had generously given up their time to help me. Whilst in hindsight I wished that I had taken time to explore with them why they felt so strongly, at the time I was more concerned to avoid

upsetting them. Consequently, the obvious difficulty that many had even considering this area is considered within the analysis, but on the basis of existing literature rather than the interviews themselves.

I was aware from the beginning that as the interviews were concerned with intimate relationships, the women might reveal that they had been victims of domestic violence and/or sexual abuse. My plan was to adopt a similar strategy to that used by Holland *et al* (1998), that is to listen to the women's accounts, allow them to decide the level of disclosure, encourage them to seek further help, and have with me leaflets giving details of local help available. However, despite having thought through my strategies beforehand, on the three occasions that disclosures occurred I was only confident in my responses once. In the first case, it became clear over the course of the interview that there was something distressing the woman about her relationship. In conversation after I had turned off the tape recorder, she revealed further details of her relationship, which, in my eyes, added up to emotional and mental abuse. However, she did not disclose any incidents of physical abuse, and although she was upset by her partner's behaviour, she did not understand it as domestic violence. I agreed with her that his behaviour was difficult, but was very unsure about how far to go in naming it as abusive. In the end, whilst I stopped short of directly accusing him of domestic violence, I did leave her the advice leaflets on local help for domestic violence. I subsequently wrote to her to thank her for the interview, and stressed that she could contact me in the future if she wanted to. I am still unsure whether I should have named her

experiences as domestic violence. Whilst research has shown that direct questioning by professionals helps women to know their experiences will be taken seriously (Humphreys *et al* 2000), I was never going to be in a position to do anything other than listen to her account and advise her on the local help available, which was what I tried to do.

On the second occasion that domestic violence was reported, the woman had already left her husband and was making a new life for herself. Following her disclosure the woman returned herself to the question that I had originally asked and thus moved the interview forward. Other than ensuring I left her the advice leaflet at the end of the interview, I did not feel that I had to take any action. The third disclosure came when a woman revealed that she had been raped by a next-door neighbour several years previously. On this occasion, it was clear that the woman was quite happy to talk about the experience, and she mentioned that she now did voluntary work to help other women who have been raped. Whilst feminist methodology has stressed the need to allow women respondents to talk about the issues in their own terms (see for example Kennedy-Bergen 1993, Holland *et al* 1998), I began to feel that in this case my strategy of listening was problematic. Whilst the woman did not appear to find talking about the rape difficult, I felt that she was expanding not because she felt that it was relevant to the research area or because she had a particular need to discuss it, but simply responding to the space I was making available. Meanwhile, I was very unsure about when I should return to the interview questions, as I did not want to appear either voyeuristic or

unconcerned. Whilst it is not possible to predict every dilemma that researchers will face in the field, in general feminist methodology seems to have assumed that women respondents will always have a need to discuss such issues, and that to do so is usually beneficial, whereas they may simply feel obligated to fill in the space created by the researcher's silence.

Another of the questions discussed in feminist methodology is how much the interviewer should reveal about her own life and ideas. Oakley (1993b) and Finch (1993) both suggest that the researcher can gain a better understanding through being open, answering any questions and discussing issues during the interviews in an attempt to build rapport. However, Ribbens (1989) reports that different respondents may have different perspectives on the extent of interviewer self-disclosure. In her research she found that sometimes when she '*volunteered* information' about her own experiences it proved to be an interruption rather than a route to greater rapport. She suggests that because respondents are approached on the understanding that the researcher wants to hear about their lives, at times self-disclosure on the part of the interviewer is considered to be breaking the research contract. Ribbens suggests that perhaps this too is an area in which the interviewer needs to be sensitive.

With this in mind, I had planned to be open to any questions about myself, the project and why I am interested in the topic, whilst at the same time trying to maintain a critical reflexivity over what levels of self-disclosure the women would feel comfortable with. During the interviews I answered the women's

questions, and although some were about the research, more often they wanted to know about my everyday life. For example, once they knew I was a mother, the most frequent questions related to my children, especially their ages, schools, my childcare arrangements, and the difficulties of combining work and caring for children. Only once was I asked about my own experiences of contraception, and this was just to ask what method I was currently using. For me this was a stark illustration of the differences between the researcher and the researched. Whilst the focus of the interviews was on topics that I feel to be important, for many of the women I interviewed contraception is only a very small dimension in their lives.

More problematic for me was when women gave accounts of interactions with the medical profession in which I felt they had been wrongly advised. It must be stressed, however, that many of the women had used the services of more than one GP or clinic over their contraceptive careers, so that these instances cannot be related directly to either of the research sites through which I worked. Although I do not have any medical or nursing qualifications, having read a lot of medical protocols on contraception, and observed in the family planning clinic, I do have a working knowledge of current medical practice. Some of the women's accounts mentioned experiences in which they had either been treated contrary to existing protocols or had been given advice which I thought was anomalous. In one case, a woman reported starting to use Depo Provera in the middle of her menstrual cycle when there was a possibility she may have been pregnant. In another case, it became clear that

although a woman had discussed having an IUD fitted with a nurse, she did not know how the device worked. This woman believes that life begins at fertilisation, and disapproves of the morning-after pill as she regards it as a method of abortion. As there remains a question mark over the exact workings of the IUD with many believing that it prevents implantation rather than fertilisation, it is likely that if she had been aware of this, she would not have considered using it. Whilst in some cases the women were discussing past events, and many issues had been resolved by the time of interview, in a few cases I was unsure of what to tell the women. I am not, and I did not want to be considered as, an 'expert', but I equally felt that I had some responsibility towards the women, especially as had these women been friends or acquaintances of mine I would have had no hesitation in mentioning my opinions.

In the end I adopted a range of different strategies, choosing between them on the basis of the circumstances. For incidents that had happened in the past, I discussed the treatment in the terms that the woman described. So unless the woman considered that she had been the recipient of inappropriate advice or treatment I kept quiet, but I did question the women about how they felt about the contraception consultation or their experiences of the method and if she was critical of her treatment we discussed why she felt like that. For ongoing problems, there were two strategies that I adopted. In the first instance, I left or sent them leaflets published by the Family Planning Association, which give details of the contraception methods available, how they work, who they

are suitable for, and common side-effects. This was the route I took for the woman considering an IUD. The second strategy I used was to suggest that it sounded like they should discuss the issue further with their health care provider. This was also the strategy I used when the women specifically asked for my advice on which contraception method they should use. For example, in one case a woman had told me she was thinking that she might have to be sterilised, as she did not want to take the pill for much longer, and did not want to risk her periods becoming heavier through using an IUD. However, it also became clear that she did not know about the Intrauterine System (IUS), and I suggested that she might want to ask if it would be suitable for her. Although these strategies may not be a complete solution to all the problems encountered, I felt that they were all I was in a position to do.

Observations at the Clinic

At the clinic, I spent much more time waiting to observe consultations than anything else. Whilst this did give me some opportunities to chat to the staff there, most of the time I was just hanging around in the waiting area doing very little. The clinic sessions varied, with some being extremely busy and others so quiet that the staff had no-one to see, even though all the sessions I attended had been fully booked. Whilst in theory the numbers of women who do not turn up for their appointments, are counterbalanced by a number of emergency appointments allowed in each session, in practice the clinics seemed to be either very busy, and running behind, or nearly empty. Although I did not observe any predictable pattern, the clinic staff told me that Monday

was usually their busiest day, and the mid-week appointments were often quieter. In my field notes I recorded the number of women approached in each session, as well as the number who agreed to participate. One thing that emerged was that if the waiting area was busy, or if women had had to wait a long time for their appointment, they were less likely to agree to take part.

Once the staff had indicated that a woman had agreed to take part, I accompanied her into the consultation with either the nurse or doctor, or on some occasions both. I took brief notes during this time, and wrote up more detailed notes in the waiting area afterwards. After the consultation, I asked the woman for contact details and tried to make arrangements for the interview. Of the five women who declined to be interviewed at this point, three had seemed unhappy about aspects of their consultation, and I suspect that this had a bearing on their decision. The refusals were unfortunate as it would have been useful to have been able to interview these women, although one did speak to me briefly just before she left about her feelings about the consultation, and her comments have been included in the analysis.

My field notes recorded aspects of the consultation, such as topics of conversation, the questions, requests and responses, and the demeanour of both the health practitioner and the woman. They were aimed at ascertaining the contours of the health professionals' practices, and how these appeared to influence or interact with the women's requests, although it must be accepted that my presence at the consultation would have had an effect. However, in

practice the observations were more complicated than I had originally envisaged. First, the numbers of staff who work at the clinic meant that it was difficult to make many comparisons between appointments. In total I observed three family planning nurses and four doctors, and whilst I observed one family planning nurse on nine occasions, some other members of staff I only saw once. So although I noted, for example, that the family planning nurses often offered condoms, in contrast to the doctors who only gave them when specifically asked, I cannot say whether this difference was due to wider medical practices or the routine of individual staff members.

Another complication for me that arose during the observations was that the clinic is able to conduct consultations in languages that I do not understand. On two occasions, parts of the observed consultation discussion took place in Punjabi. In the first instance, the consultation started in English but then changed to the woman patient speaking in Punjabi and the doctor answering in English, whilst on the second occasion the consultation changed to both the woman and the doctor speaking in Punjabi. Although many women use the clinic specifically because of the language services, I do not know whether on these occasions my presence affected the language used. It is possible that, although they had agreed to my observation, the women were not entirely happy with me being there, particularly if they could not fully comprehend the patient information leaflet that was written in English. Thus by changing language, the women could retain some privacy over the consultation. It is significant that neither of these women was willing to be interviewed, which

adds to my suspicions that the change in language could be at least partially attributed to my presence, particularly in the first case in which both Punjabi and English were spoken. I would have liked to have spoken to the doctor concerned about this issue, but unfortunately she left the building so quickly at the end of the clinic session that I did not have time to do so.

Looking at the Media

I had not planned to look at the media in any detailed way during this project, apart from asking the women how they thought media stories about contraception might have influenced them. My main aim here was to consider how health scares, particularly about the contraceptive pill, might have affected women users, and the importance of health information in the media more generally. However, in the middle of my fieldwork period the Government announced that it was changing the status of the morning-after pill, from a prescription-only to an over-the-counter medicine, albeit one with particular constraints. This became a major news story, covered by all the national newspapers and featured in both televised news programmes and investigative journalism programmes. As Chibnall (1977) has argued, the media constructs representations and accounts of events in line with their own conventions of reporting. They produce 'commonsense' understandings building on existing discourses which in turn can reinforce them. As Chibnall argues this 'may be absorbed as part of a routine and habitualized way of making sense of the world which typically operates below the threshold of consciousness' (1977:44). Consequently, I decided that this was an opportunity

to study more closely the relationship between contraceptive media reportage and women's attitudes to contraception.

I therefore collected national newspaper stories surrounding this event from four broad-sheets *The Times, Daily Telegraph, Independent* and the *Guardian* and five tabloid newspapers, the *Daily Express*, *Sun, Daily Star, Daily Mail* and the *Mirror*. These papers were chosen as they are widely circulated and have a range of political stances. I also videotaped some of the programmes discussing this issue, such as the investigative news-programme *Tonight with Trevor McDonald*, and looked at several news websites. The different forms of media did not vary much in their framing of the issues, and so I chose to concentrate my analysis in this thesis on the newspaper coverage.

Before the start of my fieldwork I had been aware that in some areas of the UK trials were already underway to supply the morning-after pill as an over-the-counter medicine. In the early interviews I had informed women of this and asked for their opinion. Although there was a range of opinions, their answers tended to be relatively short, even with further probing. This contrasted with the interviews after the announcement was pronounced. Women tended to talk at length about the issue, discussing the news coverage, conversations that they had had about the change with other people, as well as relating their own opinions on the subject. By incorporating the event into my research, and studying in detail the immediate impact of the news reports, I

have been able to develop a new area of my thesis, and take advantage of the timing of this event within my analysis.

Research Processes and the Deployment of Power

Identity Differences as Power Relationships

As the issue of power is the central concept used to analyse the women's stories, it was imperative to consider how the interviews themselves constitute a variable power relationship, and the implications that this may have had on the accounts that emerged from them. Some early feminist accounts (e.g. Oakley 1993b or Finch 1993) argued that if women researchers were interviewing qualitatively, and developed a rapport through being open and answering questions, this would prevent a hierarchical relationship between the researcher and the informant arising. However, it is now widely accepted that this position ignored the complexity of identity positions and the differences between women, including the subjective power invested in being an academic researcher (for example see Stacey 1991 or Skeggs 1997). Moreover, as Stacey (1991) has argued, the researcher and researched have different interests in the interview itself. Whilst the researcher is looking for 'data', the researched have their own reasons for agreeing to participate. Consequently, it must be remembered that the interviews are a situated activity in which both the researcher and the researched exercise levels of subjective power. The level of subjective power that each person will be able to exercise is drawn from our psychobiography, and the ideologies, disciplines, technologies and resources that we have access to.

In order to gain an understanding of the women's psychobiography, the women were asked in the interviews to identify their religion, ethnicity and social class themselves. As many authors have noted (for example, see Reay 1996) categorising women by social class is often problematic. Definitions can be based on knowledge of an informant's background gained by asking questions on employment status, income, education, and family circumstances. However, Skeggs (1997) found in her ethnographic study that many of the women she classified as working class were reluctant to identify with this placement of themselves. She points out that the women were aware of the devalued positioning in society of working class women, and were often attempting to distance themselves from this position through 'respectability'. Skeggs (1997) further argues that since no positive discursive identity position exists for working-class women, they are more likely to '(dis)identify' with their class positioning by disassociating themselves from dominant representations of working-class women.

Although within this project the women were often keen to stress their respectability (this will be discussed in more detail later), particularly in relation to questions about the risks of sexually transmitted infections, asking for a self-definition of social class did not seem to be problematic for them, and many did identify positively as working class. The exceptions to this were the women who pointed out that although they came from working-class backgrounds, their current income or occupation meant that they could be classified as middle-class now. Indeed, it was interesting that many of the

women instantly related the question of social class to the Registrar General's classification. The question was more difficult for the two non-UK born women, as the effects of migration mean that class positions cannot necessarily be transferred from one country to another (Reay 1998). The only woman who tried to reject the idea of positioning by social class was Martina, who by income, education, employment, parental background, and own admission was middle class. In answer to my question, she stated that she was 'middle-class, although I hate that term', and at further prompting said that 'I don't really see it as very relevant today'. In Reay's (1996, 1998) study of maternal involvement in children's education, she found that middle-class women consistently denied the advantages that their social positioning gave them. In Martina's case she clearly saw health professionals as her equals, and was also able to access a wide range of information on contraception. Although these factors are not wholly dependent on a woman's class position, they have to be considered as aspects of her subjective power.

Women's 'Voices', Interpretation, Representation and Analysis

The researched can deploy subjective power within the fieldwork process, but the researcher maintains the ability to exert power over the analyses, interpretation and representation of the accounts of the researched. As Mauthner and Doucet (1998) have pointed out:

> Far removed from our respondents, we make choices and decisions about their lives: which particular issues to focus on in the analysis; how to interpret their words; and which extracts to use for quotation...We are in the privileged position of naming and representing other people's realities (1998:138-9).

Within this project, all the interviews were taped and then fully transcribed by me to include pauses, half-spoken words and emotional responses such as laughter. The written transcripts were then compared to the tapes to ensure, as far as possible, that the varying tones of the interview were also recorded on the written transcript. Following the transcription of the interviews, tables were produced with the demographic information and details such as the different methods of contraception the women had used. A timeline was written for each of the woman interviewed that traced the history of their contraceptive careers, and these were also used to highlight the events each woman felt to be significant. These documents allowed easier identification of particular events, such as unplanned pregnancies, and age of first using contraception.

The transcripts and fieldwork notes from both the observations and interviews were then analysed for content. Initially the analysis was guided by the interview topics, and by comparing specific experiences identified in the timelines, such as use of a particular method, or first contraceptive use. As familiarity with the data grew other themes emerged, which necessitated the constant reassessment of data by both rereading the transcripts and repeated listening to the interview tapes to ensure that the analysis was valid. For each theme identified, the transcripts were searched both manually and using key-

word searches for the sections of interview transcripts or fieldwork notes where the theme arose. Separate documents were then produced for each theme containing all the identified sections of the data to allow systematic comparison. With the media coverage I used discourse analysis of the content to uncover the 'preferred reading' of the events, without making any assumptions that readers or viewers accept the 'preferred readings' uncritically (Tuchman 1991).

Although the silencing of respondents can occur in different ways within the research, one way is, as Reay describes it, 'the dangers of proximity rather than distance' (1996:65). I have personal knowledge and experiences of contraception, and share a similar background to many of my respondents. Consequently, there was a danger that both within the interviews and the analysis I could foreground my own opinions and assumptions, rather than hearing what my informants were trying to say. Throughout this project I have tried to critically reflect on my own responses to the informants' accounts, and to discern how subjective power is being deployed both by myself and by the respondents during the interviews and observations, alongside considering how their subjective power is deployed in relation to contraception. It is not possible to 'do away with' subjectivity but only to try to fully consider my own subjectivity as an 'actor' within the 'research process' (Holland and Ramazanoglu 1994), and consequently, allow a more reflexive interpretation of the women's experiences.

Although the subjective power of the researcher has always been present, in the past some feminist researchers have stated that they are simply making women's voices public rather than interpreting women's experiences. Whilst this desire to 'validate' and 'recognise' women's experience grew from an appreciation of their invisibility and marginalisation within many forms of social research, it has had implications for the sincerity of the research (Kitzinger and Wilkinson 1997). Some feminists have omitted, or implicitly reinterpreted accounts that do not coincide with their stance, according to Kitzinger and Wilkinson, both in order to avoid openly disagreeing with the researched and to maintain the coherence of feminist theoretical frameworks. For example, they point out that much of the material about sexual harassment excludes accounts from women who disagree with feminist definitions of the term, and often fails to mention women who say they have not been harassed. Kitzinger and Wilkinson argue that feminist research needs to do more than just investigate women's taken for granted experiences, it needs to be honest about its role in interpretation, and at times even challenge the ways that women see their experiences.

Bhavnani (1994) also suggests that feminist researchers should take the views of the informants seriously, but that this does not mean that they cannot be interpreted by contextualising them within the framework of social theory. She argues that it is a question of accountability, of considering how the research considers dominant representations of groups, and how these representations affect the groups themselves. Moreover, as it is inevitable that the researcher is

in a position of relative power over the finished account, openly interpreting women's narratives acknowledges this part of the power relationship. Consequently, within my thesis I have tried to report accurately the women's own thoughts and feelings, and indicate where my analysis has led to a different conclusion from that which the women reported. In this respect, I hope to make more transparent the issue of power in interpretation, without silencing respondents who interpret their experiences in other ways. As Skeggs reminds us, 'all experience is processed through practice, discourse and interpretation' (1997:28), and the processes of interpretation do not belong to the researcher alone. The researched interpret their own experiences for themselves, as well as in relation to how they choose to respond to the researcher's questions, although it is the researcher who publicly 'recognises' and produces 'knowledge' about their lives.

Yet whilst researchers manages the 'production' of the research (Skeggs 1994:30), they often have to meet certain academic requirements that will limit the approach, the process and the 'results' of the research. My project also had to meet the requirements of gatekeepers in the medical profession, and needed to conform to criteria set out by a medical ethics committee in order to gain their approval. Whilst it must be recognised that the researched are not powerless and do exercise subjective power within the fieldwork stage through the selection and interpretation of their accounts of their experiences, the research design, representation of accounts, and theoretical explanations were chosen by me, within the disciplinary framework of the academy.

The epistemological questions of 'who can know' and 'what can be known' have been much debated in feminist methodology, and have developed within and through challenges to positivist claims of objectivity. Kirsch (1999) argues that while feminist standpoint theory has illustrated the importance of the location of the researcher in the research, it has essentialist tendencies as it appears to build from fixed identity positions. In this research, I wish to retain experience as a means of understanding the positions of the researched in the world, but to do so without proposing that experience is the 'foundation for knowledge' (Skeggs 1997:27). It is for this reason that power needs to be a central concept through which to develop understanding of the complexities of women's lives. Individuals are socially located within networks of power relations, and their ability to exercise control over aspects of their lives shapes their experiences. Moreover, their own interpretation of their lives forms part of their psychobiography and also impacts on their subjective power. The constant re/evaluation of our lives in light of our own and other's related experiences shapes our interpretations and future actions. Yet if we accept that all knowledge is situated, then the interpretation that we perceive can only ever be partial. Consequently, this thesis critically reflects on the women's narratives in order to put forward the most plausible account of their subjective power and contraceptive careers rather than the 'truth' about their lives.

Conclusion

This chapter has outlined the 'story' of the research. It has set out the approach to my thesis, how the research progressed, and the changes that were made along the way. In particular, it has sought to make clear the complexity of the deployment of power during the research process. Like most research, my findings have been shaped by the recruitment process, whereby women who were confident about the research area and amenable to the idea of the research responded positively to my request. The women who kindly agreed to take part selected and interpreted their contraceptive careers to deliver an account in response to my approach to them. The project was further shaped by my own feminist outlook, the disciplinary framework of the academy and the requirements of the medical gatekeepers. I managed the 'production' of the research (Skeggs 1997:30), but I did so within a complex web of power relationships.

Whilst my research is based on the women's accounts of their experiences, it does not assume that this is the 'truth'. All knowledge is situated, and just as the women's accounts were their interpretations of their lives, I too have reflexively selected and interpreted details of their lives. This study has aimed to produce a theoretical model of the complexity of power in women's lives, and a reflexive account of the empirical application of the model. Therefore, the following chapters should be considered to contain the most plausible explanation, rather than an objective account of their power relationships.

Chapter 5

Encountering Medicine

With my experiences of doctors... It is sort of like they just write a prescription, and that's it... what I mean... you can't talk about if it is right for you... you mainly get information from other women, who have had the coil, who have had the pill, and things like that. (Christine)

Introduction

Christine, like most of the other women I interviewed, relies on other women in her social networks for information or validation of her contraceptive choices rather than the medical profession. As I argued in chapter 2, the medical profession positions itself as 'experts', and retains control of access to many forms of contraception. Yet contraception has an anomalous position within medicine. Rather than waiting for a diagnosis or a recommendation of treatment during a medical consultation, women have, in most cases, already decided on the required outcome: they do not want to become pregnant, and in many cases, they will have also decided which type of contraception they want to use. Thus the interaction is one of gaining access, rather than enlightenment. The importance of this distinction will become clearer later, especially in the cases where there is a difference of opinion between the woman and the health professional.

This chapter will analyse the medical site of contraception. Attitudes and actions towards contraception are obviously affected by the men the women

are having or intending to have sexual relationships with, and this will be dealt with in chapter 7, which considers heterosexuality as a site of power. As I pointed out in chapter 3, sites are locations of specific technologies of power, and thus are not just a geographical space. Consequently, within this chapter, alongside explicitly medical issues, I will consider factors that appear to have a direct bearing on the exercise of power at the medicinal site of contraception.

In order to explore the constraints and capacities which affect women's deployment of subjective power in relation to contraception I will consider the face-to-face encounter, the attitudes of doctors, as well as wider discourses which structure women's opinions and use of different contraceptive methods. The broad structure of this chapter will mirror the trajectory that women go through when accessing contraception. I will start by considering how my informants relate to circulating narratives about methods of contraception, and how these may affect their opinions of them. This will involve considering how ideas about 'respectability' can act to both empower and disempower women in relation to contraception. The next section will consider contraceptive consultations themselves, including how time and place affect the women's deployment of subjective power. This will lead on to a consideration of the ways in which the women view the technologies themselves, concentrating on the perceived health risks and responses. However, despite such analytical separations, these aspects must always be considered as part of a continuing process, as most heterosexual women

undergo numerous contraceptive consultations over the course of their reproductive lives.

The Need for Contraception

For most of the twenty-two women I interviewed, the perception that they need to consider using contraception, or change their form of contraception is a gradual process rather than a sudden decision. In this section, I will concentrate on the discourses of health and medicine which circulate on contraception, which the women re/produce and/or reject when they consider contraception, and which consequently have an effect on their ability to deploy subjective power. I will start by considering the women's early experiences of using contraception, as throughout this research it was clear that the women's reflections on their past experiences have an important effect on their later contraceptive histories.

'Growing Up', ' Getting Settled' and 'Sorting Things Out'

Almost all of the women I interviewed had their first sexual relationships in their teens, and sixteen of them started using the contraceptive pill during this period. The most common pattern was a short period of using condoms, withdrawal or not using any method of contraception, and then a move to using the contraceptive pill. It was clear from the women's descriptions of their experiences and decisions that they were embedded within a number of common discourses. In particular, notions of growing up, taking care of

oneself, and a sense of female competence and responsibility featured heavily in their narratives, as the following extracts illustrate:

Paula I decided at which point in my life I would begin having sex... ummm... and I just... assumed that... well I just assumed I knew what I was doing, and I was making the choice...[...] actually, I suppose I thought I was an adult at 16... But then I guess, all my friends that I had been at school with, they were on the pill... and it was kind of... It's what you do when you are an adult... well I though I am an adult now, so that's what you do... in some ways there was a slight pressure... ummm... from peers... and society in general I suppose... certainly not from my parents or my partner...

Patricia I think it was probably... it was me who took the initiative [*to go on the pill*] in terms of... obviously the relationship was going in a certain direction, so something had to happen... and er... we had obviously been taught about it at school, and I'd done it at a youth group, so it was a case of either I am going to get into trouble here, or I am going to sort myself out, so...[...] I think it was just a natural progression, you know, I think most people were on the pill at that time... and... er it was like the norm... [...] I read the problem pages in magazines and things and it was like go to your GP and get it...

Sharon I was getting married as well, and we knew that we didn't want to, you know. I suppose we had just started to have sexual relations and thought 'oh', you know... We are going to be getting married, might as well go on the pill. Get it settled...[...] And my Mum said "I'll book you in with the doctor". It was my Mum who booked the appointment. She said, "I'll book you in with the doctor, you are getting married soon, you know, this year". So that was it.

Lucy I suppose at 16 I didn't really know anything else... it was talked about at school [*going on the pill*]... and... that's what everyone did...[...] it was like, doing something on my own, you know what I mean... and my mum didn't know, well she found out later... but it was just like doing something on my

> own...[...] I suppose at the time, it was like I didn't want to get pregnant so they gave me the pill...[...] Looking back now... ummm... fifteen years ago like... the main concern was, as far as I remember not getting pregnant... not diseases and things like that... Nowadays it is condoms isn't it, and I can see the sense now, but then I think it was taking care of yourself, rather than expecting someone else to.

These extracts illustrate a number of different elements involved when the women first considered using contraception. Of the four cases quoted above, Paula and Sharon were having sex but not using contraception when they made the decision to go on the pill, whereas Patricia and Lucy made the decision to go on the pill before they started having sexual intercourse with their partners. Yet, despite this difference, very similar concerns emerge which affect their actions. The women see their first use of contraception in terms of their transition from child to adult. Their need for, and use of, contraception was seen by them at the time as symbolising their maturity in caring for themselves. As responsible young women they took steps to protect themselves against the risk of pregnancy (although not sexually transmitted infections). However whilst at the time they considered themselves as making mature and responsible decisions, there was a potential conflict in the way that others saw them. As Holland *et al* (1998) amongst others have clearly shown, young women are judged by (sexual) reputation and consequently going on the pill could also be read as evidence of unrespectable behaviour.

'Respectable' Users

One particular way that the young women could legitimate their use of contraception, and retain an air of respectability, was to start using the

contraceptive pill for period problems. Whilst I am not suggesting that the women were not experiencing problems with their menstrual cycle, I am particularly interested in the way that this allowed them to justify their use of contraception both to themselves and to others. As the following quotations show, both Clare and Donna were already having sexual relationships and were using condoms before they chose to go on the pill, whilst Martina stated that she was already using the pill the first time she had sexual intercourse.

Clare ... my sister... my elder sister... I think that was where I first got my information from about how reliable it [*the pill*] was... and then I... went to see the doctor who sort of endorsed it really... [...] I felt ok because I knew it wasn't just... you know... because of intercourse... it was because I had heavy periods and that as well... It just had the bonus of... [*laughs*]... being a contraceptive

Donna I think initially it [*pill use*] was... umm... irregular periods... because I have always had maybe one or two a year... so it regulated my periods, but I also did start a sexual relationship at 16... but initially, I was on for...

INT So, were you on the pill when you had sexual intercourse for the first time?

Donna No... we used condoms I think....[...] I was quite comfortable with it, [*going on the pill*] because at the time... I was quite... the fact that I was doing it for my periods rather than, I think it would have been a different story if it had been for sex... I don't think my mum... associated it with a sexual relationship at the time... she thought she was sort of... helping me with my periods really.

Martina It was my choice... I mean it depends on how you define pressured in any way. I had it well drummed into me, by my mother, that if I was going to do anything then I needed to be protected. [...]... For two reasons. One to control... umm periods, because they were a bit erratic in those days, and the other one was because I was in a relationship.

As these cases illustrate, women are often consciously aware that they need to retain an appearance of respectability and that any open admission of a sexual relationships could prove harmful to their reputations. In all three accounts, we can see how taking the contraceptive pill for their periods was an important justification for them. Indeed, in both Clare's and Donna's account we can see that although they were already having sexual intercourse, the contraceptive pill is defined primarily as regulating their periods and only secondarily as a contraceptive.

At this time, in the late seventies and early eighties, condoms were often dismissed as unreliable, and the most common recommendation to women was to use the contraceptive pill (Thomas 1985, Foster 1995). The difficulty that the young women faced was that by seeking to use the contraceptive pill, they not only had to acknowledge to a doctor that they were having or contemplating a sexual relationship, but were also signalling that they were willing to have sex, rather than having to be 'persuaded' (Pollack 1985). By taking the pill for 'medical' reasons rather than, or in conjunction with, contraceptive reasons, they could both protect themselves against the risk of pregnancy and avoid an open acknowledgement of their readiness for sexual activity.

There is some evidence that the medical profession is also implicated in re/producing this practice. The medical textbook *Women's Problems in General Practice* suggests that young women presenting with menstrual problems are unlikely to have any pelvic pathology, and so they should just be reassured that things are likely to improve in time (Rees 1995). However it also states that 'young girls using the pretext of dysmenorrhoea may really be seeking contraception' (Rees 1995:186). The implication is that doctors should consider prescribing the pill to any young woman who presents with 'period problems', in case she is too embarrassed to ask directly for the pill. Moreover, these comments also illustrate two other common aspects of the doctor's attitudes. First, doctor's dismissive attitude to (minor?) bodily inconveniences which women experience, and second their presumed ability to differentiate between 'real' and 'spurious' conditions.

These accounts all illustrate how women's subjective power can be affected by either accepting or rejecting circulating discourses. By positioning themselves as mature and adult, they strengthen their position, through the adult entitlement to both sexuality and contraception. They see their use of contraception in general, and particularly the contraceptive pill, as demonstrating that they can take care of themselves, and this in turn increases their resolve to obtain contraception. Yet at the same time, there is a risk that they may be constructed as 'irresponsible', because others may not recognise the maturity that they see in themselves. One way they use to resolve this dilemma is focusing on the problems that they are experiencing with their

menstrual cycle. To have the contraceptive pill prescribed for medical reasons constructs them as respectable, whilst at the same time affords them an efficient method of contraception. Moreover, it allows them a choice as to whether to reveal or conceal their active sexual lives from others, notably their parents, and as most of the women were still living in their parental home this must be considered an advantage at this point in time. Moreover, women's need to distance themselves from irresponsible behaviour was a constant theme which permeated most of the interview transcripts. What is interesting, however, is that although the women frequently took steps to protect themselves against pregnancy, they rarely showed a similar commitment to protecting themselves against sexually transmitted infections, as the following section will discuss.

Contraceptive Priority

As the earlier quote by Lucy makes clear, for most of the women, when they first became (hetero)sexually active, the need to protect themselves against sexually transmitted infections was not perceived as an issue. The main, or only, risk associated with sexual intercourse was pregnancy. When asked if concerns about HIV/AIDS or other sexually transmitted infections had ever affected them, most of the women stressed that this was not or never had been an issue because of their 'steady', or 'long-term' relationships and non-promiscuous behaviour. For many, the implication that they may have been at risk of HIV appeared to question their respectability, and indeed in a few cases they were obviously so disturbed by this line of questioning that I stopped and

moved on, whilst reiterating that the questions were designed to cover a range of women's experiences. In this section, I will concentrate on the women's attitudes rather than considering negotiations with men, which will be discussed in chapter 7.

It was not until the first AIDS awareness campaign that a possible need for prophylaxis became public discourse, and many of the women vividly remember the 'tombstone' campaign leaflets and health information films of the late 1980s. Yet although this campaign introduced a new discourse of safe sex, in many cases it had little effect on the contraceptive practices of my respondents, and only two women reported that they changed their contraceptive practices at this time. As Charlotte comments:

Charlotte I mean I have only had two partners any way, but er... I haven't really [*thought about HIV*].. I suppose... you hope they are decent people who er... used protection, but I suppose there is always... but no... I haven't really, er... Not initially no, but I suppose you thought about it afterwards, but it is too late then.

INT When you say you thought about it afterwards, is that now, or as the relationship progressed or...?

Charlotte Ummm... when you find out how many people, you know, how many partners they have had or... you think... ohhhh... but no... naughty you should do really, think about it before you jump in but...

This extract is interesting as it reveals the complexity involved in marking the bodies of others as risky (Miles 1993). First, Charlotte is keen to stress that she has only had two partners, and therefore she could not be constructed as either at 'risk' or immoral. She goes on to suggest that she assumed her partners would also be 'decent people', thus negating any need for safer sex practices.

However, as she learnt more about her partners' sexual history, she retrospectively constructs them as being a possible risk of infection. Yet by implying that her partner should have used 'protection' within previous sexual encounters, rather than those with her, she positions the risk in the 'other' bodies of her partner's previous encounters. Thus despite her admission that she has neglected to practice safer sex, the 'real' problem is neither her nor her partner's, but located elsewhere in the bodies of others. The location of danger in the bodies of the deviant 'other' has been a feature of popular representations of the 'AIDS carrier' (Redman 1997).

What was clear from the transcripts was that the only women concerned about the risk of sexually transmitted infections were worried about others close to them who could be at risk. This was most striking amongst respondents who had teenage children or step-children, but also appeared in relation to newly divorced sisters, or 'girls' they supervised at work. These accounts also implied that the location of the problem was in the bodies of 'deviant' others, as they recalled how they advised the younger women to 'protect themselves', rather than considering that they may be a source of risk to others. Many of the women also reported that if they were single now they would take the issue seriously, but whether this would actually happen is another matter. Bernadette, for example, had not given much consideration to a need for safer sex practices in the past, and as a widow who is not currently in a relationship, she contemplates how she might act in the future thus:

INT Have concerns about HIV or other sexually transmitted infections ever affected any decision you have made about sex?

Bernadette ... God... well no because I have been married... and prior to me getting married HIV was only just hitting the scene, you know mid eighties. I met my husband at the end of the eighties so... obviously I was aware of it... [...] I do think pregnancy, I know it is naughty isn't it. But now my circumstances have changed I should be thinking about it more...

Only in a minority of cases did women either change or redefine their contraceptive practices. For example, three of the women who currently used condoms pointed out that this had the added bonus of protecting them against sexually transmitted infections, although it was often clear that they had decided to use them for other reasons. It was also apparent that their attitudes were not constant and that while some had been receptive to the original health information campaigns, the risk of HIV/AIDS was not much of an issue now. Karen stated that she was 'getting blasé' about the issue, while Sharon reported that the risk of HIV/AIDS was much higher in the eighties, and that other sexually transmitted infections were now 'really more serious'.

The women's attitudes reveal a complex relationship to the circulating discourses around HIV/AIDS (see for example Waldby 1996 or Patton 1994 for in depth analysis of these discourses). The association of HIV/AIDS with the 'deviant' meant that their first reaction was often to distance themselves from those at risk, by emphasising their respectability. Yet at the same time, they were often concerned about the possible risks that 'others' posed to people close to them. They often made reference to the lifestyle differences between themselves and young women today, and assumed that if they were teenagers

today then carrying and using condoms would be an unproblematic practice, regardless of the fact that most of them had not done so when they were in their teens. They also tended to assume that if they should ever be contemplating a new sexual relationship, they would be empowered to practice safer sex.

Yet examining the attitudes and practices of the women who were currently single, or who had recently changed sexual partner, did not provide evidence of routine protection from sexually transmitted infections. This low level of concern over the risk of sexually transmitted infections is in marked contrast to the number of concerns expressed by the women about risks from using hormonal contraception. Yet despite their concerns over this risk to their health, all but one of the women had used a method of hormonal contraception, and all had used prescribed methods of contraception at some point in their lives. In fifteen cases, the women had depended on prescribed methods for a total of more than ten years. Consequently, contraceptive consultations have been a regular occurrence in many of the women's lives.

Contraception Consultations

Contraception is the most common reason for women to make a doctor's appointments (Doyal 1997), yet one of the most striking features of the interviews was although they recognise that the technologies have effects on their health, and they have to access them through medical professionals, the women did not appear to agree with the medical profession's construction of

doctors being 'experts' in this area. In this section, I will begin by looking in more detail at the women's early encounters in obtaining contraception. Although only a few of the women reported that the encounter had been a 'bad experience', the feelings of insecurity that many of them reported had an ongoing effect on their perceptions and expectations of future encounters. I will then move on to discuss the women's perceptions of encounters with GPs, and why they see contraception as at the boundaries of medical expertise. In the last section, I will look at how the clinic encounter differs from that of the GP's surgery, in terms of ideological and material arrangements, how specialisation constructs the staff as experts and how this can disrupt notions of medical hierarchy.

'Going on the Pill': Early Contraceptive Encounters

All sixteen women who started to use the contraceptive pill in their teenage years sought it from their GP. Although if originally prescribed for menstrual problems this would be the most obvious source, many of the women also reported that they had not known about family planning clinics and thus they were unaware of any other option[10]. Moreover, other factors may also have been important. For example, Patricia commented that the advice she remembered reading in teenage magazine problem pages recommended seeing your GP. Yet, the prospect of going to see the 'family' doctor was often daunting, and many of the women remember being acutely embarrassed when

[10] I did not ask the women where they were living at this time, so there might not have been a family planning clinic in their locality, although they are available in most areas of the UK (for details see http://www.fpa.co.uk).

they first presented to ask for the pill. At the same time they often commented on their determination to obtain the pill, and in most cases they went in to ask for the pill directly, rather than seeking general advice about contraception.

As already mentioned, teenage sexual activity is often deemed 'unrespectable', and many of the women felt embarrassed at having to openly acknowledge their sexual intentions at this time in their lives. This was often heightened by the history of the medical relationship with their GP, as the following comments illustrate:

Linda — I felt embarrassed, you know… because it was a family doctor and they had known us since we were all babies. And they would have… you know, my Mum had grown up with the doctor's kids, so… but it was fine… he asked, I think a few questions…[…] I mean I remember it was my own doctor, but apart from that, I don't remember.

Paula — [*I felt*]... embarrassed… my doctor… my GP was very old fashioned… er… my mum was clearly embarrassed, and he was disapproving... But at the time I was a rebellious 15 year old, so I didn't give a damn about either of them… although that is not true, I did feel, I did feel embarrassed as well...[…] maybe… maybe the doctor thought I was a wilful child who… who was determined to go on the pill, you know, at any cost… I could be wrong… I don't think… I don't think he saw any point in discussing it fully with me because… I had made my mind up.

Judith — … I think we had just changed doctors… you know… like when you are a kid and you have got one doctor and you feel like you're, you know… and then we changed… and so I went there, and like it is all private anyway so...

INT — So it was because it was a different doctor you felt better?

Judith — yes, you know… it was like I was older, not some kid he had been seeing...[…] it was embarrassing… just you know… asking… so he had to know... just the reaction isn't it, you know… their reaction… are you having heavy periods and then

> when you say no, it is obviously because it is for a sexual reason and then it's a different story... blunt... told me everything I needed to know... but blunt... He was older... he's retired now anyway... so maybe, you know... Somewhere... not for a medical reason... so maybe he didn't approve.

As the above quotations illustrate, going in to ask to go on the pill was often a daunting prospect, and if the women were seeing a GP who had treated their families for many years, this anxiety was increased. Yet at the same time, almost all of the women had, as Paula described it, 'made their mind up'. For some of the women the appointment turned out not to be as difficult as they had envisaged. For example, Clare commented that she felt that she was treated 'like an adult'. This also reflects back on the perception that going 'on the pill' was a feature of the transition to adulthood. Yet other women were not as lucky and had to face obvious disapproval, such as in the encounters described by Paula and Judith. In Judith's encounter we also see how the division between the respectable use for period problems and the unrespectable sexual motive affected the face-to-face-encounter itself, as she describes how the doctor's reaction changed, and he became blunt and disapproving.

Age is a central theme in the descriptions of 'disapproving' doctors, who are described as 'older' or 'old-fashioned' by many of the women. As my respondents are in their thirties, these experiences took place in the late 1970s and early 1980s; many of these doctors would have qualified before the pill was available. However, it is far from certain that things have radically changed for young people today. Although there is a more general acceptance

of sexual relationships outside of marriage, teenage sexual activity is still subject to regular condemnation, with young women in particular bearing the brunt of the disapproval (Hawkes 1995, Barratt and Harper 2000).

In these early medical encounters, we can see that the women consider themselves to be disadvantaged in the medical encounter, because of their age and ideological constructions of moral and immoral sexual activity. Yet despite their awareness of their less powerful position, all of them who tried succeeded in getting what they wanted, as they left the surgery with a prescription for the contraceptive pill. Whilst some of them were made to feel uncomfortable about their request, they all successfully exerted sufficient subjective power to access their chosen contraceptive method. Moreover, although these early encounters are distinct because of the importance of age in distinguishing between respectable and unrespectable users of contraception, they also illustrate components that continue to structure women's later contraceptive encounters. In the following sections I will illustrate that although access to contraception is often through medical gatekeepers, in most cases the women do not expect advice from the medical profession, and continue to go into contraceptive consultations with the aim of accessing a particular method. In addition, the concept of the 'family doctor' continues to impact on women's decisions over accessing contraception, with some women preferring to separate 'medical knowledge' of their family from discussions that reveal their sexual activity.

Doctor's Authority?

For many of the women, accessing contraception was an unproblematic experience. The women tended to decide what method they wished to use, they then made an appointment with either their GP surgery or family planning clinic, and successfully accessed the method they had chosen. Mary stated that at her doctors' she just told them 'what I wanted', whilst Katy stated that 'I've just been happy to go and get my prescription every six months…'. Indeed, what was often clear was that the women did not expect their decisions over contraception to be questioned, with the only possible exception being if there was a medical contraindication that they had not known about. Contraception is 'not an illness' (Linda) and this a crucial reason why doctors are not necessarily considered to be experts, as well as explaining why their opinion may often not be sought. Consequently, when the women did have their decisions denied or questioned by doctors they often felt indignant and that the doctor was exerting illegitimate power. In the following example, Alex describes her reaction to the denial of her contraceptive choice.

> I was on Marvalon, and there was a big scare, with this particular brand. I spoke to my doctor… er… and he said he thought it had been blown out of proportion, and so did I, we were both happy for me to stay on it. Then I had to go back to the doctors, in a rush, because I had to take the pill the next day… ummm… my doctor wasn't there, a locum was there, and he insisted on changing my pill. And because I had to take it the following day, I couldn't really argue with him, you see… I tried to insist, but he was not having it, not under any circumstances, no… and I had to have the pill for the following morning… I was stuck… I told him that I had discussed it with my regular doctor, and both of us were happy for me to stay on it… ummm he wasn't having it… I was very angry, very annoyed… because I had discussed it with my doctor and we both agreed, yes, I

> am happy staying on that one, and he insisted... he was almost... how should I put it... 'I know more than you, you are only a patient, take this prescription and go away'... That is the impression I got from him... I felt belittled...[...] the doctor said, you can't have it, it has been withdrawn... but I found out, I asked the chemist, he said no they hadn't withdrawn it...

In this extract, several of the main features of the contraception encounter are illustrated. In the beginning of the extract, Alex recounts that she discussed a pill scare with her GP, and neither of them felt it was necessary to change. (I discuss different perceptions of risk and its effect on women users of contraception in more detail later in this chapter.) Alex had seen the reports in the media but felt that they were just 'exaggerating' the risks. It was nothing that she did not already know about, and she waited until she needed another prescription before discussing it with her GP. In this instance, Alex has disregarded the media reports, and she has her decision to continue to use Marvalon ratified in her next consultation with her GP. However, on a subsequent visit when she sees a locum, this decision is overturned as he refuses to continue to prescribe Marvalon. In her account, she questions not only his actions but also the basis of his authority. She describes him as having an arrogant attitude, not only wrongfully exerting power but also trying to mislead her by telling her the drug had been withdrawn when it had not. She clearly does not expect to be treated as 'only a patient' who should 'go away' with a prescription, yet in conventional doctor/patient relationships that is precisely what is presumed to happen[11].

[11] Although the concept of shared decision-making has been gaining acceptance within the medical profession, research has yet to show significant moves away from the practice of paternalistic doctor/patient relationships. See discussion in Charles *et al* (1999) or Gwyn and Elwyn (1999).

The exasperation felt by women who had their requests for particular methods of contraception declined by GPs is a stark illustration of the contested boundary of medical expertise. In addition to Alex, Christine and Bernadette both described incidents in which requests for particular forms of contraception had been denied by GPs. (It may be significant that all three of these women subsequently became clinic users, although they did not all change directly after their requests were denied.) Yet, these were not the only accounts in which medical expertise over contraception was questioned. It appeared that despite contraception's medicinal classification, many women did not expect doctors to have sufficient knowledge to offer advice about different methods, or to have any interest, or time, to do so.

The women clearly distinguished between contraception and medical matters, and this disassociation was an important part of their explanation for their GP's perceived lack of expertise. GPs were understood to have a 'tough job', and to be 'pushed for time', with 'other things on their mind'. Sharon commented:

> I think GP surgeries are really rushed. Because they have that much to do, I mean they have got that many people... I suppose contraception, it is not really classed as an illness, so they don't really want to go into that too much.

For Sharon, like many of the other women, contraception is different from 'illness'. Whilst they expect GPs to take an interest in, and have knowledge about, medical matters, contraception is not considered to fit that category, and thus doctors are perceived to be either unwilling or unable to discuss it in more

detail. Sonia and Rebecca both felt that there were definite limits to a doctor's knowledge, and whilst they might tell you 'what they know', this was unlikely to be the full story. Indeed for Sonia there was a difference between medical reports and 'real life'. Although she felt that the Depo-Provera injection recommended by her doctor was a 'bad choice' as she had experienced so many problems, because it was a new method she felt that her doctor could not have been expected to be aware of all the possible consequences. She appeared to be saying that reports of medical trials were not sufficient, and that doctors could only be expected to develop an understanding of any problems such as side effects, after they had begun to prescribe new drugs to patients.

Whilst for some of the women contraception simply fell outside the range of doctors' expertise, others were far more critical of GPs. Martina felt that GPs deliberately withheld information from women, and it was only patients who knew the right questions to ask who had a chance of getting sufficient information to make an informed choice. She stated that she felt that in general doctors 'do tend to treat people as if they are not particularly intelligent', and that you were unlikely to get the 'whole story' about the side effects or health implications from a GP.

Lupton (1996) has argued that most patients are unlikely to be 'model' consumers who exercise choice over their health professional, as they are often emotionally dependent on doctors when they are ill. However, as

previously mentioned, contraception is not perceived by the women as a 'medical matter', and this allows them to move to a different provider without necessarily negating trust in their GP. Contraception is simply reclassified as an area beyond their GP's expertise. As I have previously mentioned, (and will discuss in more detail later) the morning-after pill has already been deregulated, and many health professionals are also reframing contraception as needing less medical control. Moreover, perceptions about the limit of a GP's interest and knowledge about contraception were often cited as reasons for registering at the family planning clinic for contraception.

Family Planning Clinic Encounters

The women who used the clinic described the contraception consultations in very different terms from their experiences in GP surgeries. Most felt that in the clinic they were more likely to be able to obtain expert knowledge about the different methods of contraception and the different impact that each method could have on the woman user. In contrast to an appointment with a GP, the women felt that at the clinic the encounter was 'more comfortable', the clinic had 'specialist knowledge', they could take 'time to discuss things', and it was 'easier to ask questions'. Moreover, a few of the women had moved to the clinic specifically because of failed negotiations with their GP. For example, Christine had had her request for Depo-Provera turned down by her GP so she had gone to the clinic to ask there. She commented:

> I think this clinic is so much better, because it is based around women. It is not based around a man coming in with a cold, or a man coming in

> with a poorly finger. It is based around women's contraception and not getting pregnant, well hopefully not getting pregnant. They can tell you about it...[...] they were more understanding... ummm I told them my problems, and ummm, they went through things with me. And like, I asked to go on the pill injection...[...] I explained to the woman doctor and she was fine... she accepted the reason, and she was quite happy about it... and then they gave me Depo-Provera.

In this description of the clinic we can see several of the differences that the women perceived between the clinic and their GP. The clinic is constructed as a place by and for women. It is 'based around women' and their specific need for contraception, and seen not only as a site of specialist knowledge but one where women can take time to 'go through their problems'. This meant that women felt able to make appointments just to discuss the different options, without necessarily making any decisions. On the other hand, GP surgeries were deemed to be not only far too busy for this type of appointment but also, as their prime concern was with 'medical' matters, GPs were seen as much less likely to be able to discuss the options.

Although not all the women had switched to using the clinic because they had been refused a particular method of contraception, almost all the clinic users felt that the clinic staff had a much higher level of expertise. As well as more likely to be 'up-to date', they were considered to be able to offer 'a wider range'. Many of the women changed from their GP to the clinic when they had chosen to use IUDs, because they felt that the clinic staff would be more skilled in fitting them[12]. Indeed, it was clear not only from the interviews but

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[12] Some GP surgeries do not have any doctors trained to fit IUDs, and so routinely refer women to family planning clinics. However, most of the women I interviewed stated that they had the option of being fitted at the GP's surgery, but had chosen to be fitted at the clinic.

also from my observations that many women checked the validity of advice they had obtained from GPs with the staff at the clinic. For example, Karen mentioned that whenever she was prescribed medication by her doctor or consultant she would ring the clinic to check whether the advice she had been given on its interaction with the contraceptive pill was correct. During my fieldwork period, I observed the staff routinely answering similar telephone queries, and well as talking through other issues, such as a telephone call from a young woman who had picked up her first prescription but was unsure if the doctor had given her the right instructions about how to start taking the pill. Significantly, it was the family planning nurses who gave almost all of this telephone advice. In a reversal of medical hierarchy, it was (female) nurses who were considered to be the experts rather than (male) doctors.

The other reason that some of the women cited for using the clinic rather than the doctor's surgery was that they did not feel comfortable discussing contraception, and by implication their sexual lives, with their 'family doctor'. Charlotte spoke of feeling more comfortable at the clinic, where she didn't feel as embarrassed, and stated that she had not wanted her appointment to be in the 'family environment' of her GP's surgery. On the occasion that we met, Charlotte had gone to the clinic to request the morning-after pill, and it is possible that the construction of the users of the morning-after pill as 'irresponsible' heightened her concerns about using her 'family doctor'. The particular discourses surrounding morning-after pill users will be returned to in chapter 6.

Paula had also chosen to use the clinic because of the anonymity it afforded. Paula reported that her GP had known her and her family for many years, and that if she had gone to her doctor to ask for a prescription for the pill it would have been very awkward, as the doctor knew that her husband had previously undergone a vasectomy. Paula felt that her doctor would disapprove of her new relationship, and said she did not want to be questioned about her marital break-up. By accessing the contraceptive pill through the clinic, Paula could avoid what she thought would be an extremely awkward doctor's appointment. By accessing the different space provided by the clinic, she was exercising agency in an effort to minimise any discomfort and place herself in a stronger position in relation to the health professional she needed to consult. By changing the venue of the contraception consultation, she could minimise judgements about her behaviour and would therefore not be disadvantaged within the encounter.

Embodied Knowledge

Throughout the interviews, there emerged a clear difference between medical consultations for contraception that took place at the GP surgery and those that took place at the clinic. Although there were obvious organisational differences a gendered sense of place also emerged, with the GP's surgery appearing to be a masculinisied space whilst the clinic was seen as a feminised space. This pattern did not seem to be affected by the presence either of male doctors who worked at the clinic; or of female GPs and practice nurses who dealt with contraception in many surgeries. In general, GP surgeries were

considered to be involved in a 'heroic' battle between medicine and disease (Lupton 1998). They were understood to be disciplined places with spartan communication, where staff did not have the time to indulge women with in depth discussions about contraception. Although in practice many women did feel able to discuss contraception with their GP's, these doctors were considered to be exceptions rather than representing a different model of doctor/patient relationship.

In contrast, the clinic appeared to be based on a more feminine model. It was a space for discussion, more caring and importantly for the *sharing of experiences.* This is how Sharon describes the atmosphere at the clinic:

> I like the Well Woman, I thought it was the better option… […] they are just nicer to talk to, they just explained everything… I just know that they have got the time to sit and talk to you about things as well… They understand better because they have to go through the same things themselves. They… without mentioning any names, they just explained if anyone had bad experiences or good experiences it was just nice, because you know you are getting genuine feedback, you know…

As this comment illustrates, the clinic's expertise that was valued by the women was not just found in the specialisation of the clinic but was embodied knowledge. The women all assumed that the (female) staff would be users of contraception, so the foundation of their expert status was a combination of their specialised training and the embodied knowledge gleaned from their practical experience. Women health professionals, be they nurses, midwives, health visitors or doctors, were constructed as the ones who 'know' about contraception. Furthermore, it was this expertise based on embodied

knowledge that credited the (female) family planning nurses with more authority than (male) GP's. Indeed despite male doctors working regularly at the clinic, it was considered by the women to be a predominantly female place of expertise.

However, this expectation of a caring, sharing space meant than when disputes or problems arose at the clinic the women appeared to be disconcerted. For example, I observed one woman having her request for the combined pill turned down because of her family's medical history. Throughout the interview, the woman tried to insist that her mother's history of heart problems should not affect her being able to take the pill, and at one point she asked the (female) doctor 'What would you use instead?'. In a conversation immediately after the consultation (when she unfortunately declined an interview), she commented: 'She [*the doctor*] should have let me have them. It's not such a big deal, I bet she'd take them herself if she were me… how would she like it?'. As this observation illustrates, when women consult female health professionals about contraception, they expect embodied advice based on shared female bodies and a presumed shared risk of pregnancy. The discussion is deemed to be based not just on knowledge gleaned from their medical training but from their personal use of contraception.

Whilst the clinic was considered to be a space of specific female expertise, this embodied knowledge was also assumed in female GPs and practice nurses. Indeed, many women implied that the delegation of contraception to (female)

practice nurses was increasing the level of expertise to be found within GP surgeries. As Joan stated:

> Well I think sometimes they [*doctors*] might not be able to talk it through... in which case... I think they should be saying 'I will make you an appointment to see the nurse'... because there are a lot of district nurses than ummm... can talk frankly about contraception, you know... I've had experience of that.

Although these attitudes do contrast sharply with the traditional model of doctors and nurses, it should be remembered that, for the women, contraception is not a fully 'medical' matter. Thus, the role of the 'expert' is also linked to the women's perception of contraceptive technologies themselves.

Contraceptive Technologies

Throughout the interviews, the women expressed ambiguous feelings about the different types of contraception. They were acutely aware of the need to balance their desire for effectiveness with the particular risks or problems associated with each method. Moreover, it was clear that different balances were struck at different times in their lives, with many women changing their method in line with changing personal priorities as well as changing attitudes towards the risk of pregnancy, potential health implications from the technologies, and the type and frequency of their sexual encounters. All of the women had used more than one method, and while most had tried four or five, one woman had used a total of seven different methods. Furthermore, there appeared to be an acceptance by the women that the side effects and health implications of using contraception were an inevitable part of the

technologies, and it was unrealistic to expect anything else. It was clear from the women's accounts that the need to consider uncertainty was a constant feature of their experiences of contraception. This is evidence of how attitudes to this type of ubiquitous and unknown risk are re/produced by and embedded within social relationships (Lupton 1999).

The combined contraceptive pill has been publicly associated with more health risks than most of the other contraceptive methods. This was the 'risk' that the women usually mentioned first, and had most to say about. Whilst all the women were aware of medical conditions which had been linked to taking the pill, not only were their reactions to this health information different but time also emerged as an important element in both their strategies and understanding of the risks involved. In this section, I will start by considering the women's attitudes to contraceptive technologies and their relationship to the body. I will then illustrate their perceptions of risk, particularly in relation to hormonal contraceptive technologies, and how time is implicated in them. I will then move on to discuss the temporal ways in which some of the women sought to 'limit' the risks, and how this related to particular stages in their lives.

Hormones, Health and the Body as a System

When the women were relating their perceptions of risk, the 'model' of the body they were using became clearer. Most of them referred to the body as a 'system' that could be put under threat, particularly from a sustained ingestion

of hormonal contraception. Paula illustrates this as she describes why she has chosen the pill rather than an injection or implant:

> I like something that I can administer myself over a… Not something that is like all in one go… and if there are any adverse effects you can't just stop it… whereas with the pill, I know it is in the system, but I feel that if things went wrong I could just stop… I feel I'm in control.

Although many women were aware of possible health problems, the exact nature of the 'threat' was often unknown. Some of the women did 'put the thought out of their minds'(Mary), and took comfort in the idea that it was unlikely that they would be affected. However, most of them were concerned about how hormonal contraceptives affected their 'body's well-being' (Martina). Martin (1994) has argued that thinking of the body as a system creates a paradox whereby individuals feel that they are responsible for maintaining their health but that it can be affected by many factors outside their control. The risks of hormonal contraceptive technologies are a cogent example of this. The women were often acutely aware that by using them they may be exposing their bodies to risks; but at the same time the exact nature of the risk was unknown, and they often felt that they had little other option if they wanted control over their fertility.

Many of the women mentioned medical conditions that they knew had been associated with hormonal contraception, such as cancer or deep vein thrombosis. For some of the women, the risks had been brought home after female friends or family members had been diagnosed with breast cancer or suffered from blood clots. Yet at the same time the women appeared to be

resigned to the fact that contraceptive technologies could never be 'risk free', and that the risks were a small price to pay for the freedom and control they gained over their lives. Martina commented:

> I don't know if there is something to suit every need, and I am sure a lot of development work happens, that's why you get things like the morning-after pill… The one thing that every woman would want is a perfect solution to everything, and I don't think that exists at the moment. I am sure there is scope to expand the range… umm… even though I was quite happy taking the pill… umm.. I wasn't blinkered… and ignoring information about it... I was worried about it… I am less sure now that it is an ideal way to treat your body, to muck around with the hormones… but at that age my top priority was not to get pregnant… now that I am older… I am less confident that the pill is the best way to avoid pregnancy… although I don't know if the information was available at the time I took the decision to go on the pill.

As this quotation illustrates, continuing use of a particular method does not necessarily indicate that women are happy with it. As Walsh argues (1997), the evidence suggests that most women opt for the 'least worst' option for their particular circumstances at the time. Most of the women I interviewed felt that, despite the problems associated with the different methods, they needed to be able to control their fertility, and thus they had to balance the 'risks' against the 'effectiveness' and the specific operation of each method. The quotation also reveals how women's priorities change over the course of their lives. Whilst preventing pregnancy was once Martina's top priority, now the risks from hormonal contraceptives carries much more weight in her decisions.

Throughout the interviews the women spoke not only of their own uncertainties, but also of doctors' lack of awareness as well. Many of them did

not expect the medical professionals to know about the exact nature of the risks involved. Yet, in many cases this did not seem to imply a criticism of their doctors, but that the problem was located in the technologies themselves. As Lupton (1996) argues, although there is a growing disillusionment with aspects of medical science, individuals still need to maintain a 'faith in medicine' and this is often achieved through a trust in their doctor. Consequently, these women appeared to be able to maintain faith in their doctors by the dual strategy of locating the (unknown) risks within the technologies themselves, and by reclassifying contraception as not quite within their GP's remit. Moreover, in Martina's comments we can also sense how the idea of scientific progress over time is implicated in elucidating and eliminating any risk.

Time will Tell: Contraceptive Technologies and 'Scientific Progress'

For most of the women, the risks of contraceptive technology were perceived to be of a long-term nature, and it was only with the passage of time that either problems or answers would be found. This feeling fits easily with the notion of science as 'progress', with a presumption that there will be a continuing expansion of knowledge and technology. The following passages illustrates the dichotomy of views expressed about what might be revealed:

Sonia	I think the doctor told me everything he knew... ummm... but it [Depo-Provera] was quite new at the time... and you know, obviously you have to let people try new things to see if there are any effects...[...] in my case it was a wrong decision, but the doctor didn't really know that... my doctors will give you all the information they have... but at the end of the day it's... it is just

information out of a book.. you know... and they have to go by real life in the long term.

Sharon — I think you have always got that worry about taking a hormone... because they said it is going to be in the next ten/fifteen years we are going to start seeing the effects... The people from the sixties that went on the pill, and the seventies that we are going to start seeing now... with the menopause and everything... what is going on... if anything... if there is a rise in hysterectomies and things...

The first of these extracts is from Sonia, who had tried a Depo-Provera injection following a recommendation from her GP and suffered from severe side effects. She describes above how doctors cannot be expected to 'know' about new methods of contraception. It is only through the passage of time, after they have prescribed it to women and seen its effects, that they will begin to be able to judge whether or not it is suitable for a particular woman. It is not text based information that is deemed significant here but everyday practice over a period of time. In this respect, women users of contraceptive technologies are seen as an important part of the development of these technologies, in a similar way to Franklin's (1997) descriptions of women undergoing IVF treatments.

Whilst Sonia sees the passage of time as removing uncertainty over contraception by increasing knowledge of different methods, for Sharon time is significant in revealing the problems. Sharon also believes that there are unknown effects of contraception, but for her the passage of time is more likely to bring a pessimistic outcome. The effects on women of taking hormones for a sustained period of time have not yet been fully assessed, and she feels that time will reveal the full scale of the problem; greater numbers of

women may need to be treated for gynaecological problems and possibly have to undergo hysterectomies.

The importance of time in revealing the full impact of the use of contraceptive technologies was also mentioned by several other women, especially in terms of a reluctance to try new methods. Lucy described injections as 'not that old', and she wasn't sure if they could be trusted, whilst Linda and Rebecca had similar feelings about the implant. In all these cases, there was a sense that time had not yet revealed either the 'true' effectiveness of these new methods or the possible impact on a user's health, and so it was better to avoid them for the time being. This strategy of avoiding new methods was not the only way the women tried to limit their bodily risk. In the next section, I will discuss how temporal strategies and the passage of time were both seen as affecting the level of exposure to any risk.

Time to Change?

One of the main strategies used or described by the women as 'limiting' the risks to health was to reduce the time they spent using hormonal contraception. There were two strands to this temporal strategy. In the first case the women would temporarily stop using hormonal contraception, whilst in the second they spoke of limiting the number of years that they had or should spend using hormonal methods. In both these strategies, the passage of time was considered to be the significant factor, and a way that the women could reduce the level of risk that they were exposed to.

In the first instance, some of the women described that they had stopped taking hormonal contraception for a short period of time. Breaks from the pill were seen as a way of giving their bodies a chance 'to rest', a chance to get the hormones 'out of the system'. These pill breaks seem to occur in two particular situations, first between long-term relationships, when the women felt that it was pointless to remain on hormonal contraception, with the attendant risks to their health, as they were unlikely to be having any or frequent sexual intercourse. (How changes in relationships affect women will be discussed in more detail in chapter 7.) Second, following 'pill scares' in the media. For example, Charlotte described how following 'an announcement on the telly', she thought she had better change her method of contraception, but also explained that she went back on the pill 'once it had died down'.

For some women, the growing awareness of the possible health implications of using the pill had longer-term effects. This is how Donna described her decision to come off the pill:

Donna — At the time, I didn't want to be on it long term… I think, sort of ten years ago they started this business of, you know, blood clots and the… er…I have always been a smoker… and I was always aware that smoking and the pill wasn't really a good combination…[…] they seemed to find out… I think it was when some of them were withdrawn off the market as well… or it was near to that time… I had the pill for six years and then I had the cap...

INT — So were you using one of the brands that was withdrawn?

Donna — no, I used Ovranet… and stuck to that for the whole six years… it wasn't the reason… no why did I come off? I think I came off after that… because I finished a long-term relationship, I think… And I thought I wouldn't go back on it… And then I

met my husband after that… and we have only ever used the cap or condoms…Once I came off it, after that long period of time, I thought I wanted my body to… adjust… ummm… I think … well strange as it sounds for a smoker, I think umm.. I think I wouldn't want to be on any sort of permanent drugs taking… I am just the type of person that I wouldn't want to be taking tablets everyday...

INT Why is that?

Donna umm… Just basically, I don't think you know what it is doing to your body, and how at risk you would be.

There are several themes that are illustrated by this extract. First, Donna describes her decision to stop using the combined pill because of the 'discovery' of a link with thrombosis. Although she was not using one of the brands that was withdrawn, she felt that the threat the pill posed to her health was too great, especially as she already knew that taking the pill and smoking were not 'a good combination'. Although she was not completely sure, she suggested that this followed coverage in the media, but, as a nurse, she may have found out about withdrawn brands through professional journals. Donna mentions that at the time she was not in a relationship, and this appears to be the deciding factor. The concern about the contraceptive pill's effect on the body is also mentioned in that she felt her body needed to 'adjust', and she was worried about the unknown quality of the risk it could pose. Finally, we can also see that the length of time she had been on the pill was important in her decision. She had never wanted to be on the pill 'long term', and felt that six years was a 'long period of time' to be taking it.

Many other women felt that there came a time when they had been on the pill 'long enough', expressing a belief that the risks increased with age and/or

prolonged use. Paula was typical in this respect. She had taken the combined pill for a few years starting in her teens. After the birth of her third child in her early twenties, her husband had undergone a vasectomy. Now aged forty, she had recently made the decision to go back on the pill as she had started a new relationship. For Paula, the pill was a risk that she was willing to 'put up with' but preferably only short-term. Although the brand she had used as a teenager was later withdrawn, she felt that as she had only used it for a few years it was unlikely to have affected her; 'I only took the pill for a few years so… I just told myself that I would be OK'. Although she had now started to take the pill again, she was 'anxious to get off it as soon as I can', as she felt that the risks of her taking it this time were much higher because of her age. She was hoping that her new partner would also undergo a vasectomy, enabling her once again to limit the period of time that she was exposed to the risks.

Other women also made reference to their age or length of time using the pill when they described their reasons for changing to another method. They felt that they had 'taken it long enough' (Katy), that 'the longer you are on it, the worse it could be' (Sonia). Yet, this concern was also linked to a heightened perception of their body and of risk. Many of the women described themselves as now 'worrying about the body more' (Patricia), or taking broader concerns over their 'heath and wellbeing' (Martina), in contrast to their younger selves when their desire to avoid pregnancy was more pressing.

Moreover, there was often a clear distinction made between the respondents and younger women in terms of the balance between the risks that hormonal contraception posed to health and the need to avoid pregnancy. For example, Rebecca and Paula both felt that it was much safer for their teenage daughters to use hormonal contraception than themselves, and considered this as the best contraceptive option for young women. Rebecca had never used hormonal contraception herself because she didn't like the idea of 'chemical interference'. Yet, despite her strong opinions about the health risks involved, when it came to her daughter she felt divided. In the earlier part of the interview she commented:

> I think they do [doctors]... I think they think that preventing you getting pregnant is more important, than the things that could happen to you that aren't proven. I think if they are not staring them in the face they sort of… they just say take the pill… and then you find out what ten years down the line that… oh gee, they got the dosage wrong, and actually you are doing yourself quite a lot of harm…[…] by taking something, you are actually doing something to the rest of your body, so… it's not that I think nature is best, but I don't like the idea of… sort of tampering around with it

Yet, when Rebecca began to think about her daughter, rather than herself, there was a distinct shift in her attitude:

> Maybe the injection is a good idea because some people can't even remember to take a tablet, can they?.. And maybe, you know, my daughter, I think it is probably not a bad idea for her, even though, you know there are bad health risks… The thought of her getting pregnant is awful… […] I worry about her health, I really do… but I am equally concerned about her getting pregnant… Until she is in a relationship with someone that is sensible… I don't want her turning into a one-parent family…

In the first extract, Rebecca appears to be complaining that the risk of pregnancy is taken far too seriously in comparison with the 'unknown' nature of bodily risks from hormonal contraception. She sees the latter as 'tampering' with the body, and feels that doctors either downplay the risks or simply do not know enough about the effects on women's bodies. For her, the risks from such contraception are far more important than the risk of pregnancy. However, this is in sharp contrast to her opinion about her daughter's need for contraception. Here the need to avoid pregnancy is seen as paramount and outweighs any risk to health, although it is unclear if Rebecca is concerned more with moral judgements about single mothers, or with the material struggle to support a child as a single parent.

The 'problem' of young women getting pregnant is, and has been, a prominent issue in recent years. This is reflected in the idea that hormonal contraceptives are particularly suitable for young women as prevention of pregnancy is paramount, and hormonal methods are considered to be more effective. As women get older they change to non-hormonal methods, as concerns about side effects begin to become more important. This pattern is reflected in the contraceptive careers of many of the women I interviewed. Eight of the women spent time on the pill before they had their first child, but subsequently switched to using a form of coil (although three had to have it removed due to the side effects incurred). Although the IUD and IUS can both be fitted in nilparvous women, it is not generally recommended until after a woman has given birth. In addition, many of the women had been sterilised or relied on

their partner's vasectomy, or one of these options was under consideration. This was assumed to be a 'solution' to the need for contraception, and alleviating (although the women often considered it as eliminating) the risks involved.

The women's interviews revealed a struggle at the centre of their experiences of contraception. Throughout their lives, they needed to balance the effectiveness of the method with the possible ramifications it could have on their health. Moreover, it was clear that at different points in their lives the different factors varied in their importance. Thus, the same women have used the contraceptive pill, the rhythm method, and the coil, and accepted their different levels of efficacy and effects on the body, depending on their appropriateness at the time. Although often critical of the health implications of contraceptive technologies, few of the women referred directly to the developers or manufacturers. As Wajcman (1991) has pointed out, 'market' decisions are heavily implicated in the development of contraceptive technologies, and this forms part of the power relationship. Indeed, contraceptive technologies are reputed to be amongst the most profitable of pharmaceutical products (Sun, quoted in Russell 1999). Yet, apart from an occasional reference to an anonymous 'them' when talking about the development of, or problems with current contraceptive technology, there was no general sense of this background area. Typically, the notion was that 'they should be able to come up with something better', but who 'they' were was left

unsaid. Nevertheless, there was a general sense that the current technologies were unnecessarily 'risky', and that improvements were long overdue.

Conclusion

In this chapter, I have concentrated on looking at the women's perceptions of health aspects of contraceptive technologies, and their attitudes towards medical consultations. I have argued that the women considered taking responsibility for contraception, and particularly going on the pill, as part of the transition from child to adult. At this time in their lives, using contraception could either be considered as evidence of their maturity, or evidence of sexual irresponsibility, and the women needed to be careful to construct it as the former. I have further argued that the prevention of pregnancy was uppermost in most women's minds rather than protection from sexually transmitted infections. Indeed the association of sexually transmitted infections with unrespectability meant that some of my respondents became distressed at being asked if they had even thought about any risk. The women's need to construct themselves as respectable illustrates how circulating discourses affect women, and can enable or constrain them to act in certain ways.

Their experiences of medical consultations for contraception are divided not only in terms of whether the encounter takes place in a GP surgery or a Family Planning clinic, but also in terms of whether the interaction is with female or male health professionals. Whilst my informants recognise that contraceptive

products often impact on their health and that they have to access them through medical professionals, they do not necessarily construct doctors as having expert contraceptive knowledge. Women health professionals are perceived as the ones who 'know' about contraception, through an assumption that they are contraception users. This embodied knowledge is valued above their formal medical training. In other words contraception is constructed as distinct from 'medical matters', and thus when doctors deny women's requests they are considered to be exerting illegitimate power. Moreover, GP surgeries and family planning clinics are constructed as gendered spaces, which alters both the expectations and the experience of the contraceptive consultation for the actors involved. The embodied knowledge of female health professionals adds weight to the perception that contraception is a 'women's issue', and one women can and should remain in control of. This conviction strengthens women's ability to act in relation to accessing contraception.

In the last section, I described the ambiguous feelings that women had towards the perceived health risks of contraceptive technologies. Many of the women had experienced side effects from different contraceptive technologies, and they were all aware of the association of the contraceptive pill with serious health risks such as thrombosis. Yet whilst they expressed different reactions to this knowledge, time emerged as an important element within both their understanding of the risks and their strategies to reduce it. The passage of time was seen as important in revealing the full impact of different contraceptive technologies. In time, technologies would be improved, or the risks become

more apparent. Coupled with this was a strategy whereby women 'limited' the risks by reducing the time they spent using hormonal contraception. Central to the women's contraceptive decisions was the struggle to balance a need for contraception with the possible effects on their health, and they seemed to weight the former more heavily during their twenties, the latter during their thirties.

Chapter 6

The Morning-After:

Media Conceptions and Women's Reactions

I think it is a good thing, for a responsible person to go in and take it, as long as they know what they are doing, ummm… but when it is a young girl, maybe she is going to be using it as a form of contraception, they need to realise that this is not a contraception this is just an emergency one…I think women should have the right to things like this, because at the end of the day it is our bodies… So I think it is good, I'm just a bit concerned that youngsters could get it, because they might not know what they were doing really... (Sharon)

Introduction

As I mentioned in chapter 4, during the middle of my fieldwork period, the government announced that it was changing the status of the morning-after pill from a prescription-only medicine to one that was available over the counter. Although ten of the women had used the morning-after pill, from the answers I received there did not seem to be any direct relationship between having used it and perceiving a possible need for wider availability. The women's answers were often contradictory in their attitude towards the morning-after pill, and many comments contrasted sharply with other answers they gave during the interviews. Indeed, at first glance their opinions on the morning-after pill undermined much of my general analysis of their attitudes towards medical expertise and surveillance over contraception. Yet by looking closely at the discourses surrounding the morning-after pill, it became clear that for my informants there was a symbolic difference between emergency contraception and 'proper' contraception, and rather than being contradictory, the women's

attitudes reflected their need to construct themselves as responsible users of contraception.

In this chapter I will begin by looking at how the media reported the deregulation story. As detailed previously, I collected coverage from all the main English broadsheet and tabloid newspapers. As Lupton (1998) points out, newspaper coverage on health issues often focuses on negative aspects to make them appear newsworthy. Whilst headlines are designed to sensationalise stories in order to gain the reader's attention, they also serve to frame the meaning of the story (Lupton 1998). In general, the reporting of the deregulation of the morning-after pill followed these conventions. Despite some differences in opinion and reporting between newspapers, the discourses drawn upon in reporting the story were very similar. After discussing the media coverage I shall consider how it may have affected the way that my respondents perceived the proposed policy changes and the ways they 'read' and debated them. In the final section, I will look more closely at how symbolic differences maintained by my respondents between the morning-after pill and other forms of contraception can account for their legitimisation of medical intervention regarding the former in contrast to their feelings about the latter.

Media Coverage of the Deregulation of the Morning-after Pill

'Fury at Sex Pill at Chemist' (The Mirror 11/12/00 p2)

The headline above illustrates many of the common themes in the media coverage. The papers conveyed the deregulation as a controversial move which may encourage promiscuity and could remove the necessary control from doctors. The story was originally broken in the *Independent on Sunday* on 10th December 2000, and was reported in all of the national newspapers the following day, as well as being featured on many news and current affairs programmes. The coverage on 11th December ranged from short articles in *The Times* and *Daily Star*, to the front-page headline and four pages of coverage in the *Daily Mail.*

All of the papers quoted both those in favour of the deregulation and those against. Predictably, right-wing campaigners, anti-abortion groups, and representatives of the Conservative Party were outraged, whilst the Department of Health spokesperson and Liberal Democrats stressed that this was a pragmatic and reasonable deregulation. None of the coverage carried quotes from women users of the morning-after pill, and only the *Mirror* addressed readers as potential users. I looked at how the newspapers framed the debate, and compared the amount of coverage given to supporting comments with that given to denouncements, in order to gauge what stance the paper seemed to be taking. Of the tabloid newspapers, the *Daily Mail* was outraged and its editorial denounced the move as 'a source of sadness' (11/12/00 p10). In the *Daily Star,* the focus was on the condemnation from

pro-life groups. The *Sun* had sensationalist yet ambiguous coverage, and thus was difficult to place. The *Daily Express* called the proposed change 'a common-sense move' (11/12/00 p12) and the *Daily Mirror* stated it would give 'peace of mind over the counter' (11/12/00 p6), so both of these papers appeared to approve of the move. In the broadsheets, *The Guardian* approved, but did not feel that the move had gone far enough and argued that emergency contraception should form part of the family medical cabinet. The other three broadsheets presented accounts that appeared to be more neutral. However, by considering the balance of comments I felt that *The Times* and *The Telegraph* expressed a more positive take and *The Independent* and *Independent on Sunday* appeared to be more negative. Despite the different positions taken by the newspapers, however, almost all the coverage was centred around several common themes, many of them related to existing discourses on contraception. Moreover, what is striking from the coverage is that the question of a woman's right to control her fertility was barely addressed. Instead the focus was on morality, especially of young women, and whether pharmacists can undertake sufficient surveillance of 'irresponsible' women.

Young women as (Ab)users of the Morning-after Pill

Almost all the newspapers either refer directly to young women as the predominant users of the morning-after pill, or feel the need to challenge this dominant narrative by pointing out that older women may also need to use it. Many of the papers mentioned the high numbers of teenage pregnancies in Britain, or referred to potential users as 'girls' or 'teenagers'. Moreover, the

sexual activity giving rise to the need for the morning-after pill was presumed to be unprotected sex. The possibility of condom failure, for example, was rarely mentioned. Those against widening the availability of the morning-after pill often stated that it would increase promiscuity amongst young people, whilst those in favour often portrayed it as a pragmatic move to decrease the numbers of teenagers getting pregnant. At the extreme end of this discourse is a comment by Lynette Burrows who claimed that: 'There would be no need for such a pill if young people did not break the law and have sex before the age of consent' (*Mirror* 11/12/2000 p6). This constructs all potential users as underage and deviant. Although most authorities cited did not go as far as this, many argued that despite the ruling that chemists would only be allowed to sell the pill to women over the age of 16, in reality there would be nothing to stop younger women from buying the morning-after pill. Indeed, as well as claims that young women's vulnerability to coerced sex would increase and parental control would be (further?) eroded, the nature of heterosexual relationships themselves could be jeopardised by this move according to some writers. In the *Daily Mail,* Jeanette Kupfermann wrote:

> With the morning-after pill, who needs intimacy, discussion, mutual decision-making, commitment or indeed anything remotely connected with a loving responsible relationship? (11/12/2000 p17).

This comment highlights the assumption that potential users have had unplanned and unprotected sex, and adds a further assumption that contraception is currently a shared responsibility and that wider availability of

the morning-after pill will curtail contraceptive negotiation between women and men.

The framing of reportage around young women's promiscuity and unprotected sex meant that even supporters of the move felt obliged to comment on these constructions. For example, the 'Yes' commentator in the discussion in *The Sun* argues that:

> this should not be seen as encouraging teenage promiscuity...[...] It will not just be teenagers queuing at the chemists, but young mums still caring for a baby, those with several children already and the desperately poor (11/10/12 p6).

This, and several other commentaries, also insisted that no contraception was 100% guaranteed, that we can all make mistakes, and that wider access was needed to reduce the number of unplanned pregnancies across the age ranges.

Morality Politics

As well as the debates around young women's sexual activity, several other moral issues were raised within the coverage, most notably whether the morning-after pill should be considered as a method of abortion. Most of the papers carried quotations from anti-abortion groups, such as Life or the Catholic Church, claiming that the morning-after pill is an abortifacient. Although most of the papers indicated that this was a matter of debate, some referred to making the morning-after pill available *on demand*, terminology which implicitly associated it with pro-choice calls for abortion on demand. Moreover, many of the opponents argued that the regulations for dispensing the morning-after pill would not be adhered to in practice, in direct

comparison with claims of a practical liberalisation of the terms of the 1967 Abortion Act.

By framing the debates about the morning-after pill in (im)moral terms, some of the papers felt free to link its deregulation to other 'moral' controversies. In the leader column of *The Sun*, despite a relatively balanced presentation of both sides of the debate earlier in the paper, the editor condemns the move by the Labour government as further evidence of Britain's (moral?) decline in the world. Furthermore, the editorial even managed to bring homophobia into the frame, likening the lack of debate on the issue to the 'legalisation of buggery at 16', which was, according to *The Sun,* against the wishes of most people (11/12/2000 p8). It was not just the tabloids that framed the move as a 'controversial' and 'moral' issue. Breaking the story about the proposed change on 10/12/2000, the *Independent on Sunday* likened the move to changes in the laws on embryo research, reporting that many 'Middle-England' voters may see both actions as signalling erroneous messages about Labour's family policy.

The question of votes was important as, at the time, it was predicted that a general election was imminent. The newspapers developed the story by dividing the issue along party political lines. In the original article in the *Independent on Sunday,* the paper reported that the Government was responding to a request from the manufacturer for a change in the status of the drug. In fact it is the Medicines Control Agency rather than Parliament that

takes decisions about access to individual medical products. Yet in none of the following day's coverage was the role of the manufacturer or the Medicines Control Agency mentioned, leaving the reader with the impression that the deregulation was solely instigated by the Labour Government. Prominent Conservative opponents (Dr Liam Fox and Ann Widdecombe, both of whom are well known for their anti-abortion stance) hinted that they might seek to reverse the decision if they gained power, whilst the Liberal-Democrat MP cited (Dr Jennie Tonge) approved of the proposal. None of the papers gave direct quotes from named Labour MPs, but instead referred to a Department of Health spokesperson. Indeed, many of the newspapers insinuated that the move was intended to be as quiet as possible, with the Government trying to play down the proposal in case it lost them votes. Yet, on the face of it, this is unlikely since if the policy change were kept quiet, women would not know that they could now access the morning-after pill from chemists, presumably defeating the object of the move.

One other interesting feature about the coverage is that despite most of the papers reporting that the cost of buying the pill from a chemist would be around £20, its cost was not discussed further. Yet at this price, the ability of some women to purchase it from chemists could be compromised. Indeed, for the women I interviewed, the cost, particularly when compared to a free prescription, was a major talking point and it often had a direct bearing on their opinions about the proposal in general, and whether it was a positive or

negative system of rationing. I will return to this point later, but will begin by outlining women's reactions to the announcement.

Women's Opinions of the New Access Arrangements

> I mean it's difficult, the morning-after pill is obviously targeted at a number of groups of users... umm... from your fourteen, fifteen year old or even younger...umm... to your mature professional woman, who has just had a slip up... And I suppose it is where do you draw the line? (Patricia)

The above quotation is a good illustration of how some of the women viewed the 'problem' of the increased availability of the morning-after pill. Patricia, who had used the morning-after pill herself after a condom failure, sees women like herself as 'legitimate' users. She presumably had had a 'slip-up', and so she made the decision to seek the morning-after pill from her GP. She contrasts this with her image of irresponsible users, who are under the age of consent and do not 'slip-up' but instead are likely to have had unprotected sex. In general, the women were very concerned about 'abusive' users of the morning-after pill. Such 'abusers', following the media coverage, were portrayed as young women having unprotected sex, who were seen as likely to take this new access route as a way of increasing reliance on the morning-after pill rather than using 'proper' contraception. Yet, once emergency contraceptive is needed, the alternative would be to do nothing except wait to see if a pregnancy results. In many cases this would be constructed as equally problematic, particularly for young women who are often condemned both for undergoing terminations and for continuing with their pregnancies.

(Ab)using the Morning-After Pill

Comparing the responses in the twelve interviews I carried out before the announcement with those afterwards suggests that the idea that young women are likely to be the most frequent (ab)users has been reinforced by the media coverage. In the first twelve interviews, seven of the women expressed concern that some women would repeatedly use the morning-after pill, but only three of them specifically mentioned young women. In the ten interviews after the announcement all of the women named young women as the main group of users who were likely to rely on the morning-after pill, and discussed whether or not they should be able to access it via a chemist. During all the interviews I informed the women that in the Salford trials of the service the majority of users were in their twenties (BBC 08/08/2000)[13]. Not only were the women often surprised at this, but for Donna, it completely changed her view of the service, as the following extract shows.

Donna	I think it [*over-the-counter regulation*] would become very slap happy really…and it [*morning-after pill*] would be sold to any, any youngster….
INT	Right… do you think it would be mainly youngsters using it then?
Donna	yes, I should think so
INT	Would it surprise you to know that in Manchester where they did the trials, the majority of women going to the chemists were in their twenties.
Donna	really, oh god that would surprise me.
INT	And the most cited reason was condom failure.

[13] National statistics also indicate that women aged between 20 and 25 are the most frequent users of emergency contraception (Macfarane and Mugford 2000).

Donna ahh… that changes things doesn't it

Once Donna considered deregulation as a potential service for older women, it became a worthwhile move. This is another striking example of the way in which framing the debate around the (im)moral issue of teenage sexuality means that questions of 'legitimate' access appear to be overlooked.

The discursive construction of the user of the morning-after pill as a young and/or irresponsible woman also has implications for older women as potential users. Charlotte was seeking the morning-after pill following a reported condom failure during my clinic observations. In both the consultation and during the interview, she mentioned feeling guilty and being embarrassed at needing the morning-after pill, as someone 'who should know better', particularly as this was not the first time she had taken it. Charlotte stated that her embarrassment was not due to the attitude of the staff, whom she found to be very understanding and sympathetic. Her discomfort seemed to stem instead from her own perceptions of responsible and irresponsible users.

This discomfort also had wider implications for Charlotte, in that she felt under pressure to think about an alternative to the condoms that she was currently using. She was very reluctant to start retaking the contraceptive pill, as she was concerned about the risks it posed to her health. Her sister had been diagnosed with breast cancer, and this had increased her concerns about the effect hormonal medication may have on her body. Charlotte had recently had to have an IUD removed due to the serious side effects she had suffered and

her husband had agreed to a vasectomy. Rather than continuing to use condoms until after his operation, and, if necessary, taking the morning-after pill again, she felt obliged to consider going back on the pill. Indeed the nurse suggested this as an option to think about during the clinic encounter. In this instance, it appears that the construction of the morning-after pill user as 'irresponsible' had implications for Charlotte's future contraceptive choices. During the interview, she mentioned that she would probably start to use the contraceptive pill again, despite her concerns about its health implications. Although this will construct her as 'responsible' in terms of contraceptive protection against pregnancy, it will do little to allay her fears about the long-term impact on her body.

There was no straightforward relationship between use of the morning-after pill and support for its deregulation. Of the twelve interviews I carried out before the announcement, five of the women were strongly against any move to make the morning-after pill available via chemists, two were very much in favour, and the other five had mixed feelings about it. In total, six of these women had used the morning-after pill on at least one occasion, and both supporters of the move were in this group, as well as two of the opponents and two who had mixed feelings. Both the supporters of the move appeared to be considering how changing access would have affected them; they viewed going to a chemist as a much more convenient way of accessing the morning-after pill than going to the GP or a family planning clinic. So in these two cases, there appeared to be a direct relationship between their own use and

their support for change. Of the users that were against the policy change, Shui told me a similar proposal had been discussed in Taiwan but it was felt that it would lead to increased promiscuity amongst young people. She agreed with this concern and thus condemned any deregulation. In contrast, Bernadette was concerned about the long-term health implications of taking emergency contraception, particularly if women became frequent users.

Despite the often negative coverage in the press about the proposed change, after the announcement only one woman was vehemently against the new access route. Three women thought that it was a positive move and the other six had ambivalent feelings. Four of the women interviewed after the announcement had used the morning-after pill and they included the one opponent of the move and three of the women with mixed feelings. When discussing the issue, many of the women mentioned things they had heard in the media, with some referring directly to television reports that sent women to chemists to test if the protocols were being followed.

Chemists' Competence

Whereas none of the women interviewed before the announcement questioned the competence of pharmacists to sell the morning-after pill, afterwards this was mentioned by half of the women. It might be surmised that this shift stemmed directly from the widespread coverage of the remarks made by the Conservative Health Spokesman Dr Liam Fox, who claimed that chemists were not sufficiently qualified to be able to sell the morning-after pill (for

example see *The Times* 11/12/2000 p4). However, whereas for Dr Fox the problem was of pharmacists' training, the women's concern was more, as Patricia put it, that 'there are chemists and chemists, just like there are builders and builders'. The women felt that most of the risk would come from ineffective pharmacists, those who would not follow the protocols, rather than from pharmacists being insufficiently knowledgeable of the effects and usage of the pill. Moreover, as Donna (following her reassessment of the service) pointed out, there was no guarantee that even GPs could be relied on to ask the appropriate questions:

> I think it would be a good thing then in chemists as long as it was... there was definitely some form... even if it was just a five-minute chat... some form of... you know you had to... pharmacists are usually pretty good aren't they? I suppose like everything you will get the cowboy ones, like GPs you'll get... GPs that are not bothered... you know probably half the time, they don't ask the questions... it is just issued.

The debate over pharmacist competency to sell the morning-after pill illustrates that although discourses surrounding contraception can originate in the media, they are not necessarily read directly nor accepted without questioning. None of the women interviewed prior to the announcement mentioned the qualification of pharmacists as a problem, and indeed the two women in favour of the move both mentioned that the longer opening hours and lack of an appointment system meant that chemists were ideally suited to the task. After the coverage of Dr Fox's comments, half of the women raised the suitability of pharmacists as an issue, but not in the way that he had implied it. Rather than questioning the qualification of pharmacists, the

women posed the issue as a problem of ensuring that the pharmacists followed the protocols given. Moreover, this uncertainty over compliance was one of the reasons for their ambivalence towards the move, rather than denouncing it outright. Indeed, what was clear was that a major difference between those who were for, against or unsure about the policy change, both before and after the announcement, was their attitude to the need for medical surveillance.

A Need for Medical Surveillance

My respondents drew on several inter-linking themes to back up their assertion that the morning-after pill might best be left under medical surveillance. Most of these themes can be associated with the stereotypical image of the morning-after pill (ab)user as a promiscuous young woman having unprotected sex and taking the morning-after pill each time. All the women considered the morning-after pill to be 'the last resort', and as such felt that it should not be taken regularly. If (young) women were going to be having regular sexual intercourse then they felt they need to be advised on a more 'permanent measure' (Bernadette). The assumption seemed to be that if left on prescription, doctors would advise (young) women on 'more suitable' (Sonia) methods, particularly if they asked for the morning-after pill repeatedly. As Patricia put it:

> I think the service should be limited, they should have counselling… Because you don't want them to go out and do it again. Ummm… So I think that… somebody should talk to them about it, mainly to sort out something else for later on, not necessarily to say 'you bad girl'. But to say, have you considered your other options.

Alongside the idea that young women may repeatedly rely on the morning-after pill is a concern about the risk it might pose to their health. The women were all aware that the morning-after pill contains a high dose of hormones, and they appeared to consider this to pose a greater risk than other methods of hormonal contraception. In addition, most of the women knew of the high likelihood of side effects from the morning-after pill, particularly feelings of nausea, but they did not think that this would stop some (young) women from repeatedly using this method. Indeed even women who had taken the morning-after pill on more than one occasion themselves discussed the possible need for medical surveillance of 'irresponsible' users.

Contradictory ideas about the medical risks of the morning-after pill and the distancing of one's own actions from the assumptions made about 'other' users is starkly illustrated in Joan's case. Joan was the only woman interviewed after the announcement who was completely against deregulation, despite the fact that she had taken the morning-after pill herself on three occasions due to condom failure. Joan felt that the morning-after pill was a 'dangerous drug', and that if it was available too easily then 'girls' would not really think either about the need to take 'precautions' when having sex, or about the sort of drug that they were taking. She felt that it needed to be given with medical advice, and indeed reported an incident when she obtained a prescription after only seeing the practice nurse, rather than a doctor, as evidence of the way that the morning-after pill was handed out too freely. Yet, Joan also told me of an incident that contradicted these stated opinions. She described another

occasion when a close friend who needed the morning-after pill was too embarrassed to face her doctor. Joan went to her own doctor's surgery and pretended that she needed the morning-after pill herself, and then gave the prescription to her friend. Although Joan stated that it was 'not the right thing to do', this did not affect the way that she felt about the change in status of the morning-after pill. Presumably, Joan did not consider either herself or her friend to be irresponsible users, and, as such, she saw no clear connection between her actions and those of the (ab)users of the pills that she imagined.

In the interviews following the announcement, the question of the proposed price of £20 set by the manufacturer was a major topic of conversation. All of the women saw this as 'a lot of money' and talked about the effect that it would have on access. Most of the women felt that young women would be much less likely to be able to buy the morning-after pill at this price than older women. Indeed for Donna, Katy, and Sharon the cost was viewed quite positively, as a way of ensuring that young women could not abuse the service. It was felt that by setting the price this high, young women would be forced to consult a doctor or clinic to obtain a free prescription, as they would be unlikely to be able to pay £20 on a regular basis. As Katy states:

> oh… perhaps that's not a bad thing… because… it is not so open to abuse is it? If it's that price... No that's a good thing… Because it would have to be an emergency wouldn't it… And you would have to be desperate, to sort of go out and pay that sort of money, it's not something you could do lightly, keep affording to pay that, I would have thought.

Other women were less positive about the price and felt that it was likely to exclude the 'really desperate', and unnecessarily limit access. As Karen puts it, 'I can't see how this selling over the counter is really going to help that many people, certainly at that price'. My respondents felt that the women most likely to be able to afford to buy the morning-after pill were going to be 'older', 'professional' and 'educated' or 'responsible' users.

Consequently, in the discussions around the price for the pill, the women considered two distinct types of user. The first image that they had of the main purchaser from pharmacies was of the young woman (ab)user of the pill. This was challenged by the high cost of the morning-after pill, and thus introduced a second image of 'responsible' users who were more likely to be able to pay. This level of rationing could be seen as positive, by excluding irresponsible users but easing access for legitimate users. For some of the women, it was precisely this financial rationing that was the deciding factor in their attitude towards the move. By restricting the service in this way, users constructed as irresponsible, such as young women, were much more likely to have to continue with prescription based services, and thus the move could be framed as one of increased access for 'legitimate' users.

The discussions around the deregulation of the morning-after pill illustrate several of the themes contained within discourses of contraception. The dichotomy of responsible and irresponsible users can be closely tied to ideas about respectable and unrespectable sexualities. In accessing contraception,

women are advertising their sexual activity, which could render them unrespectable, and hence their need to distance themselves from 'other' devalued users. One of the ways that they can make this distinction is through constructing themselves as responsible users in relation to others. Moreover, despite the women describing their own teenage sexual activity as non-promiscuous and usually using contraception, they often repeat stereotypical assumptions of irresponsible young women as a way of distancing their own behaviour from others.

The final issue raised by the deregulation of the morning-after pill is one that rarely enters debates about contraception within Britain, that of financial access. Because prescribed contraception is available free to women within the NHS, and indeed many clinics and surgeries now give out condoms, it is assumed that financial barriers to contraception do not exist. Yet financial pressures can limit access, for example by limiting the ability to buy condoms when your GP surgery has run out, being unable to use the Persona system which is not available on the NHS, or to find the transport costs to a clinic with a wider choice of methods. Moreover, women with very low levels of financial resources may also struggle to obtain their prescriptions of choice in medical encounters, because of their age, class, or level of education (see for example Todd 1984, Hawkes 1995). Furthermore, the lack of debate about how resources can affect the ability of women to obtain particular methods of contraception also leaves hidden questions about if or how GP or Clinic

prescribing practices are linked to budgetary pressures rather than to the preferences of women[14].

The Symbolic Difference of the Morning-After Pill

In contrast to earlier descriptions of medical consultations, when discussing the deregulation of the morning-after pill many of the women constructed medical surveillance as a benevolent practice for women's own benefit. There were three different ways in which the women justified their opinions of the proposed change, but unlike their earlier descriptions, none of these could be seen to challenge the conventional medicalised view of contraception. The first was to denounce the proposal by asserting that only doctors were qualified to prescribe the morning-after pill. The second was to construct pharmacists as equally qualified, and thus broadly support the policy change. The final viewpoint was to stress that 'professional' or 'mature' women had gained sufficient knowledge about contraception, whereas younger women were still seen to be in need of medical surveillance and 'education' about the methods available. In this case, it could be construed that it was through regular surveillance by the medical profession that women became sufficiently knowledgeable to be able to make their own decisions.

There are three interlinked factors that I feel explain why the morning-after pill remained firmly located within the sphere of medicine for many of my respondents, in contrast to other forms of contraception which inhabited the

[14] For example, the family planning clinic I observed was unable to supply women with the IUS for financial reasons. Women could ask their GP for a prescription, and then bring the IUS to the clinic for fitting.

boundaries of medical expertise. The first is the symbolic division asserted between emergency contraception and 'proper contraception', the second the discursive construction of the 'irresponsible' user of the morning-after pill, and the third, women's need to position themselves as respectable users of contraception.

As previously noted, the women did not see the morning-after pill as 'proper' contraception. This is how Katy describes the difference:

> Well I don't really see that [*the morning-after pill*] as a contraceptive… because contraceptive seems to be like a prevention… and the morning-after pill seems to be like… well it is a prevention in one way, but a bit like… they say bolting the stable door after the horse has… I mean you might not be, because you wouldn't definitely know you were pregnant, it's just in case you thought you were… but I suppose if you were… But you wouldn't know anyway would you… […] I suppose because it is like, most contraception is taken before or during, aren't they.

This extract clearly illustrates how the morning-after pill is perceived as different. Contraception should be taken before sex, and as the morning-after pill is taken afterwards, it is not seen as contraception but *it is bolting the stable door after the horse has bolted.* Although during the interviews only Clare explicitly likened the morning-after pill to abortion, it was clear that many of the others felt, like Katy, that there was a question mark over this issue. Whereas they imagined contraception taken before or used during sex as

preventing a pregnancy from taking place, the morning-after pill is seen as stopping a possible pregnancy from continuing[15].

Moreover, the symbolic difference between 'proper' and 'not quite' contraception also actively fed into the notions of responsible and irresponsible users. Based on the assumption that the morning-after pill is used after unprotected sex, it is considered as a last minute gesture, in contrast to responsible users who use 'proper' contraception. Yet, although morning-after pill users are constructed as deviant, it is often unclear whether it is the lack of attention to controlling their fertility that is a problem, or uncontrolled sexuality, as this quotation from Janice illustrates:

> I just feel... is the morning-after pill going to be an easy cop out... ummm...if you are going to be sexually active then... you have got to take responsibility... I just think if it is too freely available ... ummm... and the fact that it can be issued without parent's consent... I think parents should be involved... certainly where under 16s are involved anyway... I mean I do feel for girls that do have a lot of problems with the pill... but there is a lot of choice out there now... ummm... and I think... it is very short sighted... ummm... not to think of the... safety aspect in regards to sexually transmitted diseases and HIV...

In this extract, we can see how users of the morning-after pill are constructed as young and/or irresponsible. Janice argues that if women are (hetero)sexually active, they need to 'take responsibility', presumably by using 'proper' contraception. She has a thirteen-year-old daughter, which probably heightens her concerns about the sexual activities of teenage girls, and

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[15] I did not question the women about their knowledge of the mechanics of contraception, and am thus unsure if this perceived difference is due to the symbolic differences or to their understanding of how different forms of contraception are believed to work.

accounts for the stress on parental involvement. Moreover, in this extract, like many of the other comments, taking a morning-after pill is never considered to be a 'responsible' act, which stigmatises all women who need to use it.

The separation of the morning-after pill from the category of contraception, coupled with the discursive construction of users of the morning-after pill as deviant and irresponsible, are the main constituents of the symbolic difference between users of the morning-after pill and other users of contraception. Consequently, even if they had been previous users themselves, the women needed to distance themselves from these negative images. Once this distance is achieved, it explains their very different attitude to the need for medical surveillance. Users of 'proper' contraception are constructed as responsible and competent, and 'proper' contraception can be considered to be at the boundary of medical expertise. The morning-after pill is not a 'proper' contraception, and as its (younger) users are irresponsible they should remain under the surveillance of medicine, for their own benefit.

Conclusion

This chapter has examined the deregulation of emergency contraception as a specific media event, and how this may affect women's attitudes and experiences. My analysis of the newspaper coverage showed that the story was constructed as a 'moral' issue by newspapers, whether in favour, or against deregulation. The coverage constructed an ideal type of (ab)user of the morning-after pill as a young woman having promiscuous sex and regularly

using emergency contraception. However whilst this image was prominent in the interviews with my informants following the media coverage, they did not accept this reading uncritically, and most proceeded to bring nuances into the conditions which made this service more or less acceptable.

What was clear from the interviews was that the women were making a marked distinction between the morning-after pill and other forms of contraception, based on the symbolic difference of when the contraception is used. Responsible users of contraception were those who used it before or during sexual intercourse, and thus users of the morning-after pill are judged as irresponsible, based on an assumption of unprotected sex. By removing the morning-after pill from the category of 'proper contraception', the women were able to maintain their attitude that contraception was not really a 'medical matter', whilst retaining the view that users of emergency contraception might require medical surveillance.

Chapter 7

Negotiating Heterosexuality

How do I feel about my contraception?... now I am very happy, and very settled with what I use, with the method I use... ummm... but certainly when I was younger, like when I first started to have sex, it was all a bit confusing... and not knowing what to do for the best and finding something that I felt happy with... it was as much to do with the men I slept with as... er... my own feelings, you know... (Karen)

Introduction

In this extract we can get a glimpse of how Karen's thoughts and feelings about contraception are re/formed and re/produced through her heterosexual encounters. Her experiences are also likely to be affected by the discourses and institutions of heterosexuality, which generate specific normative patterns within which heterosexual encounters are contextualised. For example, in Britain couples are supposed to fall in love, set up home (and preferably marry), have children, and remain in a monogamous relationship in which they trust each other. Furthermore, emotional dimensions are central not just to the relationship itself, but to each individual's subjectivity. As Langford states:

> Being part of (...) a couple is held to be fundamental to our happiness, well-being and sense of place in the world. Reproduction, the family, and to a great extent social life itself, are seen as ideally based upon and around the loving (heterosexual) couple (1999:1).

Throughout the interviews, it was clear that the women's descriptions of contraceptive negotiations were structured by/around both ideas of 'normal'

heterosexual coupledom and the gendered nature of heterosexual practices. This meant, for example, that it was easier for the women to be critical of ex-partners than current ones, and those currently in relationships generally presented themselves as in a 'companionate couple' (Duncombe and Marston 1993), even when the detailed data showed that, as far as contraception was concerned, this was not the case.

This chapter will argue that men appear as an absent-presence in many of the women's explanations of their decisions. It also highlights a conflict between notions of women's right to bodily autonomy and their expectations of equality in long-term heterosexual relationships. It explores how discourses, institutions and practices of heterosexuality affect women's contraceptive experiences, as well as their ability to exercise agency. The first main section of the chapter will outline how contraceptive decisions are made in response to sexual practices, but also how choices in contraception can affect heterosexual encounters. This will lead on to a discussion of the limits of the notion of 'rational' family planning. The following sections will look more closely at how women perceived the embodied nature of contraception in relation to the risk of both pregnancy and sexually transmitted infections, and how the development of contraceptive technologies is implicated in this process. I will then discuss the dynamic relationship between contraceptive practices and heterosexual encounters by focusing on the issue of responsibility for contraception, and how this affects when and how decisions about using contraception are made. Finally, I will look more closely at the area of

negotiations within heterosexual relationships. Although I have divided the chapter by themes, it must be remembered that this analytical separation cannot happen in practice. Contraceptive experiences are re/produced within sexual practices and heterosexual partnerships. In embodied terms, it is not possible to separate sexual acts from the actors who are performing them, and thus both are enmeshed within descriptions of contraceptive experiences, as my opening quotation so clearly illustrates. But before I move on to these topics, it is important to make some points about the way that the women discussed these issues.

'Lost for Words'

In comparison to their descriptions about aspects of heath and medicine, the women were far less forthright when questioned about aspects of heterosexuality and their contraceptive experiences. Their answers were often contradictory, ambiguous, and contained far more pauses and unfinished sentences. Sometimes they appeared to find it easier to answer in terms of 'women-in-general', rather than their own experiences, even when asked specific questions. In addition, they were far more likely to assume I would know what they meant, through the nuances and subtleties of their responses, than in other parts of the interviews. For example, Sharon describes using condoms in the following way:

> We're used to it, I suppose now because we have used them so often, it's just part and parcel of it. I suppose some people feel as though there is a disadvantage, but to us, you know, my husband, it didn't bother him, I mean, at the end of the day we would rather use nothing, I mean

> there is no doubt about that. You know, it feels different for both of you without them, but we are used to it now…

In this quotation, neither sex nor condoms are referred to directly, but are simply 'it' and 'them'. Sharon also discusses the common complaint about the reduction of sensation with condoms, but argues that this is not a problem for her or her husband, without having to directly explain what she means. She assumes that I would understand what she meant, and I believed that I did, because this type of veiled reference is probably a far more common way of discussing intimate matters than more direct language. Indeed, similar non-direct language about heterosex was also used in the family planning clinic throughout my observations.

The struggle for the language to describe different experiences during this part of the interviews was as much on my part as theirs. For example, what words should be used to describe the different types of heterosexual encounter? I tended to use the phrase 'sexual partner' initially, before adopting the term used by the woman for the situation she was describing. However, whilst I thought 'sexual partner' was quite a neutral term, not all the women seemed at ease with my usage. For some of the women, 'partner', was a term used to describe cohabiting relationships, and thus did not apply to either 'boyfriends' or 'husbands'. Mary used the term 'husband' when talking about her current relationship, although, contrary to my initial assumptions, they had never married or lived together. These differences in terminology may also reflect the way the women conceptualised the heterosexual encounter and thus form

an important part of understanding their perceptions. In Mary's case, for example, she told me that she would like for them to live together, but her 'husband' did not want to.

Both Meadows (1997), and Holland, e*t al* (1998) have suggested that the problem of being 'lost for words' when talking about sex arises not just because informants have to choose between formal 'scientific' terms and often derogatory slang, but because of the lack of a female sexual discourse. Holland *et al* have described how the language available is gendered, with men having access to a 'public language of instrumental sexuality' whereas women's 'respectable language of romance', leaves them unable to communicate about practical issues surrounding bodily contact, and thus they are silenced (1998:7). Yet, despite these problems, the women did manage to describe how they felt their heterosexual encounters affected, and were affected by, their contraceptive decisions, and whose responsibility they felt contraception was.

Heterosexual Practices and Contraception

> It's the best thing I've ever been on [*Depo Provera*]... I must be one of the lucky ones, because I have lost weight, I have no periods, and I'm dead happy… Told yer, If you wanted me to get on a parapet and, you know, rave about the pill injection, I will. Cos that's how good I think it is, cos it makes me feel so happy… […] there is no lagging doubt in the back of my mind, or anything. I feel so happy, so confident. So any time, any place, anywhere, please!' [*laughs*] (Christine)

As the above quote illustrates, Christine felt that using non-coital based contraceptive methods gave her a sense of freedom to engage in sexual intercourse whenever, and with whomever, she wanted, and this feeling is

boosted by what she sees as beneficial side effects, weight loss and amenorrhoea. Yet this comment contrasts sharply with other parts of her interview in which it becomes clear that this is a theoretical freedom and a freedom which she does not admit to practising. In a later section, I will consider how discourses of heterosexuality are implicated in women's contraceptive sexual practices, but here I will first consider the more mechanical aspects of contraceptive use.

Although the women used contraception in order to have 'protected sex', the relationship between contraception and sexual practices is more complex than this term implies. As well as different types of contraceptive method having different implications for sexual practices, issues such as whether the participants were having a 'one-night stand' or were in a long-term relationship are also involved in contraceptive sexual practices. Using condoms means that contraception has to be incorporated into sexual practice, whereas the women using the combined pill did not generally consider contraception during a sexual encounter. What was clear from the interviews was that the women equated 'having sex' with penile-vaginal intercourse. Although some of the women did mention that they might 'just do other things' on occasions when they didn't have contraceptive protection, for example when they had forgotten a contraceptive pill, this was seen as an exception rather than a common sexual practice.

In this section, I will concentrate on three different aspects of the relationship between sexual practices and contraception. I will start by looking at the way that the women described how different types of contraception affected sexual practices, with a particular focus on the division between methods which are coital based and methods which give 'constant' protection. I will then move on to illustrate how changes in sexual practices have implications for contraceptive decisions. Here I will look at three different aspects; new sexual partners, changes in sexual patterns, and changes in contraceptive technology. Finally, I will look at the relationship between contraceptive choices and the concept of 'family planning'.

Barriers to Sex?

Methods of contraception are often divided by family planning literature into two categories, those that are coital-related (such as condoms, diaphragms and withdrawal), and those that are used independently (such as the contraceptive pill, IUD and Depo Provera). This division is not definitive as, for example, the diaphragm can be inserted several hours before sex is expected, and it is recommended that the regular time for taking the progesterone-only pill is several hours before you are likely to have intercourse (Family Planning Association, undated). From the interviews it became apparent that the condom was the most common coital-dependent method, with all but one of the women having used them at some time. However, few of the women felt positive about coital-dependent models, and barrier methods in particular came in for criticism:

Lucy — I have always been on the pill, and it's easy... when I remember to take it... it's easy... my husband doesn't have to bother with anything... it just fits in with our... lifestyle... [...] I mean... like this week, at this point in time... I have forgotten to take my pill, and I am waiting to have a period, so I can start back... my husband knows the importance of using condoms... but he's not keen... he sees them as just temporary... I think... the pill... It is a lot easier.

INT — So since you came off the pill, have you been using any form of contraception?

Katy — Condoms [*in disgust, and pulling a face*]

INT — Don't you like using condoms?

Katy — Oh.. [*laughs*]... they are OK... needs must... [*laughs*]... they tend to spoil the moment a bit, don't they. There can't be any spontaneity in it, you have got to know where they are and... yes, I find they spoil the moment, to stop and put one of those on... [...] I can't think... we won't go on using condoms, because I just don't feel they are... I feel they are like a stop gap, if you like... while we are trying to decide the next step.

Charlotte — I have also tried the... ummm cap... but I found that to be messy and... you had to think about it, and I didn't like that at all. It didn't come naturally, no... [...] Ben didn't like it... Not very natural [*laughs*]... saying "hang on a minute" [*laughs*], especially if we'd had a few drinks, and it was... oh no.. and in the end you probably thought, forget it, you know... putting the gel on and... and as well, you can put it in the wrong place, it is not easily... inserted. There is a knack to it... and he didn't like it because he reckoned he could feel it... it was a bit of a rigmarole.

As these comments illustrate, coital-dependant methods were considered to 'interrupt' the sexual act, and therefore detract from the experience. This was the most common opinion, with nineteen of the twenty-two women reporting that they either actively disliked coital-dependent methods, or considered them to be less satisfactory than other methods. Yet, what is clear from their descriptions is that particular discourses of sexuality are being drawn on to

explain their negative opinions. As Holland *et al* (1998) have noted, heterosex is supposed to be an emotional, intense, and escalating experience, ending with vaginal intercourse and male ejaculation. Consequently, coital-based methods are considered to disrupt this trajectory, as they necessitate a 'rational' discontinuity during sexual activity. In the above quotations this is illustrated by comments that these methods are 'a bother', or they disallow 'spontaneity', and 'spoil the moment', together with the notion that 'you had to think about it'. Overall, most of the women considered coital-based methods, and particularly condoms, as 'temporary' methods of contraception. They could be used as a 'stop-gap' for times in between 'proper' contraception. For serious or long-term relationships, it was assumed that non-coital methods were far more appropriate.

In addition, many of the women invoked ideas of 'naturalness' when discussing the differences between coital and non-coital based methods, and these seem to stem from normative notions of heterosexual practice. In the above extracts, Lucy discusses how the pill 'fits in' with her and her husband's 'lifestyle', and Charlotte comments that using a cap was not 'natural'. In the case of barrier methods, they refer to the physical barrier as being 'unnatural' as well as to the disruption to notions of 'proper' sexual practices. Other women also drew on notions of 'natural sex' when describing their perceptions of different methods. Most obviously, 'natural family planning' is a term that has been adopted to describe fertility-cycle awareness methods, and some women also referred to withdrawal as 'natural'. Interestingly, Mary indicated

that she felt that withdrawal was 'not natural', as it interrupted the 'normal' sexual pattern.

Not all of the women were as negative about coital-based methods of contraception. Three of the women interviewed were positive about using condoms as their usual method of contraception, and referred to the health implications of other methods when explaining their current choice. Shui explained how condom use is common in Taiwanese culture and is a sign that a 'husband is considerate' and does not expect his wife to risk her health with other methods. Sharon also described switching to condoms because of health concerns and further argued that, as she and her husband were used to using condoms, 'it doesn't interfere with us'. This comment demonstrates both her awareness of the discourse that considers using condoms is an interruption to the sexual act, and her dismissal of it. Joan went further in her stance regarding possible health risks and stated 'why should you put yourself through all that when a man could just put a condom on?'. (However, Joan was currently relying on withdrawal more than actually using condoms which, as she stated she did not want to become pregnant, seems to indicate that despite her comments, relying on condoms was more complex in practice.) In addition, both Sharon and Joan pointed out that they thought condoms had the added advantage of being 'clean' and leaving 'less mess', as the condom contains the ejaculated sperm. Significantly though, both Sharon and Joan did refer to the common complaints about barrier methods when justifying why these were not applicable to them. Indeed, it appeared as if they felt they had

to justify their choices to a far greater extent than women who were using non-coital methods of contraception.

In identifying these different perceptions, it is apparent that discourses of 'normal' heterosexual practice can influence women's choices of contraception. Methods which disrupt the normative pattern of heterosex often come to be considered as undesirable, as 'unnatural' and not a 'proper' contraceptive method, although most women will use them as a 'stop-gap'. As many other studies have found (for example Maxwell and Boyle 1995, Holland *et al* 1998), condoms in particular fall into this 'undesirable' category. Yet, as we can see from the different perceptions of the 'naturalness' of withdrawal, the complexity of the discourses can lead to different interpretations of 'natural' sex. Whilst some women attribute the 'problem' to the physical barrier (such as a cap), for others it is more the interruption to 'normative' sexual practices (like withdrawal), or more often a blurring of the two. Moreover, the importance of these distinctions may also change depending on other aspects of the sexual encounter, such as changes in sexual practices.

Sexual Patterns and Contraception

In this section, I will consider how changes in sexual patterns impact on contraception, but also how choices in contraception can change sexual practices. In order to illustrate this dynamic relationship, I have chosen to focus on three different extracts, but many of the women described similar changes over the course of their lives.

Patricia — I think it was probably... it was me who took the initiative in terms of... obviously the relationship was going in a certain direction, so something had to happen... and er... [...] so it was a case of either I am going to get into trouble here, or I am going to sort myself out, so...[...] I think it was just a natural progression, you know.

Heleh — The pills, they didn't affect me, so it was good... I did not have to worry about it... because when I was younger and I was more active it was good, with my husband, it was very comfortable, it was fine... [...]... and then because of our work... it is not as active as it was before, and I just couldn't be bothered to go back to counting my days to restart again as I just left it... so we use the natural... I think everybody goes through that period, you know, and why bother to take the pill, if you are not doing anything [*laughs*]... but maybe just in case... and then you make up for lost time.

Karen — I went onto having a diaphragm, and got fitted for one of them... ummm... I wasn't convinced it would work, although it did seem to be quite a safe method, but I wasn't convinced. I was just so terrified of getting pregnant again, that's why... So I was worried about using it... Ummm... My partner objected to it, and I still don't know why really... [...] It used to be 'you haven't put it in', or 'why haven't you'... or 'it got in the way'... And I wasn't convinced it was safe, I was still worried about getting pregnant, on top of which I didn't really get on that well with the spermicide again... [...] basically we really stopped having sex, well it was very infrequent... [...] so I went on the pill.

In the first quotation, we can see how the expectation of sexual activity can lead to women making a contraceptive decision. In this case, Patricia is talking about how she made the decision to go on the pill before her first sexual encounter. She describes the scenario as a 'natural progression', that the relationship was heading 'in a certain direction' and that consequently she made the decision to go on the pill. Although in this extract Patricia is describing her first sexual encounter, many of the women reported making similar decisions in response to the formation of new relationships over the

course of their lives. Similarly, other expectations of increased sexual activity could lead to changes in contraception. For example, Clare switched from using condoms to the contraceptive pill shortly before her first holiday with a boyfriend, and Sharon linked her decision to go on the pill to her forthcoming wedding.

Conversely, as the extract from Heleh's interview illustrates, women also make contraceptive decisions following a decrease in sexual activity. Whilst like Heleh, Mary also reported coming off the pill within a relationship, this occurred much more often when women had ended a relationship. For many of the women, the health risks and side effects associated with different contraceptive methods were simply not worth taking if they did not expect to have any, or regular, sexual activity. Moreover, some of the women used breaks between relationships to change their usual contraceptive method. For example, Donna stopped taking the contraceptive pill at the end of a relationship, and when she restarted sexual activity decided to use a cap. It seems that some of the women found it easier to change contraceptive methods between partners than negotiate within a relationship, particularly if the move is to a barrier method of contraception (I discuss this in more detail later). However, any decision to stop using contraception could be problematic if subsequently 'unexpected' sexual activity takes place. Christine reported that she stopped taking the pill when she separated from her boyfriend but subsequently the relationship restarted and she became pregnant before she

was able to go back on the pill. Whilst this was the only case of pregnancy mentioned, three other women reported similar circumstances.

As the quotation from Karen's interview clearly illustrates, the relationship between sexual activity and contraceptive decisions can also be reversed. In this extract, Karen describes how her and her partner's dissatisfaction with the cap contributed to a decline in sexual activity. Karen's concerns revolved around the risk of pregnancy (following a termination), and the distrust she had in the cap as a 'safe method'. These can be contrasted with her partner's dislike of the cap which she attributes to him finding it inconvenient and 'getting in the way'. Later I will discuss their different attitudes in more detail, here I just want to illustrate how a decline in sexual activity can be linked to a particular choice in contraception.

The link between sexual activity and contraception must be seen as part of the complexity of women's decisions. Whilst specific contraceptive choices may well reflect women's expectation of the frequency of sexual activity, they can also have a direct effect on that activity. Moreover, any perceived or actual effect must be considered as part of the balance that women strive to achieve between effective contraception and health implications within any heterosexual encounter. Yet the extracts above also reflect very different views concerning the risk of pregnancy. Whilst Heleh was happy to accept an increased risk of pregnancy when she stopped using the pill, for Karen it was a completely different situation. Her lack of faith in the effectiveness of the cap

contributed to a decline in sexual activity, and it is to fertility issues that I will now turn.

Family Planning?

All of the twenty-two women interviewed had been pregnant at least once, and neither of the two childfree women stated that they never wanted children in the future. Of the twenty mothers, twelve had two children, two had three, and two had four children, and the other four women had one child. Three of the women disclosed that they had had abortions, and one that she had been investigated for infertility. What was clear was that most of the women had experienced periods of time during which they would have considered a pregnancy to be a disaster, whilst at other times, although not 'planned', it would have been more acceptable to them. Indeed, as Barrett and Wellings (2002) have made clear, the conventional division between 'planned' and 'unplanned' pregnancies does not often reflect the myriad of reasons and emotions that constitute the background to women becoming pregnant. The following extract from Judith's interview illustrates some of these processes.

Judith

> Apart from Persona, I have been pleased with [*my contraception*]... I tried the mini pill, and I was quite happy with that although I was on it for a long time... that's why I changed. Persona, I was using that from the September to March/April and that's when I caught for the girls... I know it wasn't like 100%, I knew there was a risk before I started using it... which we talked about, so if it happened, it happened.. it was sort of our way... if it happened or not... So I wouldn't be using that now... and the coil I have been really happy with... I am using the Mirena...[...] I went straight to use the coil... as soon as I had my six week check. I made an appointment with the doctor then for the coil.... I didn't want to take any risk.

In the quotation we can see several different viewpoints which contributed to Judith's choices in contraception. Early on in her contraceptive career she was on the pill, and at that stage she was actively trying to avoid pregnancy. Later on in her life she reaches a stage where, although she is still undecided about having children, she makes decisions that she feels will increase her risk of pregnancy. Moreover, at this stage she seems to invoke chance as the deciding factor 'if it happened, it happened... it was our way'. Rather than making a 'rational choice' between preventing pregnancy and trying for a baby, Judith acts, as she describes it, to increase the odds. Then, following the birth of her twin daughters, she reverts to her earlier attitude towards preventing pregnancy, and starts using the IUD as soon as it is medically possible.

Seven other women reported similar experiences, whereby they chose to change to what they perceived as a less effective method to 'see what happens' (Alex), or to 'play with fire' (Heleh). Although it happened at other times, this was particularly common following the birth of a first child if the woman felt that at some stage she wanted to have another. For example, Martina reported that just after the birth of her first child they had at first used condoms regularly, but as time went on they had only used them in the 'risky periods'. Whilst this did result in a pregnancy, she described the circumstances as a smaller age gap between her children than she had envisaged, rather than either a 'planned' or 'unplanned' pregnancy. Although in Martina's case it could be argued that she had 'planned' her future family size, I do not think that this

adequately accounts for the ambivalence women appear to feel at such times in their lives.

If we use the standard definition of a 'planned pregnancy' as one where the women is actively trying to conceive, and 'unplanned' as everything else, then thirteen of the twenty-two women would be classified as having an 'unplanned' pregnancy. Yet in only six of these cases did the women classify them as 'unplanned', and just three of these pregnancies were terminated. I, like Barrett and Wellings (2002), would suggest that this dichotomy, which reflects rational family planning discourses, is a false division in what should really be seen as a continuum of attitudes towards pregnancy. Most of the women I interviewed spent periods of time when they were positive that they did not want to become pregnant. However, many appeared to move into an ambivalent state rather than 'plan' to become pregnant. I suggest that this ambivalence may be partly due to the uncertainty of any decision to have a child. First, conception itself is an 'unknown' process, and whilst some women become pregnant whilst using contraception, others cannot conceive even if no biological problem is present. Second, whilst having a child is often considered as a life-changing decision, the exact nature of these life changes can only really be guessed at beforehand. Consequently, in the face of such uncertainty, ambivalence may be a more 'rational' approach, than trying to choose between unknowable futures.

In some cases, like Judith, ambivalent acts included changing contraceptive method to one they perceived as having a higher risk of pregnancy, but it could also involve not using an additional contraceptive method following a missed pill, or choosing not to take a morning-after pill. Decisions such as these are also taken within the context of the women's circumstances, for example their current relationship (if any), economic circumstances, and general life-plans at that time. Moreover, women's attitude towards the risk of pregnancy impacted not just on which particular methods of contraception they were prepared to use, but could also affect their sexual practices, as the quotation from Karen's interview in the previous section illustrates. In her case, fear of pregnancy and distrust of the cap contributed to a decline in sexual activity.

Embodied Risks and Responsibilities

Throughout the interviews, almost all of the women interviewed appeared to consider contraception to be primarily their responsibility, although they often gave contradictory answers in this respect. In the next section, I will discuss control and negotiations within heterosexual relationships; here I will discuss the women's perceptions of the embodied risk of pregnancy and how the design of contraceptive technologies is implicated in their sense of responsibility. As I mentioned in chapter 5, few of the women gave serious or sustained consideration to the risk of sexually transmitted infections. Consequently, whilst the risk of pregnancy was a constant feature of the interviews, perceptions of the risks of sexually transmitted infections only

usually appeared when I directly asked about them. Only four of the women interviewed reported ever being concerned about practising safer sex, and had, at some point, used condoms to reduce the risks of sexually transmitted infections, and I will discuss their experiences of negotiation later. However, even these women did not seem to attach the same significance to the risk of sexually transmitted infections as to that of pregnancy.

Pregnancy: More than an Embodied Risk

With few exceptions, the risk of pregnancy was the uppermost concern in women's minds. Even within long-term heterosexual relationships, any pregnancy has embodied consequences for women which men do not have to consider, as the following extracts illustrate:

Christine — I'd like to feel… it is me that is going to be pregnant, so it is my decision, not anybody else's. Because at the end of the day, a male can walk away and you're left with what, you know, can happen… I think the woman has to have the onus on her contraception, you cannot leave it to a man… It's your responsibility… you have to take that child, you have to nurture that child inside you for nine months... it's me who is responsible to have a child. Not them, because they can walk away, oh yes they can pay maintenance and things like that, but they can still walk away.

Paula — I suppose… I suppose that I think… It is always something that I… because I am from a family where women have always taken charge in that area… and I think well it's my body that is going to have to go through a termination or a pregnancy… it would be me that would bring up a child… then I think… umm… if I want to be 100% certain… that I am not going to have another pregnancy… I'll make this choice… because ultimately it's me that is going to have to deal with the consequences of a pregnancy.

Martina — It probably is a joint responsibility… but I think my element of that is higher… I would probably take priority in the decision…

by that I mean I wouldn't do anything without consultation, no. Particularly if it was a method that might increase the risk of pregnancy. Because whilst I feel that it is my responsibility whether or not I get pregnant, he is going to play an active part in fatherhood if I were to get pregnant, and therefore, he has a responsibility, ummm sharing the decision of what we do. So when we were not using particular... ummm... contraception, it was very much a joint decision about whether we had intercourse or not, unprotected... well he has always... ummm I have always consulted him with every decision I've made, and I think if he was actually against something, then I would take that on board.

In these extracts a range of views are expressed towards the embodied risk of pregnancy, but all agree this incurs very different consequences for women and men. Most of the women stressed that they had, and should have, a greater level of responsibility for contraception because of the embodied risk of pregnancy and the likelihood that they would be primarily responsible for caring for any child born. Where their accounts differed was in their attitude towards the level (if any) of male involvement. In the first quotation, Christine argues that contraception must always be her decision as 'a man can walk away'. For Christine, pregnancy is a female risk, and as such any decision about contraception must be hers alone. She argues that carrying a child for nine months, as well as her assumption that she would be the primary carer, does not equate to 'paying maintenance', and this is why any decision must be solely hers.

In many respects, Paula is arguing from a similar position. She also considers the embodied effects of pregnancy and that 'it's my body that is going to have to go through a termination or a pregnancy'. Yet, in contrast to Christine,

Paula feels that it is 'ultimately' her decision, rather than categorically hers. Hence, Paula appears to be introducing the possibility of male involvement. It is also interesting that in this extract Paula refers to a family tradition of female responsibility for contraception. In other interviews, women also commented on this general assumption of women's responsibility: 'that's the way society sees it' (Donna). Moreover, although during the interviews many of the women mentioned their daughters' present or future choices, only two mentioned their sons.

In the last quotation, Martina is indicating a much greater involvement of her partner in contraceptive choices. Although she still maintains 'priority' over the decision, as she could become pregnant, she argues that because she expects her husband to play 'an active part in fatherhood' he has to be responsible and to be 'consulted' about any decisions. Martina also reports that the level of male responsibility can vary according to the perceived risk of pregnancy from any particular contraceptive method. In an earlier part of the interview she commented that she did not need to discuss contraception with her previous partners, other than informing them that she was on the pill. So although Martina appears to be advocating a much greater role for men in contraception decisions, it is still moderated by different circumstances.

When these three viewpoints are considered within the context of the women's lives, they reflect their very different circumstances. Christine is a single mother who has raised her eight-year-old son alone since birth, although she

did report that she has a 'good relationship' with her son's father. In the last year, Paula separated from her husband and has begun a new relationship. Her three teenage children all live with her. Martina is married and she and her husband have two pre-school children. Whilst all these women's different viewpoints reflect the embodied nature of childbearing, acknowledging that a pregnancy affects their body alone, their very different life circumstances condition their attitudes towards male responsibility for child raising. Christine has had sole responsibility for her son since his birth, she knows that men can and do 'walk away'. In contrast, Martina expects her husband to be actively involved in fatherhood, and thus her current perception of her husband's involvement in contraceptive decisions reflects this expectation.

Dryden (1999) has argued within her research on marriage that women in an interview context may feel under pressure to both construct and portray relational equality within their relationships. There is a social obligation to present an equitable partnership, and locating gender inequalities elsewhere may allow for the constructing of an equitable relationship in comparison to others. Consequently, Martina's change of emphasis from contraception being solely her responsibility earlier in her life, to it being a joint one with her partner may also be a reflection of a need to promote her marriage as equitable in contrast to her former sexual partnerships.

Embodied Technologies

At the present time, almost all of the contraceptive technologies available have a direct impact on women's bodies. For example, the ingestion of hormones through the contraceptive pill increases the risk of thrombosis. The IUD or IUS can lead to uterine embedding or perforation. There is a heightened risk of urinary tract infections associated with diaphragms and cervical caps. Tubal ligation has many direct risks, as well as those associated with any anaesthesia; and many women report adverse reactions to spermicides found on condoms. Indeed the only contraceptive technologies without implications for women's health (apart from the risks of pregnancy or sexually transmitted infections, of course) are vasectomy, withdrawal or methods based around fertility awareness, such as temperature-rhythm or Persona.

Moreover, it is generally known that there are risks associated with contraceptive technologies. All of the women were aware of some of the more serious conditions associated with the contraceptive pill, such as thrombosis, and many of them mentioned several of the more common 'side effects' as well. In total, sixteen of the twenty-two women interviewed reported that they had at some point suffered from an adverse effect from a contraceptive technology, and of the six women who had never experienced problems themselves, two had to change brands of contraceptive pill due to the health risks associated with the ones they were using. Consequently, many of the women felt that it was not just the embodied risk of pregnancy that made contraception their decision, but the impact of the technologies themselves.

Heleh — we do talk at the end of the day… it is like everything else, we talk, we discuss… he asks how I feel about it, and I ask him, you know, blah blah… but at the end of the day it is up to me to decide, he does not push me… […] the final decision is mine, because I am the one taking it.

Linda — I mean condoms we both decide, yes, because we don't want the risk… of getting pregnant again. But as to either the coil or the pill, he just feels the same as me. It is my body… I'm the one who has got to… either remember to take something everyday, or have it implanted. So…[…] I do feel it is my choice because at the end of the day, although we are married, it is my body.

INT — right… and is that because the contraception affects your body, or because you will be one to get pregnant?

Linda — …ummm… it's what goes in my body, I mean… ummm… before we had him [*indicating her baby*] I mean... if I had got pregnant then it wouldn't have been bad but we both feel, you know, we don't want anything… to get pregnant again.

Alex — I think ultimately it comes down to joint decisions… ummm… I mean if I wanted a baby and he didn't, it would be the wrong thing to do. And at the same time, if he wanted a baby and I didn't, I couldn't take a pill behind his back. I would always want to talk to him about it. But I think which contraception I use should be my choice…

INT — Why do you think that?

Alex — Because I am the one who has to use it.

These women feel that as they will be the ones using contraception, it should be their choice as to which method to use. In addition to the risk of pregnancy, the women also have to consider the impact of the contraceptive technologies themselves. Whilst all three feel that there should be some form of male involvement, the 'final decision' remains firmly theirs. Moreover, both Linda and Alex clearly distinguish between pregnancy decisions and contraceptive

choices. The notion that it is a joint decision to use a *form* of contraception, but that the *type* of contraception should remain a woman's choice, was a common theme throughout many of the interviews. This could also be linked to the idea that less reliable forms of contraception require more discussion, as described by Martina in the previous section. Yet what was also clear was that the women believed that unless otherwise discussed, men usually expected women to be using contraceptive methods with the least risk of failure. Consequently, it appears that whilst decisions around pregnancy prevention are solely or predominantly women's choice, due to the embodied risks of both pregnancy and contraceptive technologies, increasing the chance of a pregnancy or planning a pregnancy is considered to be much more of a joint issue. Since far more of the available contraceptive technologies affect women's bodies than men, the development of technologies is obviously implicated in re/producing these ideas, and I will return to these points in chapter 8. At this stage I want to illustrate the very different way that the women considered the risk of sexually transmitted infections, which appeared to be a negligible or ancillary risk rather than an embodied one.

Sexually Transmitted Infections: An/other risk

As mentioned previously, the women I interviewed rarely considered the need to protect themselves against sexually transmitted infections. Whilst both pregnancy and the health implications of contraceptive technologies were constructed as embodied risks, the risk of sexually transmitted infections, if considered at all, was located in the bodies of 'others'. However, it is also

important to note that although these views are extremely common (for example see Lewis 1997), they may also stem from the embodied experiences of the women. At the time of interview, only two of the women were childfree, and both of these women had previously undergone terminations. This meant that all the women in the sample had been pregnant at some stage of their lives. In addition, even the women who reported that they had 'planned' their pregnancies often recounted tales of friends or relatives becoming 'unintentionally' pregnant. Throughout the interviews, the women often described times they had been waiting for their period after 'taking a risk' (Alex), or their period was late and 'it crossed their mind' (Sharon) that they could be pregnant. I would suggest that menstruation acts as a monthly reminder of women's embodied risk of pregnancy, and as such leads to a higher awareness of this risk in comparison to that of sexually transmitted infections.

In a similar way, all of the women had either been personally affected by the 'side effects' of contraception technologies, or knew women close to them who had experienced problems. In contrast, none of the women disclosed that they had ever been treated for a sexually transmitted infection, and only one mentioned that she knew of anyone who had gone for tests (which were negative). Such low reporting may be attributed to the shame attached to such an admission, as sexually transmitted infections are associated with 'deviant' populations. Moreover, it seems unlikely that sexually transmitted infections would be openly discussed in a similar way to pregnancies or contraceptive

problems, and the likelihood of the women hearing about the infections of friends or family is, I would suggest, low. Due to a lack of general discussion and its 'deviant image', most of the women seemed to place the risk of sexually transmitted infections clearly on bodies of 'others' outside their everyday lives. Consequently, it is probably not surprising that they do not consider this as an embodied risk in the same way as either pregnancy or the health implications of contraception. Hence, whilst contraceptive mediations to prevent pregnancy are a regular feature of women's lives, negotiating safer sex only occurs in a minority of cases, due to the very low priority it is accorded by the women.

Contraceptive Heterosexual Navigations

> I am just trying to think how it is for me…ummm… because I never wanted to be faced with the prospect of an unwanted pregnancy… ummm… again, you know, I did assume the upper hand… but I still feel that contraception should be a joint thing… I think it is far too often… it's

able to protect herself, the process of consultation also allows her to conceptualise birth control as at least partly a joint decision, and thus more in line with her notions of equitable responsibility for contraception.

In this section, I will explore the ways that the women negotiated contraception use with different sexual partners, and, more importantly, when they considered negotiation was required in contrast with the times when they made unilateral decisions. I will begin by discussing the different ways that the women described their control over contraception, before looking at how and when women perceived a need for negotiation, and how aspects of normative heterosexuality informed decisions made. Finally I will look more closely at the negotiations and decisions surrounding vasectomy, as a way of illustrating how women try to balance their perceptions of embodied responsibility with notions of equitable coupledom.

Controlling Contraception

With one exception, all the women felt that they had more control over contraception in comparison to their partners. Throughout the interviews, 'control' refers to the ability to access or physically use contraception, rather than any notions of authoritative command. Only one woman, Shui, thought that control was equal between herself and her husband, adding that this was expected within Taiwanese marriages. For the others, 'having control' was a variable category, and different women appeared to equate 'control' with different aspects of contraception use.

INT Who do you think has more control over contraception choice and use, you or your partner?

Judith … I think we do

INT women do?

Judith yes… we can go and get the pill or whatever, it's up to us…and if you are taking the pill you are in control of it, because if you didn't want to take it you wouldn't have to… I think it is important… because like I said earlier with men… you just couldn't count on them totally anyway…

INT Who do you think has more control over contraception choice and use, you or your partner?

Sharon me…[*laughs*] I go 'no don't come next to me until you've got one [*a condom*] on' … [*laughs*]… definitely… Do you know, I think it is the women who keep their heads on their shoulders, cos I actually, because he gets all like wanting to do it, and it's me who turns round and says 'well have you got one ready… well I'm not doing this until you put one on', sort of thing. Because I think in a way sometimes he could be a bit… lax, you know. He could be 'ok, yes alright'. He doesn't seem to realise that you can get pregnant before, you know because they do, they do leave a bit before… It's me who tends to keep him in control I think… I keep my head on my shoulders… [*laughs*]… I mean he does use them, he'll say okay, but sometimes he has forgotten, especially if he's had a drink… [*laughs*]… So I mean, that's the thing with me as well. If I've had a drink, I'd still manage to think, well where is it, because I know I don't want any more, so… I think women are a bit more… They are more in control than men… of contraception definitely, especially if you know you don't want any more, you are like 'no!' You remember that sort of thing.

In the extracts above, ideas about having control over contraception stem from a complex interplay of practical and discursive factors. In the first quotation, Judith describes women as having more control because of the availability of contraceptive technologies used by women. What is interesting is that her argument is based on general unilateral action. Women can take control by accessing contraceptives, and then using them, and men are only mentioned in

respect of their unreliability. It is also interesting that Judith chose to answer this question in general terms, rather than specifically about her own levels of control. Indeed, in another part of the interview, she indicates that contraception only becomes a subject for discussion when a couple are thinking about having children. Thus, for Judith control seems to stem from the availability of contraception technologies used by women, which she assumes that women will be able to use unproblematically. Yet because she also mentions a perception of men's general unreliability over contraception, it appears that available technologies are not the only factor involved.

In contrast, Sharon's account seems to locate women's control of contraception in their ability to act sagaciously, rather than in the design of contraceptive technologies themselves. She describes her own situation, in which she reminds her husband of the need to use condoms, but also comments that women in general 'keep their heads on their shoulders'. For Sharon, women's ability to control contraception is assumed to arise from their biological risk of pregnancy. Like Judith, she assumes that control of contraception will always be unproblematic for women. In neither of the accounts is there any acknowledgement that some women may face difficulties in exerting this control. Moreover, Sharon can also be seen to be invoking ideas about men's inability to control their sexuality and women's responsibility to do so (see for example Holland *et al* 1998). She states that 'he gets all like wanting to do it', and argues 'it's me who tends to keep him in control'. Thus, for Sharon women's control of contraception is located both in gendered biological risks

and within the different discursive constructions of male and female sexuality; ironically, by assuming responsibility for condom use, Sharon is perpetuating this discursive construction. However, what was also clear from the interviews was that different types and stages of heterosexual relationships often lead to a different perception of the level of responsibility and control that the women perceive to be appropriate.

(Not) Negotiating Contraception

One of the strongest features to arise from the interviews was the tension between women's strong sense that contraception was 'their problem' and their ideas about equitable coupledom. Women seem to agree about when and under what circumstances contraception stops being solely their decision and becomes a subject for discussion, as the following extracts from the interview with Martina clearly illustrate. At the beginning of the interview, she describes her decision to start using contraception as follows:

> It was my choice… I mean… I had had it drummed into me by my mother that if I was going to do anything then I needed to be protected… I have always gone by the philosophy that it is the woman who gets pregnant so it is the woman who should take responsibility for not getting pregnant.

Later in the interview, she explains why she has only discussed contraception with her husband.

> Well effectively, once I was on the pill, apart from a couple of times when I came off it, to give my body a rest, if you like, ummm… I stayed on it all that time, I came off it before my eldest was born… ummm... so I had been on it 18 years… so there was no need to discuss it with anybody. I mean obviously I discussed it to the extent I told my sexual partners I was protected, but it didn't go beyond that. And… but

> it is since being married that I changed my method of contraception so we discussed it each time. [...]... in terms of my husband it has been more of a shared responsibility, whereas with previous partners, it was. I took responsibility.

In previous relationships Martina held that contraception was her sole responsibility; as she was the one at risk of pregnancy, it was up to her to protect herself. Moreover, as she was using the pill 'there was no need to discuss it with anybody'; and thus the design of contraceptive technology is implicated in her ability to make unilateral decisions. Now she is married the responsibility is more shared, although she maintains throughout the interview that she takes 'priority in the decision' (as quoted earlier). Yet, a closer reading of her extract appears to indicate that the discussions with her husband only took place when she changed her method of contraception, which was after the birth of her first child. Martina had been married for several years before she came off the pill to try for a child. As she was still using the pill up until that point presumably there was 'no need' to discuss it then either.

Many of the other women revealed a similar pattern in that contraception only became a subject for discussion either following childbirth or when the possibility of trying for a baby was being talked about. Judith reported that in general she did not discuss contraception with sexual partners, although she did when considering a change to the Persona system:

> I haven't really discussed... well... yes and no... I should say that really, the Persona I did... Because that obviously wasn't as reliable as the pill. But the pill was the most... reliable so... that's it... it didn't really need to be discussed.

The idea, expressed by many of the women, that the 'pill didn't need to be discussed', can be understood as having several different implications. Being on the pill gives women a sense of freedom from the risk of pregnancy, as well as meaning that they do not necessarily have to embark on in-depth negotiations with a new sexual partner. It also implies that men recognise the pill as a reliable form of contraception, and that usually men will want this as well. Moreover, as the above comments illustrate, women's assumed responsibility for contraception actually continues well into long-term relationships. For many of the women it was not until they were considering having children, or after the birth of a child, that they were likely to discuss contraception or consider it as a shared responsibility. However, as detailed earlier, what most of the women considered to be the 'shared' part of the responsibility was the decision to use, or not use, a form of contraception. Which specific method to use remained mainly or solely women's choice due to contraception's embodied nature.

This non-negotiation with many partners went further than just an assumption of contraceptive responsibility with new partners; it also contributed to the timing of decisions to change contraceptive methods. As noted earlier, many women stopped using contraception between relationships, and in particular it was very common for women to stop taking the pill. In most cases the women went back on the pill when sexual activity restarted. However, both Donna and Patricia made the decision to stop taking the pill permanently, and chose to use other methods of contraception on the commencement of new relationships.

Donna's case has already been described in chapter 5, and Patricia gave this account of her decision:

INT	why did you decide to come off the pill?
Patricia	I just felt, I'd been on it 10 years, I was smoking at the time... ummm... there was a lot of bad publicity about deep vein thrombosis or whatever, and ummm... I just thought, well I smoke and... I don't really want to take the risk... And I wasn't in a relationship at the time so, there didn't seem to be a point, and after that I just used condoms... and of course there was all that ... umm... information about HIV and AIDS and it seemed a more sensible alternative.

In both accounts the women report reacting to the adverse publicity surrounding the contraceptive pill and in particular the risk of deep-vein thrombosis. They both felt that the increased risk for themselves as smokers was too high, and that alternative forms of contraception would be preferable. What is most relevant in this context is that the decision to stop taking the pill permanently was taken between heterosexual relationships. As described earlier, Donna times her decision to stop taking the pill as 'about the time' of the publicity surrounding the withdrawal of some brands of contraceptive pill. However, her account seems to indicate that it was the ending of a relationship that enabled her to make the decision. In a similar way, Patricia reports that she made the decision to stop taking the pill between relationships, and on commencing a new relationship she used condoms. She justifies this decision with reference to the risks of sexually transmitted infections, although her decision appears to be related much more to the risk of thrombosis than that of HIV/AIDS.

Although the women did not mention it, I would suggest that it was far easier for them to make the decision to change from the pill to barrier methods between partners than if they had been in a relationship. In these two cases, the relationships were breaking down, and thus this may have contributed to the timing of their decisions. For example, the women may have felt that broaching this topic could exacerbate any difficulties, particularly if they felt that the change to barrier methods would be unpopular with their partners. Although in these instances Patricia and Donna are still 'controlling' contraception, the timing of their decisions illustrates that there are also many constraints that may implicitly influence their decisions.

One circumstance in which negotiations must take place is if women, or their partners, want to practice safer sex. As previously noted, this only happened in a minority of cases, only four of the women stating they had ever felt a need to practise safer sex. Of these four cases, Linda reported that when she met her husband he was undergoing tests for sexually transmitted infections following his previous relationship, so they practised safer sex until the results came through, as negative. Both Joan and Patricia had switched to condom use because of their concerns about the pill (although after her marriage and the birth of her daughter, Patricia changed to using a coil) and pointed out that this had the benefit of also protecting against sexually transmitted infections. In contrast, Karen had begun most of her relationships relying on condoms, which she jointly attributed to concerns over safer sex and her decision not to

use the pill due to health concerns, but had switched to other methods later within the relationships.

Neither Linda nor Joan reported that they had experienced problems negotiating condom use with sexual partners, although in Linda's case, it was her new partner's suggestion as he was attending a GUM Clinic. Patricia reported that she had refused to have intercourse on occasions when her sexual partners had objected to using condoms. She stated that 'it makes you feel a bit grotty, but the next day, you know… with the benefit of hindsight, you think, I have done the right thing'. Despite the unpleasantness of these situations, she stated that she always felt confident that she would be able to refuse.

For Karen, however, the situation was slightly different, and she felt pushed into stopping using condoms by a partner. This is how she describes her experiences:

INT	Have you ever discussed the risk of sexually transmitted infections with a partner?
Karen	…yes…
INT	was it discussed before you had sex or…?
Karen	I just er… no… but it was early on. I think it was at the point when I was being pressured not to use a condom…
INT	what sort of pressure did you feel ?
Karen	well… I mean sort of… I wouldn't say I was entirely happy with stopping but… it wasn't sort of to the extent that it wasn't my decision, more 50/50… an undecided sitting on the fence, that's me… it wasn't like an out and out refuse… it's more sort of grizzling… we didn't have a huge argument about it. But he did used to say about it. As it turns out, I don't actually get on

> with condoms... I think it is more to do with the spermicide they put on the rubber...[...] suppose I made the decision, but I felt under pressure to make the decision that he wanted me to make.

Karen reports that the decision to stop using condoms is still made by her, but she felt under pressure from her partner to agree. In this extract, we can see different elements within the decision making process. First, there is the 'grizzling' by her partner and she also describes how he used to 'say about' it. It appears that there is an ongoing contestation, rather than a direct request from him to stop using condoms, and her consent or refusal, and the matter was only likely to end either when the relationship finished or she agreed to stop using condoms. Coupled with this tension are the physical problems caused by the spermicide, which contributed to Karen's decision to agree to stop using condoms. From this extract, we can see the gradual process of her decision, and, although she remains clear that it was her decision to make, different pressures in relation to both her health and her relationship were clearly involved.

In a subsequent relationship, as detailed previously, Karen experienced similar pressure when her partner disliked her using a cap. In this case, Karen reported that he disliked the way it interfered with his sexual pleasure, being inconvenient and because he could feel it, whereas she was unhappy as she did not really trust its reliability and was concerned that she might become pregnant. In both of these instances, there are embodied issues that contribute to her agreeing with her partner to change method. In the first case, she was

experiencing physical irritation from the spermicide, and in the second she had a greater fear of pregnancy. How much these issues contributed to her decision is unclear, but it does illustrate the way the embodied nature of contraception is embedded within negotiations between sexual partners. Moreover, it appears that her partners were also working within the convention that contraception is a women's responsibility. Thus rather than a 'demand' that they stop using condoms, they put pressure on Karen instead to conform to their wishes. In Dryden's (1999) study of gender relationships in marriage, she found that not only were men unwilling to understand the perspective of their wives, but they also commonly undermined their female partners in order to get their way. Dryden's account relates how male conversational practices within joint interviews played on the insecurity of their partner in order to get their own way. From Karen's description, I would suggest her partner's constant 'grizzling' may well fit into this type of behaviour.

Although Karen gave the most explicit account of the processes of negotiation within heterosexual partnerships, many of the other women made odd comments that indicated that hers might be a more general situation. Charlotte stated that her husband did not like the 'inconvenience' of the cap, and Mary's partner found condoms 'annoying'. Whilst the women maintained that they were the ones with the final decision, they also stated that they usually took their partner's preferences on board. Many of the women reported that it was difficult to get their partners to discuss contraception, and that even when they raised it, their partners usually evaded the issue. However, at the same time

they were very clear about their partner's views on different methods, which indicates that there was some form of ongoing communication. Moreover, the women appeared to be continuously balancing their belief that contraception was their decision, due to its embodied nature, with ideas about equitable coupledom, whereby decisions and responsibilities are shared.

Emotional Labour

Whilst almost all of the women always felt responsible for contraception, the extent that the women performed emotional labour whilst making contraceptive choices varied depending on the type of sexual relationship they were engaged in. It was most obvious when women described the tension between feeling responsible for contraception and the image of the equitable long-term heterosexual relationship. Duncombe and Marston (1993, 1996) have argued that women tend to perform emotional labour within long-term heterosexual relationships, and I would argue that in many cases this also includes aspects of contraception negotiation. Although this is implicit in the comments quoted earlier by Judith and Sharon about controlling contraception, the following quotation outlines this emotion work much more clearly.

Karen	Certainly my first, I don't know if it was all of them really, they seem to hedge the issue of contraception, they sort of avoid it somehow… They don't seem comfortable with the idea of dealing with contraception or whether they just, I don't honestly believe that all men don't care but… they don't seem to be able to handle the idea…
INT	You'd like men to take more responsibility?

Karen … well… I don't know if it is responsibility, just sort of have more of an awareness and ummm… have an awareness that you're taking responsibility… that's not coming across very well… umm… I just think they put their heads in the sand about it… I can't think how to describe it … perhaps a bit more willing to… well they are never very good at discussing feelings, but discuss with you about how you are feeling about taking the responsibility so...you know you could say 'oh the pill makes me feel like this' or 'the diaphragm is making me sore or…' They tend to like 'well I'm happy with that' so they tend to switch off, and it is your responsibility rather than sitting down and having a chat with you. That's what I mean about taking responsibility rather than.... them doing something, as obviously their methods are very limited. But they don't seem to want to share the emotional side of how you might be feeling with it or empathy.

In this extract, Karen describes how the men she has been in relationships with try to avoid the issue of contraception. It is not that she necessarily wants them to take responsibility, but she wants acknowledgement for the emotion work associated with contraception. Although women might want or accept responsibility for contraception because of the embodied risks associated with it, they also feel that within serious relationships men should participate more than they do. For Karen, this participation would ideally be some form of recognition of the embodied implications of the particular contraceptive method they were using. Other women simply wanted to be able to discuss the issue more with their partners. Yet, it appeared that men's emotional participation in contraception was conspicuous by its absence.

According to Duncombe and Marston (1993), both men and women have the ability to exercise emotional labour within a relationship. For example, men can withhold emotional support that women seek, and women can withdraw

their emotional labour from a relationship. Yet whilst there is the possibility for women to manage some of their feelings regarding contraception, such as over the lack of communication with their partners, the emotional labour performed by women when using different forms of contraception could only be withdrawn if they ceased to use it. Whilst male partners were not necessarily expected to use contraception, due to both the limited choices currently available and women's aim in controlling their own body, the lack of male interest or empathy in their partner's use of contraception could be a source of considerable discomfort for the women. Hence it was often not the lack of practical involvement by men in contraception that conflicted with an image of equitable coupledom, but the lack of interest or empathy displayed by them.

Vasectomy: A Snip in the Right Direction

Throughout the interviews, it was clear that vasectomy was a very popular method of contraception with the women informants. Just over half the women were either currently or had previously relied on vasectomies, or stated that it would be their method of choice if their partners would agree. Two of the women were very indignant that their partners would not even countenance the idea, and several were still 'working on' their partners. Apart from the obvious benefit to the women should their partners undergo a vasectomy, what emerged from the accounts is that it was a solution to the tension between maintaining a level of control over their biological reproductive capacity and expectations of equality in long-term heterosexual relationships.

Katy — I've talked to him about having the snip… and he's thinking about it... he does, obviously the procedure worries him but… we were talking about sterilisation at work… and I'd always just thought Peter can have it done, he can have it done. And I… I've had the children, I've had the smears, I've you know, he can get this one thing done… And that, I was just fixed on that. […]… but I happened to mention the other week, well what if I get done then, you know, And he said 'oh no, no, you can't get done. It's an operation for a woman, it's just like a procedure for a man at the doctors'… but ummm… I think it's coming up to me or him now… now that we have the children and that, it will be one of us… I think it should be him… I have been through enough [*laughs*]... And saying about me getting done, I could get done, and we wouldn't have to worry then. You know… and that sort of like pushed him the other way… 'So if you are really thinking about it', he says 'if it's down to me or you, then I'll do it then. I don't want you to go through all that'… so it's reverse psychology, you see it's worked… [*laughs*]… I've got to get him on the 'phone to that doctors…

INT — Have you discussed choices in contraception with your sexual partners?

Charlotte — ummm… only recently, now it has come to… I think before he just let me get on with it. But… when I made the choice that I have been on the pill long enough and… And I suppose talking to other mums, you know… I mean … I could quite easily go along with staying on the pill, but when you talk to other mums they say 'oh you have been on the pill long enough, and you have gone through two childbirths, it is his turn', you know, and they are all like that. And it stops and makes you think, 'Yes, right' … And I come home and say 'Right' [*laughs*]...'how do you fancy having the snip'… Well he was completely against it… oh god… and it was only the fact that a lot of his mates have just gone through it, although you know what men are like, it is the worst thing that could ever possibly happen… and it is so painful, and whatever… but he has decided to get it done.

Both of these accounts share several common features about the meaning and place of vasectomy within long-term heterosexual relationships. On the surface they both relate a similar narrative of women initially raising the idea of vasectomy with their long term partners, having to overcome male

reluctance, and the men eventually agree to go ahead with the procedure. (Although at the time of the interviews, neither man had actually had the procedure or even taken any steps towards getting it done.) Yet within these accounts are other elements that re/form women's perceptions of the vasectomy option. The first of these is the idea that 'it is his turn'. For these women, long-term heterosexual relationships are based on notions of equitable coupledom, and in this respect, contraception is a problematic area. As discussed earlier, whilst the women are very clear that most of the responsibility and control for contraception should remain with them due to the embodied risks, this contradicts with an expectation of equality within their partnerships. However, a vasectomy solves this dilemma. It allows women to relinquish 'control' of contraception without a risk of pregnancy[16], because men cannot forget or cease using a vasectomy (unless they undergo a reversal). Vasectomy is a way of sharing the responsibility by taking turns, without incurring additional risks to the women themselves.

Another feature of these accounts is that there appears to be a common expectation that a permanent solution is necessary once a couple decide they do not want any (more) children. Indeed, sterilisations and vasectomies are common within the UK, with 44% of women aged between 40 and 44 relying on one of these methods (Macfarlane and Mugford 2000:190). However, what is interesting is that it is not just individual women who expect their partners

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[16] Although vasectomy does have a small failure rate (approximately 1 in 1000, according to the Family Planning Association) it is considered as a permanent method, both by health professionals and the women interviewed.

to have a vasectomy, but women as a group who support this notion of 'fairness'. This is clearly illustrated in Charlotte's description of her conversation with 'other mums'. Moreover, in the interview with Sharon, she referred to a discussion with the clinic nurse about the possibility of her husband having a vasectomy as '*we* are trying to talk my husband into getting it done', even though her husband was not present at the time of the discussion. Medically it is much simpler to undergo a vasectomy than a sterilisation, and women use the support of their health professionals and social networks as a way of encouraging men to undergo the procedure. These appear to be important levers in both justifying women's position and encouraging men to re/consider their position.

Despite the popularity of vasectomy amongst women, men will not always agree to the procedure. Both Bernadette and Judith commented that their partners had rejected the idea, and the General Household Survey 1995 (Macfarlane and Mugford 2000) indicates that the number of women relying on sterilisation outnumbers those relying on vasectomies[17]. However, it is also important to consider that in an era of serial relationships, a partner undergoing a vasectomy may not ultimately be the long-term 'solution' that women seek. Both Paula's and Rebecca's husbands had undergone vasectomies, but both of their marriages had subsequently ended and they had

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[17] Whilst statistical information on NHS sterilisations is available, it is not routinely collected for private operations. As only a small number of vasectomies are performed within NHS hospitals, even less information on frequency is known (Macfarlane and Mugford 2000).

formed new sexual relationships, which left them needing other forms of contraception again.

Consequently, although the idea of vasectomy as an equitable long-term solution to contraception might be popular, in practice it is not always as simple. Many men will simply not agree to undergo the procedure, or partnerships may end, leaving women to depend again on other forms of contraception. However, the popularity of the idea of vasectomy illustrates how women try to balance conflicting ideas within their contraceptive decisions. Moreover, discourses of heterosexuality and the embodied nature of contraception are part of a complex web of power relationships that re/produce and re/form women's contraceptive decisions.

Conclusion

In this chapter, I have argued that the women's decisions about contraception are made within the context of both their sexual encounters and relationships, and wider discourses and institutions of heterosexuality. Whilst the relationship between contraception and sexual practices is complex, and involves both the type of contraceptive technology and the form of the sexual relationship, certain discourses also emerged as important. Coital-dependant methods of contraception, and condoms in particular, were unpopular with the women, as they are considered 'unnatural' both in terms of a physical barrier and a disruption to discursive constructions of 'proper sex'. Moreover whilst the women made specific contraceptive choices in the expectation of sexual

activity, sometimes the technologies themselves also had a direct effect on sexual practices.

I have further argued that the concept of rational family planning does not reflect the continuum of feelings that the women have towards becoming pregnant. Rather than a dichotomy between 'planned' and 'unplanned' pregnancies, the women had very mixed feelings and this is reflected in their contraceptive decisions. Whilst the women are acutely aware of the potential risks of pregnancy, and have an embodied sense of responsibility towards pregnancy prevention, they did not express similar views towards the risks of sexually transmitted infections. Men appear as an absent-presence within women's accounts of their contraception experiences. Although the women assert that they have all or most 'control' over contraception, this refers to the physical accessing of or using of contraception, rather than any authoritative stance. Moreover, women see a conflict between their 'control' of contraception and their right to bodily autonomy on the one hand, and an expectation of equitable coupledom within heterosexuality on the other. Whilst in theory vasectomy is perceived to be a solution to this conflict, in that it allows couples to 'take turns', in practice it is often not the equitable long-term solution that women are hoping for. In this chapter, I have shown how discourses and practices of heterosexuality forms part of the complexity of women's contraceptive experiences. In the next chapter, I will consider the interplay that discourses of heterosexuality have with other sites that are constituent of women's subjective contraceptive power.

Chapter 8

Subjective Power and Contraception

'It [*contraception*] is very important in the fact that you can choose... you know... when you have your children, how many children to have...[...] but in other aspects of my life then no, it isn't important... umm... I suppose because it is there... you don't think about it too much... I suppose we take it for granted... it is only when you have a problem... then you think about it (Sonia)

Introduction

Contraceptive decisions are very often in the background, as Sonia points out, and the perception is that as long as women can control this area, they are able to get on with the rest of their lives. Consequently, contraception can be understood as connected to most other parts of actively heterosexual women's lives. The complexity of women's experiences and decisions over contraception can be understood by considering them as aspects of power relationships. Although in order to produce this analysis distinct modes of power have been identified, within women's lives they are closely intertwined, and re/form and re/produce women's subjective power. The concept of subjective power represents the extent to which individual women are able to deploy power in any social context. Perhaps a useful way of thinking about subjective power is to compare it to a child's kaleidoscope. The pattern that is viewed at any one time represents a woman's subjective power, and each different colour is a different aspect. Just like a kaleidoscope, where the pattern constantly changes as the different coloured pieces move, so the woman's ability to deploy subjective power changes as different aspects of

power relationships re/act against each other. However, while a kaleidoscope has a fixed number of pieces in each colour, the pattern of women's subjective power changes as the different aspects fluctuate in strength relative to each other. Thus in the power kaleidoscope, the number and ratio of colours is not fixed and a colour which is dominant at one point may wane as another grows stronger.

Using the model of power outlined in chapter 3, I will here explain the interdependent power relationships and their orchestration using examples drawn from chapters 5, 6 and 7. I will consider different modes and sites of power (ideology, force, discipline, technologies, psychobiography, emotion and resources) and argue that focusing on power produces a clearer explanation of the connections between women's individual circumstances and the wider social context. I will begin by identifying the various ideologies that impinge on women's contraceptive practices, including the division between respectable and unrespectable women, and women's responsibility for children. These frameworks of ideas re/produce the social context of women's contraceptive experiences. I will then discuss how varying degrees of force act to constrain women's ability to deploy subjective power. Thereafter I will consider the disciplinary regimes that encompass contraception. These will include the institutional power of medicine, the effects of the different sites in which women make contraceptive choices, women's self-discipline and the disciplinary effects of different methods of contraception. The role of the pharmaceutical industry will also be examined as a disciplinary power.

Following this, I will explore the media as an example of a technology of power, through their re/construction of normative frameworks surrounding contraception.

Whilst all the above modes of power re/produce women's individual experiences, they are not specific to any individual. In the next section, I will look at psychobiography, which is a mode of power that operates at a more personal level. Psychobiography is the effect of individuality: how an individual's history, character and attitudes re/act within the social context. I will be using two examples of abortion and serious illnesses (linked to contraception) which led different women to reflect on their contraceptive decisions in different ways. I will then go on to look at the role of emotion in the construction of subjective power over contraception, and finally at how resources can also constrain or enable women both at an individual level and within a broader institutional context. By using the research findings, this chapter will argue that the model of subjective power can be used to facilitate analysis and further our understanding of the complexity of many women's everyday lives.

Ideologies: The Social Context of Contraception

Normative ideas about heterosexuality are an ideological mode of power that affect women's deployment of subjective power over contraception. Whilst the 'naturalness' of heterosexuality itself forms a backdrop, moral judgements about different forms of relationships are also important, as well as the

gendering of responsibility for children. As Jackson has argued, 'everyday heterosexuality' is much wider than sexual acts, but encompasses routine expectations and everyday practices that perpetuate heterosexual coupledom as the norm. Heterosexuality defines normative parameters (1999:26). An example of this is the assumption that 'sex' is penile penetration of the vagina (McPhillips *et al* 2001), upon which is based the constant need for contraception. Whilst many of my informants' thoughts and decisions about contraception are shaped by this institutionalised framework, in this section I will concentrate on two specific areas. I will begin by looking at how ideas of respectability combine with use of contraception, and then look at the question of expectations regarding fertility and child-rearing.

The 'Responsible' Woman

Hawkes' (1995) identifies a division between 'responsibility' and 'irresponsibility' in explaining the different attitudes displayed by the staff in family planning clinics towards young women clients. She sees these terms as a sanitised version of the longstanding division of women as either respectable or unrespectable. Young women using contraception are seen as irresponsible, because their youth renders their sexual activity deviant. However, I found that whilst the division between responsible and irresponsible was present in my research, the women I interviewed were using it in a different way.

The ideological importance of the 'responsible woman' was reflected throughout many of the interviews. As I discussed in chapter 5, in their

descriptions of their early use of contraception as teenagers, the women stress their 'responsibility' to signify that they should be seen as adults and that their relationships were serious, and to differentiate themselves from ideas of 'unrespectable' sexuality. By taking responsibility for contraception, they were constructing themselves as grown-up and respectable. Throughout the interviews, the women often stressed their non-promiscuous sexual history, their respectability, and the way their responsible attitude towards contraception and/or sexual relationships led them towards specific understandings of their actions in particular situations, such as their early decisions about contraception and their attitudes towards safer sex. The emphasis on responsibility appeared to be a way of engaging in different forms of heterosexual encounters without transgressing the boundaries around acceptable (hetero)sexual behaviour. Although cultural taboos against sex outside of marriage may have relaxed, normative ideals of heterosexual coupledom persist in expectations of serial monogamy with a small number of partners (Jamieson 1998).

Whilst the division between 'types' of women remains, I would suggest that the women I interviewed were not using the dichotomy in quite the same way. Its usage appears to have shifted over time. Rather than directly replacing the terms 'respectable' and 'unrespectable' with 'responsible' and 'irresponsible', as Hawkes found, the division used by the women seems to have evolved to make contraception the deciding factor. 'Responsible' women are regular users of 'proper' contraception, and it this responsibility that confers on them

'respectable' status. Consequently, although the women continued to make distinctions between acceptable and unacceptable sexual behaviour, 'proper', responsible use of contraception, could be used to render borderline sexual activity respectable. In contrast, use of the morning-after pill does not render women responsible since, as I discussed in chapter 6, the morning-after pill is not deemed to be a 'proper' contraceptive.

The image of the irresponsible women is summed up in Martina's reply to a question about the general availability of contraception. She stated that:

> [*contraception*] should be easier [*to obtain*]... Because I think women will have sex whether or not they have protection. So making it harder won't make any social problems go away, it will just make them worse.

Whereas 'responsible women' have a respectable sexuality through control over their fertility, unrespectable women constitute a 'social problem', and can only be contained through the greater availability and promotion of contraception. Martina thinks that irresponsible women may not try very hard to seek out contraception, so it must be made easier to obtain[18]. Moreover by constructing others as 'irresponsible', the women distanced themselves from 'unrespectable' women, by stressing their usage of 'proper' contraception. This can be seen clearly in the construction of the morning-after pill user as deviant, highlighted in chapter 6. Furthermore, in other parts of the interviews when they described their control of contraception as stemming from the

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[18] Of course, given the shifting boundaries which determine the 'other', it is likely that should these 'other' women start using contraception, other factors would be used to define them.

embodied risk of pregnancy, the women often stressed the difference between themselves and 'other' women who didn't seem to care about either sexual reputation or repeated pregnancies. Consequently, I would argue that the ideological construction of the 'responsible woman' operates as a powerful incentive to adopt reliable forms of 'proper' contraception.

Ideologies of Motherhood

As many writers have pointed out (e.g. Gillespie 1999, Campbell 1999) motherhood has often been considered as synonymous with womanhood, and there has been an expectation that all women will want to be mothers. Yet at the same time, it is also clear that there is a hierarchy of motherhood. Certain women are disqualified from a 'natural' urge to be mothers and denigrated if they become mothers, for example if they are single, lesbian, and/or disabled (MacIntyre 1991, Campbell 1999). Whilst none of the women I interviewed spoke directly about notions of 'good motherhood' affecting their contraceptive decisions, it was clear that this was a part of the ideological framework within which they made decisions. In a similar way to the construction of the 'responsible women', women's ability to deploy power varied depending on whether they 'fitted' in with dominant frameworks or were trying to move away from them.

At the time of interviews, only two of the informants were childfree and neither of them stated that they had decided that they never wanted to have children. Consequently, whilst some of the women spoke about a 'right' and a

'wrong' time to have children, all of the women had an expectation that they would become mothers, although the strength of this expectation varied from a strong conviction to a vague feeling. This general expectation that women would become mothers at some point led to different feelings and attitudes towards contraception, as the following quotations illustrate:

Heleh — We do talk about it, but at the end of the day… it is like everything else, we talk, we discuss… he ask me how I feel about it, and I ask him, you know, how you feel blah blah… but at the end of the day, it is up to me to decide, he does not push me… but then when I, when we talked again in some ways I knew the answers, but it was joint, because I was not getting the blame for not getting a child…

Christine — Nothing on this earth would make me want to have another child. And I'm … the one thing I am more scared of is if I have… I meet a partner that hasn't got children. I would rather meet someone who has got children, and not want any more…. I really don't think I could go back to changing nappies, being up all night. I just don't think I can. And I see other people having children, and I think it isn't going to happen to me. I'm not child-minded at all, and I don't want grandchildren… I know that sounds sort of strange compared to other people, but I just think they are such a big responsibility for anybody…

In the first quotation, Heleh, who was childfree at the time of interview, is describing the discussions that she has had with her husband over contraception. Although Heleh stresses that it is up to her to decide, she states she felt it was necessary to discuss contraception with her husband because she did not want to be *blamed* for not having a child. Although the decision to use contraception is a joint one in this case, it is clear that Heleh feels that there is a general expectation that she should become a mother, and that she needs to enlist the explicit agreement of her husband in order to resist this pressure. In this case, I am not sure if the pressure to become a mother is

coming from a particular source, for example the wider family, or it is just from the general expectation within society. Yet it is clear that this pressure can affect women's contraceptive experiences.

The second quotation is interesting because although Christine is already a mother, she still feels threatened by the expectation of motherhood. She states that she is *scared* that a future partner will want her to have another child. At the time of interview, Christine was single and had an eight year old son. She was currently using Depo Provera and has used contraception continually since the birth of her son, even throughout long periods when she was not having sexual intercourse. As previously noted, Christine had stopped taking the contraceptive pill following the break-up of a relationship, and her son was conceived when they reunited, whilst she was waiting to re-start the pill. Christine was determined that this would never happen again, and this was why she continuously used contraception. Yet, what is also clear is that she felt she needed to justify her non-maternal outlook, in contrast to the presumption that babies are always welcome. Whilst her justifications may have been directed at me in particular, as a mother of three, she obviously feels that her decision not to have any more children could be a source of conflict in a future relationship.

Furthermore, the expectation that women will become mothers could also affect the attitudes of medical practitioners. During one observation, when a woman had come in for a consultation about changing her method, the doctor

seemed to assume that as she did not currently have children she would want to avoid any method that delayed the return of fertility. Although the doctor did discuss most of the available methods, she seemed to emphasise the length of time that 'normal' fertility took to return after cessation and spent far longer explaining methods with a shorter return to fertility than other methods. Yet at no point did she ask the woman concerned if fertility issues were important to her.

It was not just the expectation of motherhood that affected decisions about contraception but also notions of 'good motherhood'. Although in relation to themselves the women only really spoke of the 'right time' to become mothers, they sometimes made reference to others in order to illuminate the contrast between 'right' and 'wrong' motherhood. Judith stated that 'I planned to have children later… not when I was seventeen… I wanted to live and do everything, and have children later, which I did'. Bernadette expressed similar views when she said:

> I wanted to be able to have a family when we knew we were both ready for it. We wanted to get married, we got married and ummm… actually I don't think my husband would have minded if I got pregnant in any stage of our relationship, not at all. Me, I wanted to be married.

In this extract, Bernadette clearly feels that it is important to be married before having children, although how far her husband expressed similar views is unclear; the suggestion is that being married was not such a central requirement for him.

Whilst having a certain standard of living was not specifically referred to by any of the women I interviewed as a condition of 'good' motherhood, one woman did describe an acquaintance as being able to dress her children 'all in Next' as evidence of acceptable motherhood. Of course whilst the 'right' time to become a mother is at some level individual, certain elements reflect wider notions of 'good motherhood'. Teenage motherhood and/or lone motherhood are both stigmatised (Mann and Roseneil 1999) and were both singled out by many of the women I interviewed as being situations that they had wished to avoid.

The ideologies of the responsible woman and good motherhood are examples of how general interpretative frameworks constitute part of the women's subjective power when making contraceptive decisions. As young women they constructed themselves as 'responsible' to distance themselves from other 'irresponsible' women, and they continued to use comparisons with 'other' women to justify their own actions. Notions of good motherhood are also important and women who conform to these dominant values are likely to feel enabled. Women who reject specific ideological frameworks may feel constrained, yet rather than occupying a powerless position, they are more likely to put emphasis on other areas when explaining their position. The deployment of subjective power is a creative process which allows people flexibility to gain strength from different ideologies. Thus women may play down the importance of 'good motherhood', and draw strength from 'responsibility' or redefine the boundaries of 'responsibility' in order to justify

their position. Whilst these two are not the only ideologies that may affect women's deployment of subjective power, they appeared to be the most pervasive during the interviews, and thus are a significant constituent of women's ability to deploy subjective power.

Force: Constraints on Subjective Power

Although Cooper (1995) defines force as the use of physical or psychological violence to produce certain action, here I am using this mode in a broader sense, considering levels of coercion. Consequently, force is understood as the ability to remove some or all of an individual's capacity for subjective power, however exercised. Whilst none of the women I interviewed could be said to have been physically forced to use, or not use, contraception, there were examples of when physical or psychological violence had led to particular contraceptive decisions. First, I will consider the most obvious cases of force, whereby women's experiences of domestic violence and rape led to specific contraceptive decisions. I will then discuss less obvious examples of coercion, where women's ability to deploy subjective power was reduced.

Contraception and Violence

As previously noted, three of the women I interviewed either reported or appeared to have experienced domestic violence or rape. The case of Janice is the only one where a contraceptive decision was directly related to the use of physical force. After being raped by a neighbour, Janice sought the morning-after pill. Here we can see the most obvious link between force and

contraceptive decisions, but physical force is not the only form of coercion that can reduce women's ability to deploy subjective power.

In the two cases linked to domestic violence, although the women did not report any coerced decisions, I would suggest that abusive relationships did affect their contraceptive decisions. Rebecca, who eventually left an abusive marriage, described her husband's behaviour as 'controlling'. She stated that:

> he tried to control me, and pressuring me… it was just too much, it was horrible… it takes away your identity… it takes away your strength…[…] I felt I had to answer to him… or I wouldn't get things right… and he found fault with everything… it was just too much.

Throughout most of their relationship, they had relied on his vasectomy for contraception. He had had the operation after the birth of their second child, when they were both in their early twenties. Whilst Rebecca was grateful that this had meant that she had not had to use any form of contraception herself for a long period of time, she also stated that it had been 'mostly his decision'. In hindsight, she suggested that her husband's decision to have a vasectomy was indicative of his construction of her as 'useless', and a way to exact control over the relationship. In this case, he removed her ability to make decisions about her fertility within their marriage.

For Mary, the situation was different in that she reported her partner's behaviour as difficult, but she did not see it as abusive. Yet throughout the interview I felt that there were signs that she was able to deploy very limited subjective power. During my observation at the clinic, Mary had seemed very unsure and subdued. She had gone to the clinic for a consultation and left with

a range of leaflets to help her to finalise her decision. At the subsequent interview she had not finally decided to go ahead with any particular method, and had been relying on withdrawal for a few years. She did not live with her long-term partner, and described their sexual relationship as intermittent, although they did have almost daily contact as he took the eldest two of their three children to and from school. It was at the end of the interview that she described the 'difficulties' in her relationship, and that she really wanted them all to live together as a family. She stated that her partner would not agree (although she did not tell me why) but also that 'he would like another child, but I want us to be together if we do that…'. Whilst her visit to the clinic did not appear to be secret, as she reported that she had discussed it with her partner, I would suggest that when her actions are set in the context of her relationship they illustrate both the constraints and capacities of her subjective power. Her decision to seek contraceptive advice at this stage of her relationship was perhaps her way of signalling her intentions to hold out for co-habitation before becoming pregnant again. Yet having taken this step she had not yet been able to go through with a contraceptive decision due to the 'difficult' relationship she had with her partner. In this case the mode of force constraining her deployment of subjective power was not dissimilar to some of the more indirect pressure that other women felt.

Pressured Decisions and Male Authority

Both Rebecca and Mary spoke of 'difficult' relationships with their partners, and I have indicated how this may have affected their deployment of

subjective power over contraception. Yet although both of these relationships appeared to be abusive, the impact that they have had on the women's contraceptive choices is very similar to the descriptions many of the other women gave.[19] None of the women were directly compelled into any contraceptive decision, and indeed contraception was always seen as women's responsibility. Yet the women could feel under pressure from their partners to make specific decisions, and when partners became involved their preferences often took precedence. This can be illustrated from the interview with Donna.

Donna had been married for several years and, at the time of interview, had a four-year old daughter. She and her husband had a history of fertility problems and she had been 'absolutely astonished' when she became pregnant with her daughter, as they were on the waiting list for fertility treatment at the time, having been told that there was 'no chance' of conceiving without treatment. During the interview, Donna told me that they were currently using withdrawal as a method of contraception, but that her husband was going to have a vasectomy. Early on in the interview she stated:

> we decided to stop trying for children, we kind of set ourselves a target, and we... we sort of drew ourselves a line... and we thought that we wanted to be 100% sure about a vasectomy... before we went for it... have no regrets, it is too late once it is done. We are lucky that we have one [child].

However, in a later part of the interview she told me:

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[19] Whilst it cannot be assumed that all the other relationships were non-abusive, the women portrayed them as such, and thus these are descriptions of what the women considered to be 'normal' pressures.

Donna I would have been more keen to have another child…[…] he is the one who has advocated this withdrawal… he is the one who is more concerned… he doesn't think… you know, it is more me that is hankering… […] I think he feels that he is getting too old to be a father… […] he wouldn't expect me to… say have a sterilisation, because I don't agree with, I wouldn't have a sterilisation because that is too final…

INT ok… so that's too final for you…ummm… but if he has a vasectomy that is final for you isn't it?

Donna …ummm…. [*very quietly*] But I think he feels he is too old to be a father.

Throughout most of the rest of the interview, Donna had stressed her responsibility for contraception, although she did stipulate that once she was aware of her fertility problems she had not needed to use it. Yet it also appears that she felt under pressure to concede to her husband's point of view, and that contraception was an area of conflict. Although she had stated that the decision to stop trying for another baby was a joint decision, her later comments indicate that this was much more her husband's idea than hers. It appeared that Donna would have really liked to leave the possibility of another child open, by not using contraception, although she realised that there was only a very slim chance that she would conceive. However not only did she seem to feel obliged to go along with her husband's point of view, as the methods of contraception used, withdrawal and possible vasectomy, were outside her control, her ability to deploy subjective power was limited.

In the above case, the decision to stop trying for another child appeared to have been made by Donna's husband, and she only agreed to it reluctantly. Several other women also mentioned disputes over decisions as to whether or

not to try for a baby. For example, Sonia stated that when she was taking the contraceptive pill she wanted another baby and her husband did not, and so she made him responsible for reminding her to take it as, 'I didn't want him blaming me if I forgot'. In most cases it appears that there is an implicit assumption by male partners that contraception will be used, unless a discussion takes place to indicate otherwise, although the choice of which particular contraceptive technology is usually the woman's own decision.

It could be argued that the decision to become parents should be a joint decision, and thus a decision to stop or start using contraception should also be joint, and if the couple do not agree then perhaps the option to prevent pregnancy should be utilised. I would suggest that in common with many other areas of women's lives, women routinely have less authority than men. Thus they commonly decide which form of contraception to take, but are less likely to be able to overrule their partners preference in any decision about using or not using contraception. It appeared that whilst most of the time the women were in tacit agreement with their partners over contraception choice and use, when disagreements arose the women felt under considerable pressure to accept their partner's point of view.

In chapter 7, I described Karen's descriptions of her partner's 'grizzling', and how this had contributed to her changing her method of contraception. Although Karen's is the only detailed account of such a verbal strategy in relation to contraception, other comments were made by the women that

indicated this was not an uncommon situation. In Meadows' (2001) study of sources of contraceptive knowledge she found that whilst male partners were reported as usually silent about contraception, women could discuss their partner's preferences with ease. Like Meadows (2001), I found that direct conflicts were rare and contraceptive discussions minimal. However, there is evidence that women are well aware of their partner's preferences, and that women routinely make choices from among the narrower range of options agreeable to their partners. This evidence suggests that the 'male-in-the-head' that Holland *et al* (1998) found structured young women's experiences of heterosexuality, continues to impact on older women's contraceptive decisions.

Consequently, although here I found no evidence of enforced contraceptive decisions, this does not mean that the women made a 'free' choice either. Within individual heterosexual partnerships, men did constrain their partners' choices, albeit often in an indirect way. Furthermore, within accounts of disputes over issues of fertility, all the examples were of male partners' overruling women's wishes, and thus I would suggest that the gendered nature of authority may also constrain women's ability to exercise subjective power. Whilst force as a mode of power works more directly, women are also constrained through the varied disciplines surrounding contraception.

Disciplining the Fertile Body

In this section, I will consider the different disciplinary regimes that affect women's ability to deploy subjective power. I will begin by looking at how the medical disciplinary power is institutionalised. I will then show that the different sites where women access or use contraception each have their own disciplinary regime. Although the clinic and GP surgery are both spaces where medical power is exerted, they operate in different ways. The other disciplinary site to be considered is the home. Within long-term relationships, the home is likely to be a shared heterosexual space, and the extent of privacy within either a long-term relationship or from other family members may also discipline women's use of contraception. Another disciplinary regime stems from the embodiment of responsibility. Women discipline themselves to accept and use contraception, and a specific discipline is needed to use each particular method. Once they have chosen a method, they have to accept its disciplinary rules, or risk becoming pregnant. This will lead on to a wider discussion of the broader disciplinary regimes that constrain and enable women's ability to deploy subjective power using the example of the control that pharmaceutical companies exert over the range of contraception.

The Exercise of Medical Power

As many forms of contraception are prescription-only, doctors retain the ability to refuse particular requests and thus constrain women's choices. As detailed in chapter 5, three of the women interviewed reported that doctors

had refused to prescribe the form of contraception that they wanted, and I observed one doctor at the family planning clinic refuse another woman's specific request. Whilst I am not in a position to judge the clinical basis for any of these doctor's decisions, all of these women were aggrieved by their treatment. The women felt that the doctors had illegitimately used their power of prescription and were unnecessarily limiting their ability to choose.

All three of the women who related an account of a GP refusing their request had subsequently become family planning clinic users, although in only one case was this directly related by the woman to a refused request. Christine had been experiencing excessive bleeding, which she attributed to a problem with her IUD. She stated that she had asked her GP about changing to Depo Provera on more than one occasion, but instead had been prescribed medication to regulate her periods. On the advice of a friend, she then made an appointment at the clinic to ask for the injection, and she had been using it ever since.

In this case, although a doctor had initially constrained Christine's ability to choose her contraception, by changing her contraceptive provider she was able to overcome this constraint. Other women also mentioned changing GPs or contraceptive providers following particular dissatisfactions or because they anticipated better service elsewhere. Such changes have also been documented by Meadows (2001). However, although there was a possibility of circumnavigating medical power, this took time, energy, and authority, and

as Alex's case showed in chapter 5, sometimes women did not have these. Alex needed to start a new packet of contraceptive pills the following day, and when a locum refused her usual brand she had to either accept the brand on offer or stop taking the contraceptive pill for at least the next month. In Sharon's case, her lack of confidence in a GP contributed to her decision to rely on condoms rather than change to a different form of prescribed contraception. She stated that he was a 'strange doctor… […] he was a real old-fashioned doctor… I have got no faith in old doctors'.

Consequently, whilst the legal authority and legitimated expertise that medical practitioners have over prescribed contraception obviously affects women's ability to exercise subjective power over contraceptive choices, women can and do resist medical power. They can change their contraceptive provider, or switch to non-prescribed forms of contraception. However, whilst both of these strategies circumvent medical power, and may allow women to deploy greater levels of subjective power, they do not remove the institutionalised control that medicine has over many contraceptive methods. In contrast to many of the other power relationships, medical authority is enshrined in law and therefore its constraints on women's subjective power are ubiquitous.

Disciplinary Sites

In chapter 5, I illustrated that the different medical sites of the GP surgery and clinic were gendered. Whilst the surgery was seen as a masculine space, where 'proper' medicine, the diagnosis and treatment of illness, took priority, the

clinic was constructed as a feminine space for the sharing of contraceptive experiences. These differences had an important disciplinary effect on the interaction between health professionals and women users, and thus women's ability to exercise subjective power. In the surgery, the emphasis was on accessing a particular form of contraception, with a minimum of interaction. The women did not see GPs as having the time or inclination for longer consultations. The disciplinary regime expected was one that would be objective and strictly time-tabled, where women should know what they wanted so as to access it with a minimum of fuss. The spartan disciplinary regime of the surgery meant that women often felt unable to discuss in detail the choices in contraception. The notion that GPs were too busy with 'proper' illnesses could limit women's communication with doctors and thus this regime could affect women's ability to make informed choices.

In contrast, the clinic was described as a site where good communication was routine, and women felt happy making appointments just to talk through the different methods available. Yet, although the disciplinary regime of the clinic allowed for longer appointments, and more discussion, it still ordered bodies in particular ways. The appointments still consisted of questions and answers, and in most cases, some form of physical examination, ranging from blood pressure checks to internal examinations. Women were expected to comply with medical protocols, for example by making appointment on specific days of their menstrual cycle in order to change to a different method. Although most of the women saw the regimes as routine, some women were put off

specific methods due to the extent of bodily disciplines employed by the clinic. In her interview, Mary stated that she was 'put off' the coil, when she found out how many internal examinations were needed. The clinic's protocol for a new IUD fit consisted of a screening examination, the coil fit itself, a six-week check, plus recommended yearly revisits to ensure it was still placed correctly. For Mary, this disciplinary regime was not acceptable. Whilst women users can, of course, exert some subjective power over the disciplinary regimes, for example Mary could have had the coil fitted but not returned for the checks afterwards, they rarely have the power to overturn the regimes themselves.

The home is the final disciplinary site that may constrain or enable women's ability to exercise subjective power. Most of the women I interviewed were or had been in cohabiting relationships, and thus the home was the main space for heterosexual power relationships. Van Every (1998) argues that the social construction of gender is constituted through hegemonic forms of heterosexuality. Consequently, domestic living arrangements re/produce both heterosexual and gender relationships. For example, during her interview Katy told me that she would not let her husband buy condoms if they were out together, as she was too embarrassed. Her public reluctance to be seen with condoms can be associated with notions of 'respectable' sexuality. Yet, Katy took the responsibility within the home for keeping them out of the children's sight, and reminding her husband when he needed to buy some more. Her responsibility for maintaining the home included the monitoring of the

quantity and placement of condoms. Thus, although Katy avoids being publicly associated with condoms, the gendered division of contraceptive responsibility remains unaffected, through Katy's overall responsibility for them.

The above example also illustrates that some women feel a need for privacy for their contraceptive supplies. Whilst in Katy's case, she did not want her children to find the condoms, in other cases, particularly when women were younger, they had tried to ensure that parents did not find their contraceptive supplies. Whilst younger women were afraid of parental disapproval, the general need for privacy seemed to stem from a risk of embarrassment should the contraceptives be found, and a desire to keep their sexual relationship private. Consequently, the women either tried to organise their home in a way that their contraceptives were concealed, or chose methods of contraception that do not require any, or as much, management. As Katy highlighted in chapter 7, to use condoms 'you have got to know where they are' and thus we can see how the disciplinary regimes of family life and home can also affect women's subjective power.

Embodied Disciplines

In chapters 5 and 7, I have outlined the embodied nature of contraception. Not only are the technologies themselves embodied, but women also assume an embodied responsibility for them. In Howson's (1998) study of cervical screening, she found that women felt an embodied obligation to comply with

invitations to screening programmes. She asserts that normative femininity is open to scrutiny from the medical gaze and screening is one aspect of this. Increasingly the maintenance of health has moved from surveillance by others to self-surveillance, in which disciplinary power works through normalisation. Thus, Howson argues, the presentation of the rationale for screening invests the programme with a notion of responsible citizenship, and when this is coupled with normative medical scrutiny, compliance becomes an embodied obligation, although this does not mean it will be accepted uncritically.

As accessing contraceptive technologies is part of the medical management that Howson described, and a sense of responsibility in/forms contraceptive decision making, I would argue that the embodied obligation she describes could equally describe the disciplinary regimes of accessing contraception. Howson has stated that:

> Despite considerable ambiguities, anxieties and ambivalences, many women see themselves as moral agents who, by placing their own bodies under surveillance, also meet social expectations, or exercise social duty through the expression of what they see as rational action (1998:230).

In the case of cervical screening, the 'rational action' is the embodied obligation to comply. Moreover, most of the health promotion literature, from both feminist and traditional sources, sees compliance as beneficial, encouraging the notion that compliance is rational, the benefits outweighing the costs. Yet I, like Howson, would argue that it is the normalisation of embodied obligations that implies that compliance is a rational action, and as such it acts as a disciplinary power. Consequently, whilst the self-discipline

that women exert through their acceptance of the embodiedness of contraception may appear 'normal', it is this 'normality' itself that is exerting disciplinary power. Women's ability to deploy subjective power may thus increase or decrease depending on whether they are complying with or rejecting normative roles.

Methods as Disciplinary Regimes

Each specific method of contraception operates in a different way (see Appendix B for details of methods). Consequently, when women choose a specific method they have to discipline themselves to conform to its requirements. Indeed, a common theme within family planning literature is that very often women do not conform, and their non-compliance is considered to be a major problem, attributed either to ignorance or irresponsibility (for example see Edwards *et al* 2000 or Hawkes 1995). The disciplinary rules that accompany each method vary considerably. For example, to use Depo Provera a woman needs to attend a surgery or clinic for four appointments a year, and these appointments must fall on specific days, in order to ensure continuation of contraceptive coverage. To use a cap a woman needs to insert it, with spermicide, before sexual intercourse, and leave it in place for at least six hours afterwards, adding additional spermicide if intercourse takes place on more than one occasion during this time.

As well as having to access contraception in certain ways, or on certain days, and to follow the mechanical instructions that accompany each different

method, the regimes of different contraceptive methods can also have important effects on other aspects of women's lives. Most of the hormonal methods of contraception affect women's menstrual cycle, and thus women have to discipline themselves to deal with any changes. In some cases, the change might be welcomed and seen as an incentive to chose that method. Christine 'loved' having no periods with Depo, and Lucy described the contraceptive pill's regulation of her menstrual cycle as an important reason for her choice. Other women found the effects were disruptive or unpleasant. Sharon disliked the irregular bleeding pattern she endured with the mini-pill, and Charlotte reported that her periods became so heavy after an IUD was fitted that she had to organise her life round them. This is how she described the effect on her life:

> Well, I don't normally suffer at all, and some of my friend's periods are horrendous. I mean I don't really get... you know a severe like mood swing or pains, or heavy at all, I mean you would hardly know, it only lasts a couple of days, and it is great normally... But on the coil... I ended up wearing super-plus tampons, plus a pad and having to change no end of times in a day, and get up in the night and change, because the amount of times I have flooded in the night. And I thought I have brought all this on myself, you know, to think that, you know, I wasn't like this and I was having to think about occasions when like we were going out, and I was having to wear a long jacket, black you know, it was... it was starting to affect... well affect... my life really, and I brought it all on myself really. And I thought a minute, I don't want that. So er... in the end I had it removed.

Although this is an extreme example, it does illustrate how the effects of contraceptive technologies can have a broader impact on women's lives requiring self-discipline. In this instance Charlotte describes how the heavier

periods she endured as a side effect of the coil impacted on the rest of her life. First she had to ensure that she used much more sanitary protection than she was used to; not only did this cost more money, but it also meant that she had to plan the frequent changes, disciplining herself to organise her day and night with frequent visits to a toilet. She also had to consider what colour clothes to wear, choosing black to go out in case her sanitary protection failed. The concerns that Charlotte felt were doubtless intensified by the societal taboo around menstrual blood (Douglas 1980). As a consequence of the contraceptive technology she was using, she initially exerted self-discipline in changing the organisation of her time, budget, and wardrobe, until she made the decision that the disciplinary regime was unacceptable and she had the coil removed.

Throughout the interviews, most of the women expressed strong opinions as to which contraceptive regimes they found acceptable. Both the way each method had to be used, and its broader disciplinary effects, such as the need for medical appointments or effects on menstrual cycle, needed to be balanced with the many other factors involved. Whilst women can choose between the different methods, with their associated disciplinary regimes, women have to choose one of them if they are heterosexually active and wish to protect themselves from pregnancy and/or sexually transmitted infections.

Corporate Power Relationships

Many methods of contraception rely on medication and/or devices that have been developed and marketed by large pharmaceutical companies. Yet as I mentioned in chapter 5, the women I interviewed rarely considered this aspect in detail, other than an occasional claim that 'they' should refine the existing technologies to reduce the risks, or develop new ones with fewer problems. However, even if they do not directly consider it, the role of the pharmaceutical industry is implicated in women's ability to deploy subjective power.

As I have previously mentioned, contraceptive technologies are believed to be amongst the most profitable of pharmaceutical products (Sun, quoted in Russell 1999). If nothing else, contraceptive technologies have the potential to be used by a huge percentage of the female population for periods of twenty or thirty years, and this potential is not dependent on the diagnosis of an illness, disability, or any other health condition. Foster (1995) found that in 1993, when the British government considered excluding the more expensive brand of contraceptive pill from the NHS prescribing list, drug companies were quick to react. They claimed this would not only be a threat to research and development, but that they might also be forced commercially to 'pull out of the market' (*Doctor* 1/4/1993 quoted in Foster 1995:18). Whilst the threats had the desired effect, and the government did not impose a financial restriction on the brands available on the NHS, I believe that it would be highly unlikely for the pharmaceutical industry to have carried out this action. However, this

incident does highlight one of the ways that the drug industry is implicated within power relationships surrounding contraception.

Another important element is that although women make choices between methods, the range of methods available is determined by the contraceptive development industry. Moreover, in Britain, the industry does not market its products directly to women, but to their healthcare providers. Consequently, pharmaceutical companies' decisions as to the form that a new contraceptive technology should take are likely to be influenced by the potential appeal to the purchasers of the commodity, rather than the users of it. Wajcman (1991) argues that birth control became a major area of research during the 1950s as population growth was deemed to be a social problem. She further argues that the form of contraceptive technologies that were developed were influenced by the demands of population planners and the medical profession. Consequently, although women can choose to accept or reject specific contraceptive technologies, the extent of their choices is restricted by decisions made by the pharmaceutical companies, and further complicated by the complexity of a model of consumption in which, in many cases, the user is not the buyer.

Despite their control over the research, development and marketing of contraceptive technologies, pharmaceutical companies do face restrictions on their products. In Britain and the US, for example, medicines have to be approved by safety committees before they can be licensed for sale. In the US,

it took Upjohn, the manufacturer of Depo Provera, twenty-five years to get it approved for sale by the Food and Drug Administration, because of continuing public fears about its safety (Russell 1999). As I pointed out in chapter 6, the change in status of the morning-after pill was officially the decision of the Medicines Control Agency, although I would suggest that the timing coincided with a sympathetic government which had set itself a target to reduce teenage pregnancy (Social Exclusion Unit 1999). Women's ability to deploy subjective power over contraception is thus shaped by the range and means of access which are often determined by power relationships between the pharmaceutical industry, health care providers and the state.

Media Images as Technologies of Power

In this section, I will consider the role of the media in re/constructing contraceptive discourses, and the way this may also constrain or enable women's subjective power. In chapter 6, I looked at the media reportage of the deregulation of emergency contraception, and illustrated how the discursive construction of the morning-after pill user as young and irresponsible affected women's perceptions of both the deregulation itself and users of the morning-after pill in general. I outlined a symbolic difference constructed between responsible users of 'proper' contraception and the irresponsible, reliant on emergency contraception. My analysis of the media coverage highlighted the way that proposed change was constructed as a 'story', with protagonists from both sides quoted, and linked to other 'moral' issues and a general election that was assumed to be forthcoming.

The media can be understood as a technology through which power operates, in that it serves to re/produce categories of 'normal' and 'abnormal'. In the case of the morning-after pill, most of the papers utilised other 'controversial' social issues, such as the 'problem' of teenage pregnancy, in the construction of the story, which reinforced the 'abnormality' of users of the morning-after pill, highlighting a need for surveillance of this 'deviant' population. The media re/produced a new discursive category of women, the serial (ab)user of the chemist's dispensary, a woman who would repeatedly buy the morning-after pill. In constructing this category of women, it (re)defined the production of 'normal' and 'abnormality'.

Women who need to use the morning-after pill, and are considering accessing it through chemist shops, may be affected by this discursive construction. I have previously highlighted the embarrassment expressed by Charlotte in having to access emergency contraception at the clinic, and how this affected her ability to deploy subjective power. It is likely that the media re/construction of the morning-after pill (ab)user has further reinforced existing discourses, as well as highlighting the chemist as the main site of their transgression.

By using the example of the media reportage of the deregulation of the morning-after pill, I hoped to illustrate how the media is implicated in disciplinary power. By re/constructing the discourses surrounding particular forms of contraception and/or users, the media re/produces perceptions of

'normal' and 'abnormal'. If women conform to these norms this may strengthen their ability to exercise subjective power. A rejection of such norms may not necessarily lead to a powerless position, however, but instead to a need to look for alternative ways to support their contraceptive choices or justify their position. Whilst the media may not directly prevent or encourage a woman from making a particular decision, it is part of the social context in which the decision is made. Yet other more individual factors may also have an important role in constraining or enabling women's subjective power.

Psychobiography: Individual Lives in a Social Context

Notwithstanding the importance of the social context, women's ability to deploy subjective power over contraceptive decisions is also affected by specific circumstances within their own life history. Layder (1997) describes an approach that acknowledges this as one considering people as individual, as emotional beings, who respond to social situations and influences in different ways. A full picture of psychobiographical factors can never be obtained; I can only describe the factors that the women related to me during the interviews and many may not have been mentioned. Nevertheless, it is necessary to consider how life history events might influence women's decisions, even if our understanding may only ever be partial. Our psychobiography can be seen as a filter through which all our attitudes are formed.

Here I will use two examples to illustrate the effect of psychobiography in constraining or enabling women's ability to deploy subjective power. First, I

will consider abortion, and how this life history event may affect women's attitudes towards contraception and strengthen or weaken their ability to deploy subjective power. The second example will consider the effect of serious illnesses amongst family and friends, and how these variously influence contraceptive decisions. In both cases, I will show that the women re/act differently to similar events, suggesting that the impact on their ability to deploy subjective power is likely to be variable.

Abortion

The different attitudes that women in general have towards abortion could always be a factor in contraception choices. For example, women who consider abortion as an ordinary event may be happier to accept methods of contraception with a higher stated failure rate. In this section, I want to consider the way that undergoing an abortion may affect women's ability to deploy subjective power. Three women reported that they had previously terminated a pregnancy, and I am going to consider here both the effects on them immediately after the event and in the longer term.

Charlotte had terminated a pregnancy some years ago. She had discovered that she was pregnant just after her first husband had left her for someone else. She describes the situation as 'the worst decision of my life', but said she knew that she had to terminate the pregnancy, although she had always wanted children. It was obvious during the interview that even though this had happened years previously she still found it very upsetting. Charlotte described how following

the termination she lived in fear that she would never be able to have children, and how much she disliked the reminder caused by the routine recording of terminations on pregnancy medical notes.

Charlotte reported that at the beginning of her next sexual relationship she was really concerned that she did not become unintentionally pregnant again. However, later on, after she had married her new partner, the threat of pregnancy was not as acute. Charlotte and her husband have decided that they are happy with the two children they now have, and they regularly use contraception, and she does not feel as apprehensive about an unintended pregnancy should it occur, as her circumstances are now so different. Her abortion led her to re-evaluate contraception whilst she was single, but now she feels she is in a secure relationship, it is no longer such an important factor.

In many respects, Karen's story is very similar. She too had undergone a termination after becoming pregnant in an insecure relationship. As I have outlined in chapter 7, Karen was very concerned that she might become pregnant again, and had initially switched to using a diaphragm following her termination. This was not very successful, both because she did not have faith in its reliability and because her partner disliked it. Shortly afterwards she changed to using the contraceptive pill, despite her concerns about the heath implications. In this case, Karen's termination led to her acceptance of a contraceptive method that she had previously rejected because of its health

implications. She told me that in her current relationship (which was quite new) her partner had told her he was sterile, but that she would continue to take the pills until she saw a sperm count from the hospital, as she was not going to trust his word. Thus, Karen, like Charlotte, reassessed her attitude towards contraception in the immediate aftermath of her termination. As her abortion was far more recent than Charlotte's, I cannot compare the longer term effect.

In comparison, Heleh's termination did not appear to have had such a profound effect on her attitude towards contraception. Heleh had become unintentionally pregnant as a teenager, whilst she was still in full-time education. At the time she was relying on withdrawal as her main method of contraception, which, according to Heleh, was the most common method used by young people in Turkey at that time. Following her termination, she continued to rely on withdrawal until much later. She stated that although it would not have been easy to access a different method, she did not really consider changing, and it was not until well after she was married that she first considered prescribed methods of contraception. In contrast to the strong negative feelings that both Charlotte and Karen described, Heleh considered her experience as just unlucky. Whilst her different attitude towards contraception is obviously also shaped by her ethnic and cultural background, in this case her termination did not appear to have made her reassess her contraceptive options. Yet attitudes are shaped not just by personal

experiences. Events happening to those around us also shape our outlook on life, as the following shows.

Life Threatening Illness and Risk Assessment

Although all the women were aware that many methods of contraception carry risks to women's health, some of the women became more sensitive to this after family or close friends were diagnosed with life-threatening conditions. In this section, I will consider three cases in particular; the diagnosis of breast cancer in relatives of Martina and Charlotte, and a friend of Linda's who had deep vein thrombosis. Both of these illnesses have been associated with the use of hormonal contraception, but in the latter case it is widely accepted, whilst in the case of breast cancer it has been disputed by some medical researchers (Kaplan and Tong 1996)[20]. In each of these cases, the women re/assessed the risks of hormonal contraception in different ways.

Of all the women I interviewed, Martina was the most critical of doctors and of medicine as an institution. As I mentioned in chapter 5, she felt that doctors deliberately withheld information from women, and she mentioned health magazines as a preferable source of alternative information on the risks and health implications of contraception. Although she had previously used the contraceptive pill, following the birth of her second child she had switched to the coil, and she strongly believed it posed less of a threat to her health. During the interview, she mentioned that an aunt had been diagnosed with

[20] A review published by the World Health Organisation in 1990 dismissed the link between the contraceptive pill and breast, cervical or liver cancer (Kaplan and Tong 1996). However, the Family Planning Association Leaflet (undated) refers to a possible increased risk of some types of these cancers.

breast cancer and that she believed the contraceptive pill was a 'contributory factor'. As I mentioned in chapter 5, many women believe that they should limit the time that they spend on the pill, as a way of reducing the health risks, and in Martina's case this notion was accentuated by her aunt's illness. Martina took the assessment of risk very seriously, and her middle-class background and current circumstances allowed her to access a range of resources, including health magazines, the internet, and discussions with both conventional and alternative health practitioners, in coming to her conclusions. In this case, it was obvious that Martina felt very strongly about the risks of hormonal contraception, and had made a positive decision against using it.

In contrast, Charlotte's re/action to a family diagnosis of breast cancer was more complicated. As I have previously outlined, Charlotte had had a complex contraceptive history, including a termination. When we first met, she was attending the clinic for emergency contraception, following a condom failure. Her current reliance on condoms followed the removal of a coil after extensive bleeding. Charlotte's husband had agreed to have a vasectomy, but she was in a dilemma as to what form of contraception to use until then. She was very reluctant to return to using the pill, but she had found the cap as well as the coil and condoms to be unsatisfactory. This is how she describes her dilemma with the pill:

> My worry is, it had been in the papers, scares on the pill. Although I was on quite a low dosage, it still makes you think, ummm... You know, so I thought I would try another method, but... I am considering going back on it... I mean I had no problems on the pill and... as I said

> I never caught, it never let me down. But umm… my sister has got breast cancer at the moment, you know and you think all these things you put in your body… and you know, sun-beds and everything… and what's the pill done to your body and she gets breast cancer and it did put me off, … it did affect me. I do stop, listen and think.

Although Charlotte felt that her sister's breast cancer may be linked to using the contraceptive pill, she also felt that, in the short term at least, she had little alternative but to return to using it herself. Whereas Martina had only recently changed to the coil, and had not experienced any problems, Charlotte had had to have her coil removed, which narrowed the options available for her and may have influenced her assessment of risk. Both women reassess their attitude towards hormonal contraception following the diagnosis of breast cancer in family members, but while in Martina's case she asserts that she will not use it again, Charlotte may do as a short-term measure.

Not all women re/act in the same way to such a diagnosis in close friends or family, and their attitudes towards hormonal contraception may not change much. During her interview, Linda explained that a close friend had been diagnosed with deep-vein thrombosis two years previously:

Linda — My friend who worked at the GP surgery, she was on the pill, but er… she ended up with blood clots… That was about two years ago, I feel they should do more checking to make sure… they only give you a check up once a year don't they, I think that it should be done every six months, you know they should do it more often than they do

INT — Is she alright, your friend?

Linda — yes… yes.

INT — And did what happen to her change your opinion of the pill at all?

Linda ummm... it didn't with me, no. I mean it certainly, drastically changed their attitudes, both her and her sister, they have both made their husbands get sterilised. And my attitude is why be so extreme, you're both young couples, what is wrong with the coil... It's like... it seems extreme to me.

In this extract, Linda reports that although she thinks health checks should be more frequent for women using the contraceptive pill, there is no real need to reassess the general risks of hormonal contraception. She states that her attitude towards the pill remained unchanged[21]. Moreover, in this extract she appears to consider that her friend and her sister had overreacted, as they could have merely changed to a different form of contraception rather than *make* their husbands undergo vasectomies. The idea that a potentially life-threatening illness caused by one form of contraception could make women distrust the other forms is considered by Linda to be 'extreme'.

Linda is also reasserting the need for medical caution over contraception, by asking for check-ups more often. Yet in other parts of the interview she commented that she makes her own decisions, without advice from health practitioners. Linda's contradictory position represents the tension between ideas that contraception is not a 'medical matter' and the risk of health implications when using it. Whether her decision to change to the coil was directly related to her friend's experience is unknown. However, her dismissal of the sisters' decisions to persuade their partners to have vasectomies may

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[21] Linda changed from using the contraceptive pill to a coil, but was unsure of whether it was before or after this incident. She stated that she changed to the coil, because she kept forgetting to take her pill, and wanted a method she did not have to think about on a day to day basis.

have been influenced by a need to validate her own choice of the coil to women who did not consider it to be a viable option.

In each of these different cases women re/act in different ways to an association of hormonal contraception with life threatening illnesses. Their responses illustrate how individual attitudes can affect their ability to deploy subjective power. Martina feels very strongly about the association of the contraceptive pill with the risk of breast cancer, and this conviction is likely to strengthen her ability to deploy subjective power in minimising the risk to her health. Whilst Charlotte is also concerned about this potential risk, other factors have made her reassess her position, and thus she has less conviction in this area than Martina. In the final case, Linda stated that the diagnosis of deep vein thrombosis in a close friend did not alter her opinions of hormonal contraception, although she did feel that women should be monitored more regularly. Consequently, her friend's illness is less likely to have had an effect on her level's of subjective power, as she did not appear to feel strongly about the risks. Through each of these different reactions, we can see how psychobiography can act as a variable in women's ability to deploy subjective power.

It is clear that similar events within women's life histories can have different effects on their psychobiography. This variable nature of individual reactions to similar events illustrates the importance of considering psychobiography as a mode of power. Individuals reflect and draw on many life history events

when making decisions, and their personal attitudes and character will always be reflected in their ability to deploy subjective power in any given situation. A women like Martina, who feels very strongly that the contraceptive pill is linked to breast cancer, is much more likely to resist medical pressure to accept it. Despite her previous rejection of it, Karen accepted the health implications of the contraceptive pill, as she felt that the risk of another unintended pregnancy outweighed the medical risks of the pill. In Charlotte's case, we can see the complexity of some women's positions, and the need to balance conflicting elements within her decision. Whilst she was worried about the risks of the contraceptive pill, she had experienced severe problems with alternative methods, and her previous termination still affected the way she thought about contraception. As contraceptive choices are always made in the context of individual women's lives, psychobiography is an important factor in their ability to deploy subjective power.

The different modes of power sometimes support and sometimes conflict with each other. Women may need to trade off between different elements, and whilst some may find the outcome strengthens their position, others may not. Charlotte's case is an example of this. Her decision to have her IUD removed and rely on condoms was supported by drawing on narratives of the health implications of hormonal contraception, and the unacceptable embodied discipline that the IUD imposed. Yet when a condom failed, this resulted in a danger of being seen as 'irresponsible', due to her need for a morning-after pill. Whilst at the time of interview, she had not yet decided if she should restart

taking the contraceptive pill, it was clear that she was balancing the ideology of 'responsibility', with the psychobiographical event of her sister's diagnosis of breast cancer. Moreover, as many of the experiences and dilemmas that affect women's psychobiography involve emotion, it is also related to the emotional work women typically exert over contraception, and this is now considered.

Emotion

As I argued in chapter 7, women's sense of embodied responsibility often led to the performance of emotion work in contraceptive decisions. Contraceptive decisions are made in the context of many different emotional responses, and the emotional work performed within long-term relationships is just one aspect. Many of the ideas I have outlined previously, such as the need to establish themselves as 'responsible' users in order to distance themselves from other devalued women, and the notions of embodied knowledge and embodied responsibility, all have an emotional component.

The case of Karen illustrates the role emotion plays in women's ability to deploy subjective power. Earlier I described how her fear of another unintended pregnancy impacted on her contraceptive decisions. She described how despite her concerns about the health implications of the contraceptive pill, her lack of faith in the effectiveness of the alternatives meant she took the decision to go on the pill. She also described the emotion work exercised within heterosexual relationships surrounding contraceptive decisions. The

absent-presence of men in women's contraceptive decisions, and the tension that exists between women's sense of embodied responsibility for contraception and their ideas of equitable coupledom, both have an emotional impact on women's ability to deploy subjective power. Consequently, the role of emotions must be considered within women's ability to deploy subjective power, as it re/acts with and re/produces the other modes of power.

Resources

Under the NHS, women have free access to contraception and thus resources do not feature as significantly in British women's ability to deploy subjective power as it may do in many other parts of the world. This is evidenced by the feeling from some of women that a charge of £20 for the morning-after pill was prohibitive. If these women felt that an occasional payment of £20 would be difficult to pay, it is likely that if they had to regularly pay for contraceptive supplies their choices would be influenced by the relevant costs.

Yet despite the nominal free access, financial rationing within the NHS itself may have also affected the choices offered to women. The clinic where I carried out my observations stocked most methods of contraception. However, they were unable to stock the hormonal IUS due to the high cost. If a woman wanted to be fitted with the IUS she had to ask her GP for a prescription, and bring the IUS with her to the clinic to be fitted. The advantage of the IUS over the ordinary IUD is that it reduces the risk of heavy and/or painful periods. Several of the women suffered from excessive bleeding with IUDs, yet

changing to the IUS had only been mentioned to one of them. Whilst cost is unlikely to be the only factor involved, I would suggest that the relative cost of prescribing different methods may influence the range of options given to women by some health professionals. This cost is determined by pharmaceutical companies, who also deploy corporate resources in deciding which areas of contraceptive technologies they invest research and development budgets in.

Whilst only the expectation of primary responsibility for children was mentioned in the interviews, I would suggest that the material cost of raising children could also feature in the resources mode of power. Women may feel that they need to use a contraceptive method with a lower stated failure rate if they do not have, or do not feel they could access sufficient financial resources to pay for a child.

The interviews also revealed that cultural capital can affect women's ability to deploy subjective power. Earlier I mentioned Martina's dismissive attitude towards doctors. Martina stated that she always felt confident within medical encounters and she clearly felt that she was the intellectual equal of the doctor, even if they did not always recognise her as such. She felt it was imperative not to rely on doctors as a major source of information, and whilst she did talk to other women, she also relied on sources such as alternative heath magazines for information about contraception. In contrast, Christine relied on female members of her social network as her primary source of data. Whilst she was

also critical of doctors, Christine did not report being confident in medical encounters. Indeed she described being unable to convey her wishes to her GP, which resulted in her changing to the family planning clinic in order to access the method of contraception she wanted. In these cases, Martina's cultural capital arising from her middle class background appears to give her confidence in medical encounters, whereas Christine's description of her relationship with her GP is much more circumspect; whilst she did not necessarily feel unequal, communication was strained and she was unable to convey her opinions. The differences in cultural capital that she experienced between herself and the doctor left her unable to exert sufficient subjective power to access her chosen method of contraception through her GP. Having changed contraceptive provider, she successfully accessed her chosen method which demonstrates not just the variable levels of subjective power in different contexts, but also how constraints may be worked around rather than directly confronted.

Conclusion

In this chapter I have explained the complexity of power relationships through separating the different modes and sites of power: ideology, force, discipline, technology, psychobiography, emotion and resources. Each of these re/acts with the others to re/produce a polysemic model of subjective power that women deploy within a particular time and space. The ideologies of the responsible woman and the good mother are drawn on or subverted, and re/inforce the social context of reproductive decisions. Violence or coercion

directly constrains women's ability to deploy subjective power, but indirect pressure and male authority within heterosexual relationships may also limit their decisions.

I have outlined the different disciplinary regimes that act to constrain or enable women's subjective power. The medical profession retains power over prescription, and although women can exercise strategies to circumvent medical power they cannot remove its institutionalised basis. Disciplinary regimes can operate through specific sites, such as the GP surgery, clinic or home, or they can be embodied through responsibility and specific technologies. Whilst many of these act at the level of individuals, broader disciplinary regimes such as the role of pharmaceutical corporations set the context of contraceptive decisions. I have also used the media to highlight a technology of power by drawing attention to its role in the construction of discursive categories which frame the context of women's contraceptive experiences. Looking at psychobiography and emotion recognises the individual within the social context. Whilst the experiences of life-threatening illnesses and abortion may be constructed within specific frameworks of meaning, individuals may respond to them in different ways and this will affect their ability to deploy subjective power. Finally, access to resources can also affect the deployment of subjective power. This can be on an individual basis, such as having confidence within medical encounters though cultural capital, or include the decisions made by pharmaceutical companies to place corporate resources in the development of certain forms of contraception.

Although a focus on subjective power may appear to privilege the way individual women balance complex power relationships, the context of their decisions is always informed by the wider social, political and economic of contraception.

By analytically separating these modes and sites of power, I have demonstrated how subjective power is re/formed and re/produced through the intricate and multi-faceted web of power relationships. It shows how women draw from discourses and resources to manage their reproductive lives. It recognises that individuals exercise agency within the social context, and considers the complexity of power relationships in order to understand women's contraceptive experiences.

Chapter 9

Conclusion

I suppose probably contraception is mainly a woman's thing...(...) and I think that is indicative of the types of contraception available, because they are mainly for women... and I think it is something that women have to feel 100% comfortable with, or confident with... and to be able to get it easily (...) it's about being in control of your own destiny, your own body... (Patricia)

In the above quotation, Patricia highlights both the embodied nature of contraception and its centrality in many women's lives. Whilst modern contraception is seen in popular opinion to hold out the promise of freedom and control, this thesis has argued that women's experiences of contraception are re/formed and re/produced through a complex web of power relationships. Moreover, it is only by considering the intricate and multi-faceted webs of power relationships that we can begin to achieve understanding of the complexity of contraception. Focusing on women's ability to deploy subjective power reveals the way individual women balance complex power relationships within the context of the wider social, political and economic frameworks within which contraception is embedded.

This thesis has considered the many interrelating discourses that surround contraceptive usage, for example the need for the women to construct themselves as responsible users and the symbolic difference between 'proper' contraception and the morning-after pill. Yet these discourses are not static and women can make strategic and creative use of them to both strengthen

their subjective power and justify their actions. The action of going on the pill as a young woman was framed by my respondents as being responsible, as evidence of maturity, rather than sexual irresponsibility. Yet circulating discourses also constrained the women. The association of sexually transmitted infections with deviance meant that the women rarely practised safer sex, leaving them at risk of infection. By using the model of subjective power, this thesis has been able to consider the effects of such discourses on women's experiences of contraception.

Contraception is an embodied technology. Not only does it physically operate through women's bodies but also the need for contraception arises through women's embodied sense of responsibility towards the risk of pregnancy. The intertwining of embodied technology, risk and responsibility is important in the construction of contraceptive knowledge. Women health professionals are constructed by my informants as experts on contraception through a presumption that they will be contraceptive users. Consequently, (male) doctors are often not assumed to be able to give advice and this adds weight to the conviction that contraception is not really a 'medical matter'. The construction of GP surgeries and family planning clinics as gendered spaces arises out of and reinforces such perceptions. The concept of 'embodied expertise' may be relevant to other health consultations, and I believe warrants further investigation.

The women typically expressed ambiguous feelings towards the health risks of contraceptive technologies. Most of my informants had experienced side effects from contraceptive technologies; and although some of these were viewed positively, such as preventing menstruation, more often they were considered as the disagreeable penalty that had to be paid to achieve control over fertility. Whilst the depth of knowledge varied, all the women were aware that there were associations between some forms of contraception and serious health risks. The passage of time emerged as an important element both for the women's understanding of the risks and for their strategies to reduce exposure to them. An ideal of scientific progress was invoked leading to the assumption that the technologies would be improved in the future, or that the full impact of different contraceptive technologies would become apparent, and so 'new' methods of contraception should be avoided. Women also tried to minimise their exposure to any health risks by reducing the time they spent using hormonal contraception in particular. They constantly tried to balance the need for contraceptive efficacy with the possible effects on their health. Over the course of women's lives the relative weighting of efficacy and health risks seemed to change, with the possible health risks gaining in importance as women moved into their thirties. Whilst further research would be needed to generalise these findings, I would suggest that these type of attitudes towards risk may be found in other users of contraception, and perhaps similar health technologies such as hormone replacement therapy.

The symbolic difference between the morning-after pill and other forms of contraception is based on when the contraception is used. The media coverage of the deregulation of the morning-after pill further enforced the division between it and 'proper' contraception. The newspapers constructed the story as a 'moral' issue and produced an image of a typical (ab)user as a young woman having promiscuous sex and regularly using emergency contraception. However although the women I interviewed following the announcement were aware of this reading of the media coverage, but they did not accept it uncritically. Most of the women discussed the deregulation in more complex terms, and many felt that on balance this service was acceptable.

Men appear as an absent-presence within the women's accounts of their contraception experiences. Although they assert that they have all or most 'control' over contraception, and that they rarely discuss contraception with male partners, it is clear that many of the women are aware of their partner's preferences and often make decisions based on this. Moreover the women respondents often feel a conflict between their right to bodily autonomy and the expectation of equitable coupledom within long term heterosexual relationships. This is further complicated by the complex relationship between sexual practices and contraception. The women made specific contraceptive choices in the expectation of sexual activity within a particular form of heterosexual encounter. Moreover whilst the type of contraceptive technology chosen is related to these factors, sometimes the technologies themselves had a

direct effect on subsequent heterosexual practices. So, for example, the 'inconvenience' of using a cap (in comparison to the contraceptive pill) may reduce the frequency of sexual activity. I would argue that theories of heterosexuality need to pay more attention to the centrality of contraception in structuring heterosexual practices, and this is an area which could be usefully explored further.

Contraceptive decisions are further complicated by the women's prevailing attitude towards the risk of pregnancy. Whilst all the women had times when they definitely did not want to become pregnant, few of my informants discussed 'planning' a pregnancy. The women's feelings seem to continually ebb and flow, and they were more likely to downgrade their pregnancy prevention strategies rather than ever experiencing a decisive shift between 'preventing' and 'planning' a pregnancy. The lack of attention given to mid-life women's contraceptive experiences may stem from an assumption that becoming unintentionally pregnant would not be as problematic in comparison to younger women. Whilst this may be true for some women in this age group, it is not true for many others. In addition, whilst the potential risk of pregnancy was a constant feature of the women's contraceptive decisions, the risk of sexual transmitted infections was rarely considered, and despite the admittance by some of the women of sex with multiple partners, none of the women took this issue seriously.

The age of women researched in this thesis is likely to be a significant factor in their attitudes towards contraception. When this generation of women became sexually active, contraception was freely available (at least to those over 16) and the contraceptive pill in particular was widely considered to be safe and effective. It was only after they became users of contraception that hormonal contraception was publicly linked to long-term health concerns such as an increased risk of cancer. In addition, most of the women interviewed were already contraceptive users when the risk of sexually transmitted infections began to be acknowledged as campaigns around HIV/AIDS were begun. Thus at the time that these women began using contraception, the contraceptive pill was seen to be the safest option, and was generally recommended as such. Consequently, this cohort of women have a particular relationship with hormonal contraception, that women in other generations may not share.

Using the model of subjective power highlights the complexity of power relationships re/produced in women's contraceptive experiences. It draws attention to how power operates at an individual level, and aimed to achieve a better understanding of how the different modes of power interact to constrain or enable particular actions. It considers how the wider social context, such as specific ideologies or disciplinary regimes, structure individual's decisions, whilst retaining a focus on their agency. It also recognises the individual

within the social context by drawing attention to the role of psychobiography and emotion as important elements within power relationships.

Consequently, the model allows us to recognise the fluid nature of power relationships. It highlights how individuals may creatively work around structures, rather than confront them head on. Whilst ideologies do create 'norms' and expectations, women can work to actively redefine their meanings, to place themselves in a more powerful position or justify their actions. However this may also serve to reproduce rather than undermine existing discourses. Women may circumvent medical power by changing their health care provider, but few of them challenged the institutionalised power of medicine itself. The model also allows us to consider that whilst women may have day-to-day control over contraception, they do so within the gendered power relationships of heterosexuality. Men's power over contraception often lies in unspoken assumptions. For example, it is assumed that women will use a method with a low stated failure rate, unless it has been agreed otherwise. Whilst women are often complicit in accepting these assumptions, they also take other factors into consideration when making contraceptive decisions. Women's subjective power over contraception varies according to the relative strengths of the different elements, and the levels are in constant flux. Using the modes of power as an analytical tool allows us to see how subjective power is re/formed and re/produced through conflicts and congruencies within individual women's lives.

Whilst the model of subjective power recognises that individuals exercise agency within social contexts, it is less successful at interrogating the nature of these wider structures; its focus on the individual draws attention away from wider structures of inequality. In order to fully understand the polysemic nature of power we need to consider how it is deployed at all the different levels. I believe the model of subjective power is a useful tool in drawing attention to the myriad of ways in which power re/produces women's everyday contraceptive decisions. However, it is less successful in measuring the relative importance of the various factors, although it is clear that women often need to balance conflicting or contradictory constituents.

The model was also unable to fully explore the modes of psychobiography and emotion in this study. Within the interviews themselves these areas were not fully explored, partly due to my own hesitancy in some cases, and partly because the women themselves were less forthcoming. For example, whilst the women were often candid when discussing consultations with doctors, they were less forthcoming about any 'negotiations' with their partners, particularly current relationships. These areas are also less well theoretically developed, so there are fewer conceptual tools available to aid the analysis of data. Yet these areas are clearly important and future work concentrating on them could be very productive in furthering our understanding.

Consequently whilst the theoretical framework did go some way in combining the wider social context that structures the women's experiences and the individualistic elements of psychobiography and emotion, in this study this is underdeveloped. Any future study using this model would need to both develop tools to more accurately balance the different factors, and to give greater importance to the individualistic areas within the data collection stage.

This study has shown that contraception remains a complicated issue for women in their thirties, and that many of them value the specialist services provided by family planning clinics. The current policy emphasis on the 'problem' of teenage pregnancy has meant that some resources have been redirected towards younger women. In some areas, family planning clinics are now only providing services for those under 25. Yet older women face many of the same dilemmas as their younger counterparts. The loss or downgrading of specialist services for older women may limit their ability to confidently discuss different options, and thus restrict their choices or possibly even lead to more unintended pregnancies.

Another important issue raised by this research is the lack of attention given by the women to the risks of sexually transmitted infections. Many of my women informants had changed sexual partners during their late twenties or thirties, yet rarely did any of them practice safer sex. Statistics showing the trend for later marriage and current divorce rates gives evidence of a need to

promote the safer sex message across a wide age group. Whilst I have not directly researched this area, I suggest that health promotion campaigns may need to consider the way the message is delivered for different age groups. Amongst the women I interviewed, condoms were not really seen as 'proper' contraception, and using them did not easily fit with the embodied responsibility to prevent pregnancy that the women feel. The continuing association between sexually transmitted infections and deviance also needs to be addressed, or it will continue to allow the 'respectable' to distance themselves from risk.

Women have long been defined by and through their ability to reproduce, and this has also been used to justify their subordinate status. The advent of modern contraceptive technology was hailed as a freedom for women, allowing them to control their fertility, rather than being defined by it. Contraception does give women a feeling of control over their lives, as Patricia puts it; *'control of your own destiny'.* Yet women's ability to exercise agency over contraception is re/produced by multi-faceted power relationships. However rather than seeing these relationships as a definitive list, I would argue that we need to understand that it is complexity itself that defines women's contraceptive experiences.

Appendices

Appendix A

The Women Interviewed

GP recruitment

Clare is white British and was 32 years old at the time of interview. She is married with two children aged 5 and 9. She described herself as lower-middle class, she works part time as a playgroup assistant and cleaner, but stated that they are struggling financially. She has only had one sexual partner, and has used the contraceptive pill most of the time. Clare is Church of England and although not a regular churchgoer, feels that she is quite religious. She believes that life begins at fertilisation and generally disapproves of the morning-after pill and abortion, although she admits that in exceptional cases it might be necessary.

Donna is also married. She is 31, has a 4 year old daughter, and describes herself as white Irish descent. She is Catholic, and has just returned to full-time work as a district nurse. She describes herself as working-class, and she says although they do not always struggle financially, they tend to live to their means. Donna has a history of infertility, and was on the waiting list for treatment when she conceived their daughter. Before she tried for a baby she had used the contraceptive pill, condoms, safe period and the cap. After the birth of her daughter, they did not use contraception and she had been hoping for another pregnancy. Recently, her husband has started to use withdrawal, and they have discussed whether now is the time to give up trying for another child.

Heleh is a Turkish Muslim aged 34 who has been permanently settled in Britain for about ten years. She holds dual nationality. Heleh attended university in Turkey and has a degree in electronic engineering, although she says she never enjoyed the subject and has never worked in the industry. She works full-time in hotel management, and she states that she and her husband

have a reasonable income. Heleh got pregnant while still a student and had an abortion. The couple do not have any children, but Heleh states that she is still undecided if they will in the future. Heleh is currently relying on the safe period, although she has used both the contraceptive pill and condoms in the past.

Janice is married, aged 39 and has two children aged 13 and 15. She stated that she was white English, and working-class. Janice originally trained as a nurse but now works full-time as a medical sales representative. She described their financial situation as very comfortable, although this in part is due to her husband inheriting some money recently. Janice's husband has had a vasectomy, but prior to this she had used both the combined and mini-pill, condoms and a coil. Janice also had to take a morning-after pill after she was raped.

Joan is 35 and a Baptist. She is currently in a long term relationship but not co-habiting. She has a 10 year old son, who lives with her half the time, and the rest of the time with his father. Joan has also always worked in the care sector, and is currently a part-time team leader in a residential home for older adults. Joan describes herself as white European, although she is of British origin. She stated that she is middle-class, although by level of education, income and occupation she would be classified as working class. Joan currently uses condoms or withdrawal as her methods of contraception. Previously she has also used the contraceptive pill, the rhythm method and the morning-after pill.

Judith is 31 and has 2 year old twins. She is cohabiting, and her partner has a 7 year old son, who stays with them frequently. She describes herself as white British, and working class, and works part time as a self-employed hairdresser. She describes their financial situation as reasonable. Judith has used a variety of contraceptive methods, including the combined and mini pill, condoms withdrawal and the morning-after pill. She became pregnant after she switched

to using the Persona system, and following the birth of the twins she has been relying on the IUS.

Katy describes herself as white, English and working class. She is 34 and is married with two children aged 6 and 9, and stated that she doesn't want any more in the future. She works full-time in day services for adults with disabilities, and stated that she has always been in this line of work. She thinks they have a reasonable standard of living. Katy has used the combined and mini pills, withdrawal and the safe period, although they are currently relying on condoms.

Lucy is 31, married and her daughters were aged 3 and 9 months at the time of interview. She also has a 17 year old step-daughter who stays regularly, and has lived with them in the past. Lucy is undecided about having any more children, although she stated that her husband was against it. She describes herself as white, British and working-class, and following her BTEC national in business and finance, she has always worked in the same bank. She now works part-time in their call centre, and fits her shifts around her husband's engineering technician shift-work. Lucy describes their financial situation as okay, but she says they have expensive tastes. Lucy's main method of contraception is the pill, although she has used condoms when she has forgotten to take it.

Rebecca is 38 and has two children aged 17 and 18. She has separated from her husband and is currently living at her parents' house while she attends university for a Masters degree. She is struggling financially, and her main income is currently maintenance payments from her ex-husband. She left school at 16, and did a variety of jobs before returning to education as a mature student. She describes herself as white, British and working-class. Rebecca has used a cap and condoms in the past, although for many years she relied on her husband's vasectomy. She describes her husband as being psychologically abusive towards her, and as she has not had any sexual

activity since she left the marital home, is not currently using any form of contraception.

Shui is 37, and is from Taiwan. She is married with two children, aged 2 and 5. The family have been in Britain for four years due to her husband's occupation and they are planning a return to Taiwan in the next few years. She describes her circumstances as financially secure, and she does occasional work as a freelance translator. Shui has used condoms mainly, although she has needed the morning-after pill on occasions. According to Shui, condom use indicates that a husband is a considerate person who values his wife, and generally amongst their Chinese friends, most other methods are considered as detrimental to women's health.

Sonia is 39 years old, and describes herself as white, British and working class. She is married with two children aged 14 and 15 and works as a doctor's receptionist, and describes their situation as reasonable financially. They can pay for things they need but not everything they would like. Sonia suffered from prolonged and painful periods for years. She was diagnosed as having endometriosis, she underwent a hysterectomy, and suffered from some complications following the operation. Until her operation, Sonia mainly used condoms. She tried the combined and mini contraception pills, and Depo, but these were all unsatisfactory due to side effects.

Clinic recruitment

Alex was living separately from her husband at the time of interview, and stated that they were working on their relationship. She is 33 and has three children aged 13, 6 and 3. Alex described herself as white, British and working-class and her religion as Church of England. Alex normally works full-time in light engineering, but was on sick leave due to depression. Alex had used the contraceptive pill and condoms, and when we met was having swabs taken to enable a coil to be fitted.

Bernadette is a full-time secondary school teacher. She is 39, and had been widowed the year before. Bernadette has two children aged 6 and 5. She is white, Irish, Catholic and she said she came from a working-class background, but she thought she would be considered lower middle-class now. Bernadette has a coil fitted, and has previously used the combined pill, condoms, withdrawal, rhythm method and emergency contraception.

Charlotte is married, 37 and has two children aged 5 and 10 months. She works part time in an administration department. Charlotte stated that they often struggled for money, although at the time of interview they were just extending their kitchen. Charlotte is Catholic and stated that she was working class and white British, although her parents are Irish. Charlotte is currently relying on condoms, although we met when she needed emergency contraception. Previously she had used the combined pill, condoms, cap and a coil. She also told me that she had had an abortion several years ago, and how although she knew it was the right decision, it still upset her to think about it.

Christine is a single mother with an 8 year old child. She works part-time in a supermarket, and says that she can manage on her income and benefits. Christine described herself as British, but of Italian descent. She is 35 and stated that she is working-class and Catholic. Christine currently uses contraceptive injections. Previously she has used the combined pill, condoms and a coil.

Karen has just started a new serious relationship, although as they live some miles apart, they do not see each other very often. She is currently sharing a house with friends. She is 33 and describes herself as white, English and probably lower middle-class. Karen is a Taoist, and although she usually works full-time as a graphic designer, she is currently on sick leave due to depression. Karen has a BA in design and has always worked in this area, although she said that her income is quite low as she works in the public rather than private sector. Karen is undecided if she wants to have any children in the

future, and currently uses the contraceptive pill. Previously she has used condoms, cap, withdrawal and the rhythm method, and has also had an abortion.

Linda is 30, married and has two children aged 9 and 3 months. Her eldest child is from a previous relationship. Linda was not in paid employment at the time of interview, but usually works in catering. She thinks that their financial situation is reasonable considering they have just moved house and have a new baby, but they live in one of the poorer areas of the city, and their house was poorly decorated with mostly older furniture. Linda described herself as white, British and working-class. When I met Linda, she was trying to have a coil fitted, although this failed, and it had not been carried out by the time of interview so they were still relying on condoms. Previously Linda had used the contraceptive pill, emergency contraception and she had also used a coil before.

Martina is 39, has two children aged 2 and 5 months and was still on maternity leave from her part-time work as a strategic analyst. She went into marketing straight from university. Martina describes herself as white, British and middle class. She stated that her own and her husband's income was reasonable, but they live in a large newly built detached house, and appeared to be quite well-off. Martina had recently had a coil fitted, but had previously used the combined pill, condoms and withdrawal.

Mary lives with the youngest three of her four children who are aged 12, 7 and 8 months. Although she is in a long-term relationship with their father, they do not cohabit. Mary's eldest child by a previous partner is 18 and lives locally. Mary described herself as white, British and working-class. Currently, she is not in paid employment, although she normally works in catering. She was 37 at the time of interview and is Church of England. Mary currently relies on withdrawal, although previously she has used the contraceptive pill, rhythm method and the morning-after pill. Mary told me how lonely she is,

and although from her description of her relationship I would consider it to be psychologically abusive, she did not seem to think of it in that way. Mary stated that her partner is very well off, and although he does provide clothes and toys for their children, her main source of income is from state benefits.

Patricia is 35 and works full-time as an office manager. She is married and has a 2 year old child, and describes their financial circumstances as reasonable. Although she has usually worked in offices, she has also worked part time as a youth leader which involved advising young people about contraception. Patricia stated that she was white British and working-class. although she is much better off than her parents were at her age. Patricia has used the combined pill, morning-after pill, condoms, coil and withdrawal in the past. At the time of interview, she was not using contraception as she was trying for another baby.

Paula has recently separated form her husband, and is now in a new relationship. Her three children aged 15, 17, and 19 live with her. Paula is 39 and works part-time as a further education college lecturer and is also studying for a Masters degree. Although until recently her income was good, they have not finalised the financial details from her separation, and so her income currently is fluctuating. Paula describes herself as white English and from a working-class background, although she stated that her income and occupation made her 'middle-class now'. Paula is currently using the contraceptive pill, although until recently she relied on her husband's vasectomy. Paula has also used condoms, withdrawal, rhythm method and has taken emergency contraception.

Sharon is also married and she has four children, aged 11, 7, 5, and 18 months. She is 30 and was in paid employment at the time of interview. Sharon stated that her usual line of work was secretarial, although her last job was as a nursery nurse assistant and she chose this because the post was term-time only. Sharon is Catholic, and describes herself as white English and

working class. She stated that they sometimes struggle for money as their income relies on her husband's bonuses and overtime, but this is topped up by state benefits. Sharon is currently using condoms as her method of contraception, and has previously used both the combined and mini-pill's, withdrawal and the rhythm method.

Appendix B

Methods of Contraception

Listed below are the most common methods of contraception in Britain, including all those mentioned within this thesis. However, this should not be considered as a definitive list, as there may be methods that I have not come across, or are not generally categorised as contraception within Britain. For example, early termination of a pregnancy is today categorised as an abortion, and is not considered as a method of contraception. Yet in Britain in the last century, and in many other cultures, the classification of abortion was reserved for terminations after the first three months. Unless indicated, all the following information has been taken from *Controlling Our Reproductive Destiny* by Kaplan and Tong (1996).

Hormonal Methods of Contraception

There are four main types of hormonal based contraception, all of which aim to prevent pregnancy by suppressing ovulation or implantation. These methods do give women control over contraception, as they are taken separately to any sexual act, and could therefore be used by women without their partner's knowledge. However, they do not offer any protection against sexually transmitted diseases, and are associated with considerable risks to women's health.

Combined Pill

The 'combined' pill consists of doses of oestrogen and progestogen, and is only available on prescription. The known side effects of the combined pill include weight gain, nausea, headaches, hypertension, depression, psychological disturbances, gallbladder disease, liver tumours, and thrombosis. The combined pill usually follows on a 21/7 regime where 1 tablet is taken daily for 21 days, and then 7 days gap follows, although sometimes women pill tri-cycle, and take a tablet for 63 days, before a 7 day break. This is sometimes recommended for conditions such as endometriosis, but is also as a convenient way of reducing the number of 'periods'. Although the combined-pill should be taken at the same time everyday, women users will still be protected against pregnancy if the pill is up to 12 hours late.

Progestogen-only or Mini-Pill

The 'mini' pill only contains progestogen, and so although it carries many of the same risks of the combined pill, the chances are reduced in the 'mini' pill. However it has a greater risk of ectopic pregnancy or ovarian cysts. The mini-pill also only requires 1 tablet a day, but it needs to be taken everyday with no pill free weeks. The mini-pill must be taken at the same time everyday, and preferably several hours before sexual intercourse, and women will only be protected if they take the pill less than three hours late.

Injectable Contraceptives

Injectable contraceptives do vary in their length of effectiveness, with some lasting eight weeks and some 12 weeks. They have the same hormones as the contraceptive pill, and therefore carry the same health implications. The main advantage over contraceptive pills is that it cannot be forgotten on a day-to day- basis. However, their long-lasting effects mean that if side-effects do develop, it is impossible to withdraw the hormone, and should a women become pregnant the foetus' development may be affected. There is also some evidence that ovulation may be suppressed for longer, and thus it could lead to fertility problems if a women wanted to become pregnant in the future. The most common injectable contraceptive in Britain is Depo-Provera.

Implants

Implants are the longest lasting hormonal contraceptives, and as yet are not very common within Britain. Norplant was the first implant to be introduced, and it gave protection for five years. It consisted of six match-stick size rods which are implanted just below the skin, usually in the upper arm. It also contains progestogen, and it is designed to slowly release the hormone into the woman's bloodstream. As well as being associated with the side effects of other hormonal methods, since Norplant has to be surgically inserted, its removal is difficult, and will often result in permanent scarring. The problems associated with Norplant led to its withdrawal from Britain. In the last couple of years a newer implant has been introduced Implemon

Emergency Contraception or Morning-After Pill

The emergency contraceptive, or 'morning-after', pill is a post-coital method of contraception. It can be taken up to 72 hours following intercourse and is

designed to prevent implantation of a fertilised egg in the womb. However, its high hormonal dose means that most women suffer from severe nausea after taking the tablets. Although it is considered to be less effective than the other forms of hormonal contraception, it does offer women some belated protection against the risk of pregnancy, should other methods have failed or not been utilised. Since January 2001, emergency contraception has become available over-the-counter in chemists (following specialist training by pharmacists).

Barrier Methods of Contraception

There are three main types of barrier methods of contraception, and all of them work by physically stopping sperm from entering the women's uterus.

Condoms

The condom or sheath is the most widely used barrier method of contraceptive, and second only to the contraceptive pill as the most popular method. It is also one of the few methods of contraception that men can choose to use. Condoms also give protection against sexually transmitted diseases, including HIV/AIDS, and they have been heavily promoted in recent years as a safer sex practice. Condoms are now widely available to buy, although they can also be obtained free from family planning clinics and certain GP practices.

Female Condom

The female condom is a sheath that lines the vagina and the area just outside it. Like the male condom it should give protection against sexually transmitted diseases, and it is also generally available both to buy or obtain free from family planning clinics.

Diaphragm and Cervical Cap

The diaphragm and cap are flexible rubber dome-shaped devices that are placed inside the vagina to cover the cervix. To be effective, they must always be used in conjunction with a spermicide. Although they can be inserted some time before intercourse, they must be left in place for at least six hours afterwards, and additional spermicide must be added if sexual intercourse takes place again. Side effects include a risk of urinary tract and bladder infections, as well as a small risk of toxic shock syndrome. The diaphragm is believed to give some protection against sexually transmitted diseases, but not

HIV/AIDS. Although the diaphragm and cap are different in size, the diaphragm is also known as a Dutch cap, which mean that references to the cap can indicate either method. Both are available in different sizes, and doctors need training to prescribe the correct size.

Other Methods of Contraception

Intrauterine Device (IUD) or Coil.

The IUD is a small plastic and copper device that is placed inside the womb, and can stay in for up to five years. Although it is not actually known exactly why it works, it is generally considered to be an effective contraceptive. Side effects include heavy and painful periods, uterine embedding or perforation, and pelvic inflammatory disease. There is also a greater risk of ectopic pregnancy, or miscarriage should a pregnancy occur. In addition, the IUD is also painful to insert and remove, and is not generally recommended for women who have not had any children. The IUD does not provide any protection against sexually transmitted diseases. Doctors need specialist training to be able to insert an IUD.

Intrauterine System (IUS)

The IUS is similar to the IUD only the device that is placed in the womb contains progestogen. It often causes periods to be lighter and shorter, which is the advantage it has over the IUD. However, users may experience side effects similar to the progestogen-only pill, as well as many of the drawbacks of the IUD, such as an increased risk of pelvic inflammatory disease.

'Natural' Methods (e.g. Withdrawal and Safe Period)

Methods of contraception which do not require any drugs, devices or operations are usually classified as 'natural'. The two main methods often referred to as 'natural' are withdrawal and safe period, but non-penetrative sex could also be classified as a 'natural method' of contraception. Withdrawal is when the penis is removed from the vagina before ejaculation, thus considerably reducing the amount of sperm available to fertilise an egg. The Safe Period involves calculating a women's non-fertile period by either the dates of the women's menstrual cycle, or by noting changes in her body temperature and cervical mucus. During the fertile period, other forms of contraception should be used, or sexual intercourse avoided.

Persona System

The Persona System could also be classified as a 'natural' method of contraception. It is a machine that calculates a woman's safe period from monitoring the levels of hormones in her urine. It claims to store information from urine samples to build up a profile of a woman's individual cycle, and aims to predict when ovulation will take place. The machine requires women to record when their period has started, and it will then calculate which days are safe and when there is a risk of pregnancy, using results from urine samples. The Persona System is not currently available on the NHS, but is for sale in *Boots* shops. The user has to buy the machine outright, and also needs monthly packs of urine test sticks. (All this information has been taken from the Persona Information leaflet, dated August 1997)

Sterilisation (Tubal Ligation) and Vasectomy

Both of these are permanent methods of contraception which require an operation. In women, surgeons cut or block the fallopian tubes to stop eggs reaching the womb. The operation takes place under general anaesthetic, and requires a stay in hospital. Serious complications can include infection, haemorrhaging, and pelvic abscesses. The procedure can also induce a range of less serious post-operative problems including headaches, cramps and nausea. Vasectomies can be carried out under a local anaesthetic, when a doctor cuts the tubes carrying sperm so the sperm is no longer present in the semen ejaculated. There may be some bruising or discomfort shortly after the operation, and in rare cases scrotal abscesses or painful spermatic granulomas may develop. Occasionally, spontaneous reconnection takes place leaving the man fertile again.

Contraception Reliability

All the following reliability estimates have been taken from the Family Planning Association's leaflet *Your Guide to Contraception* (1995).

Method of Contraception	Reported Reliability per year
Combined Pill	97-99%
Progestogen-only Pill	96-99%
Injections	99%
Implant	99%
IUD	98-99%
IUS	99%
Condoms	85-98%
Diaphragm or Cap	82-96%

According to its sales leaflet, the Persona System is 94% reliable.

Appendix C

Interview Schedule

Date.....

Time.....

Interview length.....

Age.....

Ethnicity & Nationality.....

Religion.....

(Dis)ability.....

Education.....

Income.....

Class.....

Relationship.....

Child/ren.....Y/N

If yes.....No.....Ages.....

Hoping for more?.....Unsure.....

If no.....Decided Against

Unsure

Hoping to have in the future

Methods mentioned

Combined pill	☐	Mini	☐	M/After pill	☐
Condoms (M/ F)	☐	Cap	☐	Coil	☐
Injection (self/partner)	☐	Implant	☐	Sterilisation	☐
Withdrawal	☐	Safe period	☐	Non-penetrative	☐

This research is looking at women's experiences, thought and feelings about contraception. You do not have to answer any questions that you don't want to, and if you want to stop the interview at any time, please tell me. Everything you say is confidential, and your real name will not be used in any report on the research. However, although, there are no questions about child safety in the interview, should you tell me that a child is being abused, I can not keep that to myself and I would need to work out with you the best way to report it.

The questions hope to cover the experiences of women in all different circumstances, so you may find that some of them do not apply to you. If that is the case, please just say so, and we can move on.

Introduction

1. I would like to start by asking you generally how you feel about your experiences of contraception? *(Good/not so good, usual/unusual)*

2. What or who do you think has had the greatest influence on your use of contraception?

If GP go to question 15

Clinic Recruitment

3. You recently attended the FPC, is that where you normally go for contraception? *(If no observation made)*

4. What did you go there for?*(advice/new method/repeat prescription)*

(If observation made write in question before interview)

5. On your visit you were given
   .....
   .....

   Is that what you wanted to happen?

6. Generally how did you feel the appointment went?

7. Did the discussions with the clinic staff cover everything you wanted to know about using (*the method*)?

8. Do you feel that you know enough about using (*the method*)?

9. What made you opt for the (*method*) in particular?

10. How are you getting on with (*the method*)?

11. What do you think are the advantages about using the (*method*)?

12 What do you think are the disadvantages about using the (*method*)?

13 What does your current or last partner think about using *(method)?*

14 Have their been occasions when you have not taken/used *(method)? What happened?*

Go To Contraceptive History Question 32

<u>GP Recruitment</u>

15a. Are you currently using a method of contraception. If so what?

15b *(if not using)* What was the last method you used?

16 How are you getting on/ how did you get on with (*the method*)?

17 What do you think are the advantages about using the (*method*)?

18 What do you think are the disadvantages about using the (*method*)?

(if sterilised go to question 26)

19 What made you decide to use the (*method*) in particular?

20 What does your current or last sexual partner think about using *(method)?*

21 Have there been occasions when you have not taken/used *(method)? What happened?*

22 Where did you/your partner(s) get the method? *Is that where you usually go? Why?*

23 How do you feel about your last visit to obtain contraception?

24 Do you think the appointment met all your needs?

25 Did you discuss the different options for contraception at that appointment?

(if sterilised)

26 Why did you/your partner decide to be sterilised/have a vasecomy?

27 Were you/your partner in a relationship when you made the decision?

28 (*if yes)* Why did you/your partner have the operation rather than the other way around?

29 How do you feel you were treated when you asked the medical profession to be sterilised?

30 Did you discuss the different options for contraception with the doctor before you/your partner decided to have the operation?

31 Do you think the consultations you had met all your needs?

32 Do you think you were given all the information you needed to help you decide?
(failure rates, risks of operation, irreversability)

<u>Contraceptive History (ALL)</u>

I'd now like to go back to your earliest use of contraception.

33 What was the first method of contraception that you ever remember using?

34 How old were you then?

35 Can you remember why you started to use contraception?
(avoid pregnancy/period problems/avoid STD)

36 Did you use contraception the first time you had sexual intercourse?

37 Who made the decision to use a form of contraception?

38 Thinking back to that time, do you think you felt pressured in anyway about using contraception?

39 Did you pressure your partner about contraception?

40 What or who do you think had the most influence on your choice of contraception at that time?

41 Where did you/your partner get (the method)?
Why there in particular?

42 Do you remember if anyone went with you?

43 Can you remember how you felt about asking for contraception then?

44 Do you remember how you were treated by the (*doctor/chemist*)?

If not prescribed go to Question 49

45 Do you remember if you asked for that method in particular?

46 Was there a discussion about the alternatives?

47 What advice do you remember receiving about that method?
(*how to use, what side effects/health implications contraindications*)

ALL

48 How did you get on with (that method) at that time?

49 What do you think were the advantages about that method for you at that time?

50 What do you think were the disadvantages about that method for you at that time?

51 Looking back, to you think you made the right decision about contraception? *Why?*

52 Are you still using that method?

53 What method did you change to?

If changed to a different method (but omit if current method)

If using the same method go to question 69

54 What made you decide to change to the (*method*) in particular?

55 What did your partner(s) think about the change?

56 *Were there occasions when you did not take/use *(method)?*
What happened?

57 Where did you/your partner first go to get *(method* ?

58 Why there in particular?

59 *Did you discuss the different options for contraception with anyone before you decided to use the (*method*)*

(if prescribed)

60 Do you remember if you asked for that method in particular?

61 Was there a discussion about the alternatives?

62 What advice do you remember receiving about the method when you first got it? (*how to use, what side effects/health implications contraindications*)

ALL

63 How did you get on with (that method) when you started using it?

64 What do you think were the advantages about that method for you at that time?

65 What do you think were the disadvantages about that method for you at that time?

66 Looking back, do you think you made the right decision about contraception? *Why?*

67 Are you still using that method? *(If no)* when/why did you change?

Usage and Constraints

68 So, you have used (list methods)? But you have never used (list methods not mentioned to double-check)?

69 What factors are important to you when choosing between methods of contraception?

70 (*If more than one method used)* Which method did you get on best with?

71 Why, what factor(s) made it best? *(health/relationship factors)*

72 Are there any methods that you would never consider using? *Why?*

73 Many religions have particular teachings on methods of contraception. Has religion ever been a factor in your decisions over contraception? *In what way? How important are/were religious teachings to you?*

Sexual Partners

74 Have you discussed choices in contraception with your sexual partner(s)?(*who/which partners, why them and not others)*

75 How much have your partner(s) been involved in the decision making?

76 How important to you is a partner's preference in choosing contraception?

77 Have you ever taken or stopped taking contraception and not informed a sexual partner? *Why? What happened?*

78 In your current/last relationship, do you think of contraception as your responsibility or a joint responsibility?

79 On balance, who do you think has taken most of the decisions ypu or your partner(s)?

80 Who do you think has more control over contraception choice and use? *Why?*

81 (*if more than one partner*) Has this always been the case, or has the control been different with different partners? *In what way?*

Reflect back to question 80, if answered joint responsibility, but thought they had taken most of the decisions, and/or has more control asked to explain any difference

Some women have said that they have used different methods depending on whether they were in long-term or more casual relationships, or that they have changed their method of contraception as their relationship changed.

82 Have you ever changed your method of contraception because of a different partner?

83 What about changes within a relationship? Have they ever made a difference to the way you think about or use contraception?

Sexually Transmitted Diseases

84 Have concerns about HIV or other sexually transmitted diseases ever affected any decision you have made about sex?

85 Do you think about both preventing pregnancy and sexually transmitted diseases when you think about contraception?

86 Have you always thought like that?

87 (*if no*) Why do you think you it differently about it now?
(*AIDS, maturity, different sexual partners*)

88 Have you ever discussed the risk of sexually transmitted diseases with a partner(s)?

89 At what point(s) in your relationship? (*before having any sex*)

90 Have you ever chosen to use condoms in order to protect yourself against both pregnancy and sexually transmitted diseases either on their own or in combination with another method?
(*all partner's/specific partners/different point in time*)

91 Have you ever not had intercourse in order to protect yourself against both pregnancy and sexually transmitted diseases?
(all partner's/specific partners/different point in time)

92 Have you ever wanted to practice safer sex, but your sexual partner either objected or refused? *What happened? How did that make you feel?*

Medical Encounters

93 So, you have obtained contraception through (list places).

94 (*If more than one*) which place did you prefer? *Why?*

95 (*If one*) why did you go to (that place) in particular?

96 Have you ever had a consultation that was particularly helpful?
What was it that made it good?

97 Have you ever had any bad experiences of obtaining contraception?
What happened?

98 Have you ever wanted to use a particular method of contraception but a doctor advised against it? *What happened?*

99 What do you think doctors should take into consideration when recommending different methods of contraception?

100 Do you think these factors are always considered or do they ever miss some out or recommend particular methods for other reasons?

101 Do you think generally that doctors and nurses have given you enough information about the different methods?

Information

102 Where do you think your knowledge of contraception has come from generally? *(sex-education, leaflets, medical consultations, newspapers & magazines)*

103 Have you ever discussed the advantages and disadvantages of different methods with friends or family? *Who and why them in particular?*

104 Have (*they*) ever influenced your decisions? *In what way?*

105 Do you think you have ever influenced anyone else's decisions? *Who and in what way?*

106 Can you think of a newspaper, magazine article or something on TV that has ever had an effect on the way you thought about or used contraception? *What happened?*

107 Do you remember reading or hearing about problems with the contraceptive pill in the past?

108 *(If past or present pill user)* Have you ever used a brand of pill that has featured in one of these scares?

109 *(if yes)* How did it make you feel seeing the news coverage?

110 Have reports such as these ever altered your opinions about the pill in any way?

General Points

111 What do you think about the range of contraception currently available?

112 Do you think that it should be made easier or harder for women to obtain contraception? *(all women/certain groups) (prescription/over the counter)*

Recently, there have been trials allowing chemist shops to dispense the morning-after pill directly to women, without them having to go to a doctor.

113 Do you think this is a good idea or not? *Why?*

114 What do you think about the idea of a male contraceptive-pill?

115 Would you trust a partner to use it? *(all partners/some partners) Why do you think like that?*

116 Do you have any general concerns about using contraception either now or in the past?

117 *(if yes)* Why does that (concern) you more than (pregnancy/ STD's/health)? *Have you always thought like that?*

118 Do you think about contraception now in a different way that you used to do? *In what way?*

119 What has made the difference?

120 Do you feel that you have more (or less) control over contraception now than you used to? *In what way? What has made the difference?*

121 What about in relation to (doctors/ partners)?

122 Looking back at your life, do you think you have always made the right decisions about contraception? *Why do you think that?*

123 How do you think that your choices in contraception have affected your life?

124 How important has contraception been in your life? *In what way?*

125 How important do you think contraception is in women's lives generally? *In what way?*

126 Is there anything else about these issues, which I have not asked about, but that you think is important

Background questions *(if details not already known)*

127 How old are you?

128 How old were you when you left school?

129 Have you ever attended college or university?

130 Did you take any qualifications?

131 Are you in paid employment at the moment?

132 (*Is that/what is*) your usual line of work?

133 Does your current income give you a reasonable standard of living, or would you say that you sometimes or always struggle financially?

134 Would you describe yourself as being middle-class or working-class?

135 Would you say you are in the same class as your parents were?

136 Would you describe yourself as being in a relationship at the moment?

137 Do you have any children? (*If yes)* How old are they?

138 ***(all)*** Have you thought about whether or not you want to have (any more) children in the future?

139 Do you regard yourself as belonging to any particular religion?

140 How would you like me to describe your ethnic background?

141 Do you have any disabilities which have impacted on your life and/or sexual relationships?

Thank you for taking part in this research project.
Do you have any question that you would like to ask me?

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