

The London School of Economics and Political Science

**The Social Life of the Pill: An Ethnography of Contraceptive
Pill Users in a Central London Family Planning Clinic**

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Declaration

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Abstract

This is an ethnographic study of users of the oral contraceptive pill at a London specialist clinic. The pill was introduced in the United Kingdom in 1964 and is currently provided free of charge to twenty-five percent of British women. It has had a major impact on the sexual and reproductive lives of people in contemporary Britain. This ethnographic analysis of the pill contributes to our understanding of the cultural meanings and practices associated with the pill and shows some of the fundamental assumptions and expectations of pill users about their lives, including particularly ideas of femininity and nature.

In this thesis, the central question of how the ‘natural facts’ of femininity are constantly negotiated in both private and public domains will be explored through the related examples of pregnancy, sex, and menstruation, as experienced and conceptualised by the women in this study. The ways in which these women use, think and talk about the pill demonstrate their efforts to balance the often contradictory demands made upon their bodies and persons in various social fields as they participate in social terrains once inhabited primarily by men. Therefore, a key argument will be that the social life of the pill is inseparable from the constitution of femininity and female bodies more broadly.

This thesis contributes to the anthropological theory of “natural facts” by providing an example of how they are mobilised by women using the pill. It suggests that “natural facts” continue to provide a privileged ground for femininity. It adds to research on gender in the UK by illustrating the strategies employed by women at both symbolic and relational levels as they attempt to control their identities in the face of changing conventions and institutions. Finally, it is hoped that this ethnographic illustration of the experiences of pill users will provide insights relevant to the work of public health practitioners.

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Abbreviations

ALBs	Arm's Length Bodies
COC	Combined Oral Contraceptive
DoH	Department of Health
FFPRHC	Faculty of Family Planning and Reproductive Healthcare
FPA	Family Planning Association (UK)
FSH	Follicle-stimulating hormones
GU	Genito-urinary
GP	General Practitioner
GRH	Gonadotropin-releasing hormone
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPV	Human Papilloma Virus
IUD	Intra-Uterine Device
IUS	Intra-Uterine System
IVF	In Vitro Fertilisation
LARCs	Long Acting Reversible Contraceptive
LH	Luteinising hormone
MHRA	Medicines and Healthcare Products Regulatory Agency
NBCC	National Birth Control Council
NICE	National Institute of Clinical Excellence
NCT	National Childbirth Trust
NHS	National Health Service
NHS PASA	National Health Service Purchasing and Supply Agency
PCT	Primary Care Trust
POP	Progesterone-Only Pill
REC	Research Ethics Committee
STI	Sexually Transmitted Infection
WHO	World Health Organisation
Ug	Microgram

Chapter One

Introduction

Early on any routine weekday morning, women gather in front of the street entrance to a public building in central London eagerly waiting for the doors to open. These women are dressed for work, with briefcases and laptop bags, and as they wait they are talking on the phone, checking their Blackberries and glancing at their watches. They huddle on the steps of this anonymous building, a building that could be any office block in the backstreets, and wait. At the entrance, there is a single distinguishing feature, an inconspicuous sign that reads 'The Margaret Pyke Centre'. The Margaret Pyke Centre, or 'the Pyke' as I will refer to it following the usage of those who work there, is a specialist contraceptive service that provides hundreds of prescriptions for the oral contraceptive pill every week, mostly to young women who commute to central London for work or study.

These women have woken up extra early to beat the crowds and get their contraception before their busy work day begins. The preparation and waiting that this involves represents just one small part of the complicated and complex process that characterises the contraceptive practices of most of the women in this study. Women wait outside the clinic, they wait in the clinic, they tolerate repeated inconvenient clinical consultations, they systematically take the pill every day at roughly the same time, they endure the discomfort of side-effects and they continually worry about possible health risks. They also worry about how the pill will affect their fertility, their sexual relationships, their menstrual cycles and their bodies more generally. And yet, for them, it is almost impossible to face the contradictory demands of their lives without the pill. The pill has become integral to how they experience and act out their daily lives. The following ethnography of the oral contraceptive pill, based on the accounts, experiences and practices of these women, examines the relationship between the pill and femininity in London.

In England and Wales, over twenty-five percent of women are currently using the oral contraceptive pill through specialist contraceptive services.¹ The oral contraceptive pill, which is free of charge through the National Health Service, is the most popular method of contraception (NHS 2007; Office of National Statistics 2008). Fifty years after it became available, continuing media coverage of this phenomenon demonstrates that the pill still holds a special place in the popular imagination.² Yet, in spite of its social prominence, the pill has not received detailed ethnographic attention. Many of the existing studies of the pill have focused on historical, demographic and economic aspects, either charting its impacts or modelling the factors that affect its use.³ However, as McLaren has suggested, in reference to historical accounts of fertility, demographic and social statistics calculate the rise and fall of fertility but leave unanswered the most interesting questions:

They tell us little about abortions and miscarriages which were not recorded, of the recourse to contraceptives that did not work, of the attempts not to control family size per se but simply space births; they say nothing about the relationship of the sexes, attitudes towards sexuality, and the woman's right to control her own body; they show little interest in whether a couple had recourse to traditional means of contraception or relied on quack potions, sought medical aid or patronised the surgical shop; most important of all they do not broach the vital question of the social, moral and political forces which made birth control 'thinkable' or unthinkable' (1978: 12).

In today's studies of the pill the situated voices of pill users remain unheard and the social values and cultural processes that shape its use and that are, in turn, shaped by it, remain unelaborated.

The Margaret Pyke Centre, where this study took place, is located off one of London's busiest commercial roads and serves hundreds of women every week.⁴ The location of the Pyke is significant because it determines the composition of the clientele using the service and, hence, of the respondents participating in this study. The majority of

¹ Contraceptive prescriptions for the contraceptive pill from General Practitioners and private health care providers are unavailable.

² Recent news coverage of the pill indicates how the pill still captures public attention. Headlines have included: 'The Pill has had its day as an effective contraceptive' (The Times 25 June 2008); 'Underage girls could buy the pill from chemist shops' (Metro, 13 December 2007); 'Fears of Free-for-All on the Pill' (The Daily Mail, 23 June 2008); 'The Breakthrough Pill' (The Daily Mail, 27 September 2007).

³ The critical social history of the pill and its societal ramifications in the United Kingdom are well documented (see Marks 2001; Djerassi 2001 Oudshoorn 1994; Watkins 1998; Cook 2004).

⁴ The Pyke is one of over two hundred specialist community contraceptive services run by the National Health Service in England and Wales (FFPRHC 2006). A million people use these services and another three million women access the pill through their General Practitioner (NHS 2007).

current, former, continuous and intermittent users that I spoke to were well-educated, professional, middle-class, unmarried and pre-parturient women aged eighteen to forty-five who had migrated to London for study and/or work in the media, civil service, public relations, financial sector and academia. They represent the age group that predominantly uses the pill, for women aged 20-24 around 55 percent use the pill and this decreases to 31 percent for women aged over 35 (NHS 2007). Community-based contraceptive services located in residential areas but administered by the Pyke, as I will explain later in this chapter, were also included in the study and extended the range of women to include, for example, a 20-year-old woman who had recently migrated from Poland and who was working for the minimum wage in the service sector and a 55-year-old deputy CEO with no children. All of these women attended the Pyke and its community-based services because the facilities were close to work, had convenient opening hours and/or provided specialist contraceptive services. These women represent an emerging model of femininity that has arisen from recent changes in the wider political economy of the United Kingdom, and is related to macro-economic shifts in the structure of the labour market and widespread transformation in gender roles and household organisation. They are not a representative sample of pill users in the United Kingdom yet they represent an exceptional section of contemporary British life.

In the United Kingdom, Euro-American folk models of reproduction inform the construction of gender as they provide the form and content of a cultural model which posits fundamental differences between the sexes, which are in turn used to legitimise and normalise different statuses, roles and ideologies for women and men. Gender roles, norms and ideologies, defined primarily by reproduction, started being displaced by reproductive technologies, by women entering the formal workforce, and by the diversification of the relationship between sex, marriage and parenthood. Sociological and technological changes created new possibilities for working women; these changes displaced conventional social expectations about what should count as appropriate feminine conduct and introduced, often conflicting, new ones. The women who participated in this study are living out possibilities that result from a struggle for emancipation over a century, though they do not claim an affiliation with feminism (Biographical details of the respondents is provided in Appendix 1). They live at a time when the cultural arrangement of sexuality, reproduction and gender is shifting. This re-configuration affects how they understand and enact femininity and their contraceptive practices must be understood in this transformative and constantly changing context.

The women in this study use the pill within a cultural context in which sexual reproduction is the core organising symbol of kinship and gender. The capacity of sexual reproduction to act as an organising principle of kinship and gender is a culturally-specific knowledge practice in which 'natural facts' have classificatory and constitutive power. By understanding the term 'nature' as a potent polyvalent cultural construct, I argue that femininity, like kinship, is a hybrid concept constituted through the juxtaposition of biological and social assumptions. The result is that this socially defined role is naturalised and the meanings and implications of 'femininity' appear self-evident. The pill intervenes in the 'naturalisation of femininity', i.e. in the grounding of femininity in 'nature', by temporarily separating sex from reproduction and reproduction from femininity.

The separation of sex from reproduction, of marriage from parenthood and the rupture of the apparently 'naturalised' association between sex, reproduction and gender contribute to a destabilisation of conventional constructions of femininity. Twenty years ago, Jane Collier and Sylvia Yanagisako (1987) posed the question 'What is it that the conception of gender as rooted in biological difference does and does not explain about relations between men and women in our society?' (1987: 42). This thesis engages with this question in order to examine what role the 'natural facts' of sexual intercourse and reproduction continue to play in the construction of gender difference and femininity in our society, the way in which social and cultural processes and practices are used to constitute new ideas of femininity and how particular categories are employed in ways that make them appear self-evident and unquestionable.

The social life of the pill is analysed here within this cultural context. The 'social life' of this particular 'thing' (Appadurai 1988) is examined primarily by looking at the role of the pill in mobilising and altering femininity and gender relations. The pill is a medicine, a commodity, a regime. It is a complex type of object, with multiple meanings and functions. It acts upon different social domains (private, public) and institutions (family, work, sex). While it operates primarily upon women's bodies, it has indirect consequences for several other categories (partners, born and unborn children, colleagues, employers) and areas of life of related to pill users (kinship, intimacy and work). Looking at the pill therefore allows us to explore how femininity and gender are currently constituted in a range of social fields.

This ethnographic study of the pill offers an alternative to theoretical approaches that have looked at modern contraceptive use as a rational, self-interested action intervening in conception, sexual and familial relationships. Ethnographically informed critiques of these approaches stress the complex cultural and social meaning of contraceptive practices.⁵ They provide a point of departure for this analysis, which focuses on how the pill is incorporated into a set of practices aimed at negotiating femininity.

The following analysis, based on respondents' categories and priorities, on how they experience their bodies and lives and on how technological interventions are significant to these experiences, further contributes to understanding the cultural meaning and significance of contraceptive practice. I focus on emic concepts and categories that define, describe, interpret, evaluate and make claims about everyday experiences, relationships and practices. These women's culturally-embedded and -embodied contraceptive practices are constituted as matters of anxiety, reflection and strategic deliberation. These areas of relevance connect with wider cultural and social processes that shape their experiences both on and off the pill.

This thesis is organised around two main themes that run across all chapters. First, it looks at the theme of 'nature' and at how the pill intervenes in the 'natural facts' of femininity. The second theme is that of agency, and concerns how these women attempt to shape their lives and relationships strategically. In these accounts, the pill is both a source of disruption and a provisional solution to everyday contradictions. This work attempts to reconstruct the social life of the pill, or more specifically, the role of the pill in the everyday negotiation of femininity.

Introducing the Pill

The pill is a small tablet, approximately ten millimetres in diameter, containing synthetic oestrogen and progesterone that, when ingested by women, have several contraceptive effects. Firstly, and primarily, the pill changes the body's hormone levels to inhibit ovulation. Secondly, it thickens the cervical mucus to generate a 'mucus plug' in the cervix that obstructs sperm from accessing the uterus. Thirdly, it thins the lining

⁵ See Collier (1997); Hirsch (2003); Luker (1975); Fisher (2006); Paxson (2004); Sobo (1995); and Schneider and Schneider (1996) for ethnographic studies of contraceptive practices.

of the uterus to impede the attachment of a fertilised egg. To achieve these effects, pill users are required to follow a set regime. The pill must be taken consecutively for twenty-one days followed by a seven-day interval. And repeat.

Currently there are three types of oral contraceptive pill available. The monophasic combined oral contraceptive (COC) pill has a fixed dose of oestrogen, 15 to 50 micrograms (ug) of ethinoloestradiol and progestin consistently across the 21-day cycle.⁶ Multiphasic pills have two variations of phased dosage: biphasic (two phases) or triphasic (three phases). Each phase has varying doses of oestrogen and/or progesterone across the 21-day cycle. The final type of oral contraceptive is a progesterone-only pill (POP) that contains only progestin at a lower dose than the monophasic and multiphasic pills. The contraceptive effects and administrative regime of POP differ from COC pills. With POP, a pill is taken continuously at the same time of day every day without a monthly interval. It only affects the cervical mucus that inhibits sperm from accessing the uterus and prevents part of ovulation.

All oral contraceptive pills manipulate the hormonal feedback system of the menstrual cycle. The post-puberty female body exhibits repetitive cyclic change through the hypothalamic-pituitary-ovary feedback system. The pill introduces and elevates synthetic oestrogen and progesterone into the body and alters the call and response system between the hormonal bio-synthesis and secretion of the hypothalamus, the pituitary gland, the ovaries and the uterus that regulates the menstrual cycle and ovulation (Guillebaud 2004).⁷ The pill works on the endocrinology of the menstrual cycle which has two phases: the follicular phase, approximately the first fourteen days of the menstrual cycle, and the luteal phase, approximately the following fourteen days.⁸

In the un-medicated follicular phase, the hypothalamus releases gonadotropin-releasing hormones (GRH) that prompt the pituitary gland to synthesise and secrete follicle-stimulating hormone (FSH). FSH stimulates the ovaries to mature follicles and produces oestrogen. The ovarian secretion of oestrogen has several effects. Increases in oestrogen cause the development of the uterine lining and has 'negative feedback' with the hypothalamus and pituitary gland to decrease FSH production and prevent further

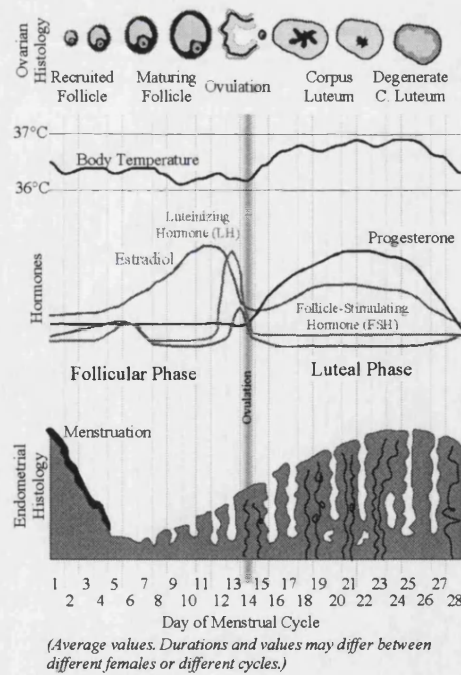
⁶ Currently used progesterones are levonorgestrel, norethisterone, desogestrel, gestodene, cyproterone acetate, drospirenone and norgestimate.

⁷ John Guillebaud was the medical and research Director of the Pyke for several decades and now runs a lobby group called the Population and Sustainability Network.

follicular development. The increase in oestrogen also has a 'positive feedback' with the hypothalamus and pituitary gland to increase the secretion of luteinising hormone (LH) that releases the mature egg from the follicle for ovulation. After ovulation the corpus luteum, the matured follicular sac, produces oestrogen and progestogens.

The unmedicated luteal phase differs depending on whether fertilisation has occurred or not. If fertilisation has not taken place, the corpus luteum ceases to produce progestogens and oestrogen and so the hormone levels drop. This causes the shedding of the uterine lining which has a 'negative feedback' prompting the hypothalamus to secrete GRH, thus reinitiating the follicular phase. If fertilisation has occurred, the corpus luteum continues to produce high levels of oestrogen and progestogens that thicken and nourish the uterine lining for the implantation of a fertilised ovum. The fertilised ovum secretes human chorionic gonadotropin (hCG) that prolongs the development of the corpus luteum and produces high levels of progestogens and oestrogen. These high levels of oestrogen and progestogens have a 'negative feedback' that stop the hypothalamus and pituitary from producing FSH and LH and thereby prevents the maturation and release of another follicle.

The diagram below depicts the menstrual cycle.⁹



⁸ The first day of the cycle is defined as the first day of the shedding of the endometrium.

⁹ <http://www.answers.com/topic/menstrual-cycle> accessed 26 October 2008.

Hormones produced by the pituitary gland or the ovaries are carried throughout the body by the bloodstream and have both topical and systemic effects. High levels of oestrogen and progesterone introduced into the bloodstream by the pill inhibit and suppress the hypothalamus and pituitary gland bio-synthesising and secreting FSH, LH and GRH. The artificially elevated levels of oestrogen and progesterone mimic the high hormonal levels during the luteal phase and pregnancy and thus prevent the pituitary gland initiating the follicular phase and ovulation (Guillebaud 2004; Senanayake and Potts 2008). The physical effects of the pill are generally standard and produce a universal standard menstrual cycle.

This sophisticated pharmacology of the pill was little understood by most of the women I spoke to; they were typically unaware of how the pill worked and which pill they were taking. They vaguely mentioned the effects of ‘artificial hormones’ or how the pill ‘fooled their bodies’ into making them behave as if they were pregnant. Yet despite the limited knowledge and interest in the workings of the pill, many of these women were effusive about its physical, social and personal effects. I argue that the pill’s appeal derives not only from its contraceptive effects but also from its unique pharmaceutical mode of administration.

The oral contraceptive pill and other contraceptives are reproductive technologies as they are biomedical interventions into reproduction that alter biological processes. However, unlike other reproductive technologies they do not aim to assist conception but rather to prevent it. Like many modern contraceptives, the pill is taken at a time unassociated with sex but is distinct as it is a pharmaceutical medicine which is ingested. This also distinguishes it from other reproductive technologies. Its application is individualised, in that the user solely chooses and controls its administration without the required involvement of others, not even a sexual partner. This distinguishes it from other modern contraceptives and other reproductive technologies, all of which require a clinical practitioner’s or sexual partner’s involvement. As a user-controlled pharmaceutical technology it has systemic effects on the whole body and provides users with an imagined process by which they interact with and affect their bodies and lives. As the following ethnography outlines, it is precisely the pharmaceutical qualities of medicine – individualised choice and control – that make the pill a popular form of contraception. Despite advances in contraceptive technologies and the effectiveness of

other methods, the pill remains the most widespread and accepted method.¹⁰ As a mass-produced and consumed pharmaceutical product which has become available over the last fifty years, this analysis of the pill also contributes to the analysis of current pharmaceutical practices.

A History of the Pill in Great Britain¹¹

In 1974 Great Britain became the first country in Western Europe to provide universal free contraceptive advice and services and today it continues to serve approximately four million women a year (NHS 2007). The history of the universal provision of contraceptive services in Great Britain is closely related to the introduction of the pill. The availability of an easily-administered pharmaceutical contraceptive made the provision of contraception, something previously unaccepted by medical professionals and government officials, an acceptable and legitimate medical activity. The particularities of the historical development of the national provision of contraceptives have had long-lasting implications for the institutional structure of contraceptive provision and have resulted in a bias towards prescribing the pill and, consequently, high levels of pill use in the UK.

The distribution of information was considered obscene and was therefore restricted by several nineteenth-century Acts of Parliament in Great Britain (see Fisher 2006; Latham 2002).¹² From the 1920s up until 1967, philanthropic voluntary groups such as the Family Planning Association (FPA) set up private clinics to provide regulated contraceptive information and services. These private clinics were tolerated by the government in order to improve maternal health but were not supported by the medical establishment (Latham 2002; Leathard 1980). The opening of private clinics in the

¹⁰ In 2005 the new government-led policy on sexual health and the White Paper 'Choosing Health' increasingly emphasised balancing clients' informed choice about contraceptive options against cost-effectiveness. The National Institute of Clinical Excellence argues that 30 percent of pregnancies are unplanned due to contraceptive failure and the continued low uptake of Long Acting Reversible Contraceptives (LARC), such as intrauterine devices, progestogen-only injectable contraceptives and implant contraceptives. In Great Britain approximately 8 percent of women aged 16–49 use LARC compared with 25 percent for the oral contraceptive pill (NICE 2006). The government is now endorsing the LARC as a way to improve services by giving women more choice as well as a more cost-effective use of NHS resources compared to the high use of user-dependent contraceptives such as the pill.

¹¹ Elements of this section were previously published in Boydell (2007): 'The difficult birth of free contraception in Britain' in *The British Journal of Sexual Medicine* 30 (2).

¹² Prior to the medicalisation of contraception, contraceptive and fertility control information, commodities and services were widely available in the public domain. Historical records show that contraceptive information was available in the form of sexual manuals, handbills and recipe books from the sixteenth century onwards (see Himes 1936, McLaren 1984 and Fisher 2006).

1920s marked the beginning of the progressive state regulation and medicalisation of contraceptive information, commodities and services. In 1924 these clinics were permitted to provide contraceptive services to those women who risked being gravely affected by further pregnancy. In 1934 these services were extended to women with treatable gynaecological and medical conditions and in 1961 they were further extended to married women on medical and, later, social grounds. Finally, in 1967, all women aged over sixteen were offered contraceptive services without restrictions. Since 1974 contraceptive services have been provided free of charge as part of the National Health Service (NHS hereafter). In a span of fifty years, contraceptive information, services and commodities went from being an unregulated individual concern to a state regulated medical service.

Many of the changes from the 1920s onwards were spearheaded by the British family planning movement. The National Birth Control Council (NBCC), later the Family Planning Association (FPA), was formed to promote the state provision of family planning services. Margaret Pyke was first the secretary and later became the director of the FPA. Affiliates of the NBCC provided a more regulated contraceptive service through private facilities which operated with differing levels of support from local health authorities. The Pyke has its origin in these early pioneer clinics. With the creation of the NHS in 1947, private clinics continued to function autonomously with local health authorities providing facilities and funding. Not until 1967 and the Family Planning Act, which was passed unopposed in a single sitting, were local health authorities empowered to further support private clinics and to extend services to all women over sixteen years of age without restrictions. In 1974 the NHS Reorganisation Act incorporated the inclusion of free universal contraceptive provision through contraceptive clinics and general practitioners (GPs) and, as a consequence, the existing private clinics became part of the NHS.

This incorporation of family planning into the public health system was achieved by birth control campaigners who had enlisted the support of medical professionals and government officials (Latham 2002). This required advocates emphasising the health effects and medical considerations of repeated or unplanned pregnancies in order to make it acceptable to the medical community. At the time it also proved to be an effective strategy as medical professionals who were initially resistant (for reasons I will explain below) became important advocates for the inclusion of contraception in

the 1967 and 1974 reforms. The technological innovation that the pill represented further contributed to the medicalisation and medical acceptability of family planning.

It took thirty years from when Ludwig Haberlandt first experimented with reproductive hormones in the 1920s to develop the pill (Djerassi 2001; Oudshoorn 1994; Marks 2001). In the 1950s Russell Marker and Carl Djerassi developed orally administered steroids and synthetic hormones and Gregory Pincus and John Rock, with political and financial backing from Margaret Sanger and Katherine MacCormack, developed and tested an orally administered synthetic progesterone and oestrogen tablet that suppressed ovulation (Marks 2001; Clarke 2000, Watkins 1998). In the late 1950s and the early 1960s the FPA ran clinical trials on the pill in Great Britain.¹³ After receiving FPA approval, the first pills, Conovid and Anolvar, were introduced into clinical practice under strict medical guidance; their use was exclusively limited to married women for medical purposes (Latham 2002). Throughout the 1960s there was then a dramatic increase in the attendance of women at GP surgeries and this has been attributed to the growing phenomenon of women seeking the pill (Watkins 1998; Leathard 1980; Marks 2001).

Prior to the pill, contraception provided by general practitioners and other medical professionals was limited as it was seen as a non-medical issue that did not require medical supervision (Leathard 1980; Marks 2001). The introduction of the pill, a medical and scientific contraceptive method, made family planning a legitimate medical activity since it required professional supervision (Leathard 1980). Some argue that the pill was also readily accepted by medical professionals because it did not entail intimate medical examinations, such as diaphragm fitting or in-depth clinical histories (White and Marks 2002). At the start of the 1960s the FPA clinics were the main providers of contraception but they were replaced as the primary providers by GPs, who had a preference for prescribing the pill. In the 1960s GPs began to receive a prescribing fee for the pill and this continues to be a financially significant element of GPs' service payment.

The introduction of the pill, the emphasis on the medical aspects of contraception and shifts in the institutional structure of contraceptive provision all made contraceptive

provision a legitimate medical activity. The pill thus changed medical professionals' views of contraception and this was central to its acceptance as part of the national medical repertoire. This has resulted in contraceptives being widely and freely available and easily accessible. This particular historical development of contraceptive provision has led to a bias in prescribing the pill and an inflated pill use in Great Britain.

As a consequence of this particular history there is currently a two-tier system of contraceptive provision in the UK: the general practice and specialist contraceptive services.¹⁴ Ideally, the GP provides the first level of care, which includes contraceptive advice and services as well as referral. Specialist contraceptive services provide a second level of care for complex contraceptive services such as long-acting reversible contraceptives (LARC hereafter). Of the 1.2 million women that attended contraceptive services in 2005-06 (NHS 2007), twenty-eight percent were for the pill, resulting in 7.2 million prescriptions (NICE 2006). The exact number of women receiving the pill through general practices is unclear but approximately eighty percent of women requesting contraception from their GPs are prescribed the pill (NHS 2007). This high number of pill prescriptions has been attributed to general practitioners preferring the ease of prescribing the pill since they are not required to have specialist family-planning training to do so as well as women specifically requesting the pill (NICE 2006).

Theoretical Approaches to Contraceptive Practices

The history of the pill and its institutional implications provide an overview of the *supply* of the pill in the United Kingdom, however, understandings of the demands and motivations of pill users are highly contested. Most theoretical approaches to understanding the motivations for using the pill assume a rational actor approach in which the adoption of modern contraception is the outcome of an individual, self-interested, cost-benefit analysis of fertility. However, ethnographic research on contraceptive practices raises challenges to these approaches by highlighting the social and cultural complexity of these situated contraceptive decisions and reflecting the fact that fertility is entangled in a web of social, cultural and gender relationships and

¹³ White and Marks (2002) argue that the FPA was charged with testing the pill since there was no formal drug approval process and because the FPA was considered to be at the forefront of contraceptive knowledge and scientific testing. .

¹⁴ These were often private clinics that were incorporated into the NHS in 1974.

attitudes that vary with economic and social conditions. This type of work represents the point of departure for this analysis.

The dominant models explaining of modern contraceptive demand and use (demographic and economic) are based on macro-level explanations derived from the aggregation of the outcomes of individuals' and couples' reproductive and contraceptive decisions.¹⁵ For instance, extended modern contraceptive use is seen to have increased women's educational attainment and professional status which consequently is used to explain contraceptive behaviour. The aggregated statistical correlations are projected back onto the rationalisations of individuals and couples so that it appears that individuals are deliberately using contraception to ensure educational and professional advancement. These demographic and economic models rest on particular assumptions about modernity and modernisation (see Greenhalgh 1995).

Demographic and economic models of contraceptive practice are rooted in a 'demographic transition model'. The demographic transition model explains the transformation in fertility from high fertility and mortality to low fertility and mortality based on the experience of industrial countries over the last two hundred years.¹⁶ The causal factors are industrialisation, urbanisation and education, which alter the cost of having and raising children, desired family size and attitudes to fertility limitation. The fertility transition was seen to be accompanied by a 'modernisation' of attitudes. According to this view, prior to widespread education and the availability of modern contraceptives people were passive and fatalistic about their fertility, but with knowledge about and access to modern contraception, they were freed from the constraints of nature and tradition and became active, rational, self-interested fertility decision-makers.¹⁷ In this model, 'culture' (read as 'tradition') acted as a constraint that prevented people from making rational fertility decisions and interventions, while with modern contraception they could adopt a modern way of rational thinking in which 'deliberate individual decision-making is freed from cultural constraints' (Carter 1995:

¹⁵ The models described here are based upon the aggregation of average behaviour of a population taken from statistical data and then reduced to generate the representative individuals (Carter 1995).

¹⁶ The model breaks down the transitional period in fertility into three phases. The first phase is when a population has both a high fertility and a high mortality rate. The high fertility and high mortality effectively balance each other out and this means overall slow population growth. The second phase is characterised by a drop in mortality rates due to improvements in medicine and quality of life; fertility rates, however, remain high. The decreased mortality rate combined with the phase one birth rate results in rapid population growth. In the third phase fertility and mortality rates balance to decrease the rapid population rate of phase two.

¹⁷ See Notestien (1945).

60). Therefore these models frame attitudes to fertility and contraceptive decisions as either 'traditional' or 'modern' 'ideas, aspirations and attitudes', this binary being typical of modernisation theory (cf. Fisher 2006; Greenhalgh 1995; Kzertter 1995). The critiques of this model are addressed later.

The Princeton European Fertility Project found no correlation between the timing of the fertility transition and shifts in social and economic development and thus empirically disproved the transition model, at least in Europe.¹⁸ The authors of this study suggest that other variables accounted for changes in fertility practices. 'Culture' was identified as the key factor that facilitates or inhibits the diffusion of knowledge about fertility limitation and its uses as well as its acceptability (see Knodell and van de Walle 1979; Cleland and Wilson 1987). The opposition of 'modern' and 'traditional' attitudes that characterised the transition model also informs this diffusion model because changes in fertility practices were again associated with more knowledge about modern contraceptives. Susan Greenhalgh (1995) argues that the diffusion model was problematic as 'the human drama of fertility decline is now reduced to a technological decision, one of the adoption of modern innovation – contraception – through diffusion' (1995: 9).

These premises about modernisation are similarly apparent in recent feminist economists' examinations of the causal relationship between women's status and contraceptive practices. Karen Mason (1986) argues that improvements in women's statuses are correlated with fertility reduction. For her, women's status in the family and household changed due to economic independence and improved social status which affected their attitudes towards fertility. In response to this, Birdsall and Chester (1987) reversed the argument and suggested that availability and access to contraception contributed to improvements in women's educational and employment status. They argue that the introduction of the pill was critical because before this fertility uncertainty resulted in women making different decisions with regards to education and employment. The pill provided 'near-perfect' control over the timing and spacing of pregnancy and enabled women to pursue education that required investment and commitment, which had been previously curtailed by fertility uncertainty:

¹⁸ See Coale and Watkins (1986); Knodell (1974) and Van der Walle (1974).

We believe that low fertility, at the societal level or the individual level, is not sufficient or even necessary for improving the status of women. Rather, it is women's knowledge that they can, if they wish, control the timing of their childbearing (and society's understanding that women can do so) that enlarges women's economic choices and enhances their status' (Birdsall and Chester 1987: 17).

Goldin and Katz's (2002) time-series analysis from 1950 to 2000 in the United States directly correlated the availability of the pill and women's increased participation in professional spheres. They argue that when women control their fertility this reduces the investment cost of long-term education and careers and increases the age at which women marry and have their first child: 'The pill, because of its reliability, ease of use and female control, enabled young women to plan their reproductive lives almost flawlessly and to delay marriage to pursue career training' (Goldin and Katz 2002: 462). Silvia Pezzini (2005) conducted a similar study for twelve European countries over the last thirty years and found that women are having fewer children, are better educated and have higher incomes.¹⁹ She argues that contraceptives improve women's lives by reducing the number of unwanted children, improving their status and ensuring better-planned educational and career choices that would otherwise have been limited by unwanted pregnancies.²⁰

In these models, as in the demographic models discussed, it is knowledge and access to modern contraceptives that changes women's attitudes to fertility from one of reproductive uncertainty and 'traditional' fatalism to one of 'modern' rational planning. The availability of modern contraceptives is seen as a tool by which women enact rational, self-interested action as well as gaining reproductive and productive autonomy. Peter and Jane Schneider elaborate on how modernisation ideas underlie theories of ideational change:

The proposition that birth control practice was historically connected to a rational turn of mind, and that the first minds to be so affected were European, well expresses the core dualism of modernisation theory – a dualism that opposes 'traditional values' (collectivist and fatalist) to 'modern values' (individualist and rational). The dichotomy between 'natural' and 'controlled'

¹⁹ Also see Aloysius Siow's (2002) study of women's status improvements with increased access to and use of contraception.

²⁰ Some would argue that it was not the availability of reliable contraception that increased women's professional participation but shifts in the requirements of the labour market that favoured women. This would require shifting the causality from better contraception enabling women's increased professional participation and delayed marriage, to changes in the employment market requiring women's participation which necessitated delayed marriage and child-rearing.

(that is, intentional) fertility parallels the dichotomy between tradition and modernity. ... Turning to low fertility regimes exemplified by western Europe, however, they award theoretical significance to an individual's thoughts and actions, and portray contracepting couples as motivated by self-reflection and self-control (1996: 5).

These same authors have argued that this vision of the rational, self-interested decision-maker does not provide an adequate explanation for contraceptive practice, but rather represents an ideology of family planning (see Greenhalgh 1995; Paxson 2004; Adams and Pigg 2005; Ali 2002). Andrew Russell (1999) distinguishes two perspectives in the ideology of family planning: population control and birth control. The population control perspective frames procreation as a problem in need of a cure and implicit in contraceptive services' notion of care is assisting the nation regardless of the desires of individual women.²¹ Instead the birth control view, derived from the suffragettes movement, sees contraception as an issue of personal decision-making and contraceptive services as a form of care aimed at helping the individual. Whether from a population or birth control angle, both approaches model behaviour around an assumed rational actor yet, Russell argues, the ethical issues of caring and the social position and context of users are marginalised in these debates. The underlying assumption is that women, when provided with information, technology and services, will make instrumental, self-interested and autonomous choices about reproduction and contraception based on personal utility and maximisation. Contraceptive practices are reduced to the 'economic calculus of fertility decision making' (Greenhalgh 1995: 8) and assume an ideational change from being fatalistic and passive to being rational and responsible self-regulated individuals, that is, 'modern subjects'.

Heather Paxson (2002) has commented on this supposed 'rational turn of mind' in her ethnography of contemporary reproduction and family planning in urban Greece:

In these appeals to the liberating effects of knowledge can be read committed belief in human rationality such that even sex, often regarded as the most chthonic of human impulses, is drawn into a realm of logic and calculated action. Institutionalised family planning operates on the assumption that not only can people gain control of their lives, but that given certain knowledge they will make certain rational decisions and act accordingly. ... Thus, rational models

²¹ The birth control movement was closely aligned with the British eugenics movement and birth control was seen as a means to end the cycle of poverty and deprivation. It was thought that enabling lower birth rates amongst the poor would prevent further degeneration of the British population (Leathard 1980; Latham 2002). It is interesting to note that the history of the Pyke is directly connected to the conceptual link between birth control, personal betterment and personal responsibility that respondents express.

purport not merely to influence how people act, but to determine their actions.
(Paxson 2002: 312)

Paxson also draws attention to the implicit idea within the ideology of family planning that it is equally open to men and women. It seems, therefore, to be gender neutral and to have the potential to overcome gender inequality.²²

In juxtaposing 'traditional' and 'modern' mindsets, demographic and economic models suggest that fertility control was not thinkable before the fertility transition in the nineteenth century and that prior to this natural fertility raged uncontrollably, evidenced by high fertility rates. Yet historians, such as McLaren (1990), have argued that there have always been concerns about fertility and attempts to influence it: whether to reduce it, to increase it or to control the timing, who had children, when, how far apart and up to what age:

The idea of fertility control was rarely absent, but the motivation to act on such ideas varied. The technological means necessary to restrict fertility could always be produced when necessary. There was accordingly no unilinear growth in fertility control practices; they emerged at times and disappeared at other times ... each gave its own meaning to effective family planning and invented its own methods of exerting control (McLaren 1990:5).

Many authors have argued that people have always been intervening in fertility, reproduction and contraception regardless of whether they have access to information, services and modern contraceptives (see Bledsoe 1990, 1993; Fisher 2006; McLaren 1990). There is ample evidence to suggest that people were devising ways to regulate their fertility without modern contraceptives in order to ensure that pregnancies were wanted and occurred at favourable times prior to modern contraceptive technologies (Carter 1995; David et al. 1985). Examples of this include pre-natal strategies of late marriage, traditional birth control, abstinence, breastfeeding and abortion and post-natal strategies of infanticide, fostering and adoption (Bledsoe and Isiugo-Abanihe 1989; Devereux 1955). This challenges the underlying distinction between 'traditional' and 'modern' attitudes to fertility.

²² This can be seen in the ways that social scientists have interpreted the social implications of contraception, particularly the introduction of the pill (see Giddens 1992 and Firestone 1979 for the liberating effects of the pill in social theory and see Djerassi 2001, Watkins 1998, Oudshoorn 1994 and Marks 2001 for social histories of the pill).

There is an abundance of historical material from Great Britain to suggest that people have always known how to limit births by not having sex and/or delaying the age of marriage and using variously effective methods or technologies (cf. McLaren 1978; Himes 1936; Hajnal 1965; Hartman 2004; Laslett et.al 1966; MacFarlane 1986; Stone 1978). In the early modern period in England, delayed marriage was key to low fertility and was part of an inseparable mixture of cultural, religious, gendered and financial motives closely linked to inheritance patterns (cf. Hajnal 1965, Schofield and Wrigley 1989; Hartman 2004). There is also evidence that people used post-partum abstinence, extended breastfeeding, abortion, observation of a woman's monthly cycle, coitus interruptus and various barrier methods to control fertility. McLaren (1984) found that withdrawal was first mentioned as a contraceptive in the late thirteenth century. Popular recipe books, sex manuals, medical texts and common folklore provided advice on herbal potions, aphrodisiacs, positioning and timing of intercourse and recipes to 'restore' menses (see Porter and Hall 1995; McLaren 1984; Himes 1936). Also rituals marking pregnancy and birth suggest that fertility was not left to fate, but was seen to be socially and culturally mediated. Pregnancy and childbearing were, of course, always of great social importance and are accompanied by complex and elaborate cultural and social frameworks to deal with them, including their management. Controlling conception was both thinkable and possible prior to the nineteenth century and couples saw themselves as playing an active role in their reproduction.

Historical accounts of active intervention, calculated decisions and practices involving varying degrees of contraceptive knowledge and access collapse the analytical separation of traditional fatalistic and modern rational attitudes to fertility to explain contraceptive motivations. Moreover, contraceptive decisions do not represent a one-off invariable event since a child has a changing value that is adjusted and adapted across the life-course with different partners. Women may experience a great deal of ambiguity, indecision and improvisation depending on their context, timing and partner preferences, as well as changes in their social and economic circumstances (Luker 1975; Barrett and Wellings 2000; Santelli et al 2003; FPA 1999).

This is not to suggest that modern contraceptive technologies did not have an impact on contraceptive practices. Modern contraceptives are more reliable, safer and provide an increased degree of control (though 'traditional' contraceptive methods such as rhythm method and withdrawal are also highly effectively when used properly). For instance,

the distribution of low-cost, easily accessible and reliable condoms during World War II to prevent the spread of sexually transmitted infections (STIs) was effective in preventing unwanted pregnancies. In addition, these technological advances have occurred within a particular constellation of economic and social conditions and religious, moral and medical concerns. Kristin Luker (1999) argues that the idea that fertility as a deliberate and conscious action is the outcome of technological and legislative developments, namely the introduction of the pill and the legalisation of abortion. The pill introduced an unprecedented degree of contraceptive effectiveness and reproductive certainty: 'Truly effective contraception, backed up by legally available abortion, meant that for the first time in history, people had to decide actively whether to have a child, rather than passively let nature take its course' (1999: 248). Even so, Luker (1999) does not reduce the impact of these technologies to 'the economic calculus' of future options and to access to information and services. Rather, she recognises that a host of other factors influence contraceptive decisions and practices: 'often human behaviour refuses to conform to our models' (Luker 1999: 248).

No doubt modern contraceptives like the pill are different from earlier interventions into fertility, in that they are highly effective and tend to work on the biological processes of reproduction. I would also argue that modern contraceptives cannot be grouped together as an analytical category as each practice has a unique technique, impact and administration. The pill is distinctive amongst them as the only pharmaceutical technology that does not require external party involvement and is solely dependent on users for effective administration and regulation. Other modern contraceptives (such as IUDs, injections and implants) require clinical intervention for their application, administration and discontinuation. The pill is unique as it takes contraception and fertility control out of the hands of social institutions and relationships and provides users with individualised reproductive control, choice and autonomy.

The pill users who participated in this research did not see or represent their contraceptive motivations and practices as autonomous decisions working in their own self-interest without natural or social constraints. As many of the contraceptive narratives demonstrate, they made contradictory ad hoc contraceptive decisions that were not informed by explicit long-term reproductive strategies. Indeed, their initial interviews for this study were the first time that the majority of these women had put their contraceptive and reproductive decisions into a comprehensive chronological

sequence of events. Each contraceptive and reproductive episode varied from the previous one. None of the women were systematically following an explicit rational plan of their reproduction; rather, they ‘bumbled along’ with a combination of peer, familial and professional advice in changing personal circumstances. A host of other social, economic, affective and physical considerations affected their contraceptive decisions, which this thesis demonstrates. Educational and professional aspirations are apparent in the accounts of the women I worked with, but a closer examination reveals that these aspirations are embedded within a series of related social and cultural values and practices that factor into their decisions to take the pill. For instance, women take the pill to postpone pregnancy and child-rearing in order to be better mothers and their anxieties are, therefore, about being a mother and parent. Moreover, these women’s pill use is not only limited to scheduling pregnancy and being a good mother, it also includes having good sex and managing menstruation and their bodies in public settings.

Ethnographic studies of contraception and fertility illustrate how theories positing human behaviour as disembodied rational actions mask the personal, social and cultural complexities of contraceptive practice. Though the overall outcome of a macro-set of (possibly ad hoc) ‘modern’ decisions may result in the patterns captured in the aggregated rational models of contraceptive behaviour, these models do not capture or explain the in situ, contradictory and competing rationales for episode-specific choices and practices. Kate Fisher’s (2006) work, based on qualitative studies of individuals’ contraceptive choices and practices, maintains that:

[I]nterviewees’ rationales for birth control use contrast starkly with a depiction of “rational” contraceptive behaviour in which couples make deliberate and calculated choices about the children they desire, based on a clear assessment of the costs and benefits of childbearing. ... Most couples made uncertain choices and mild resolutions based on a perception of limited options and vague desires (2006: 4).

These studies illustrate the point that contraceptive practices and fertility decisions do not occur in a social and cultural vacuum but draw on situated moral and cultural norms and social and economic conditions that inform and guide people’s desires, aspirations and actions (see Rapp and Ginsburg 1995; Luker 1976; Fisher 2006; Paxson 2004; Hirsch 2003; Sobo 1995; Ali 2002). Modern contraceptives may enable people to deliberately control and be responsible for their reproductive choices, yet only certain decisions are regarded and coded as acceptable and reasonable within historically

specific social, economic and moral conditions. Defining 'culture' as a catch-all for non-economic and non-demographic factors underestimates the importance and impact of social values and cultural processes on contraceptive practice as well as the social and cultural significance of modern contraceptives (see Kzerter 1995; Greenhalgh 1995; Russell and Sobó 2000; Paxson 2002).²³

There is no doubt that modern contraceptives have changed sexual, fertility and contraceptive practices and that they are linked to the rise of ideas about modern subjectivity, specifically the privileging of individual rational action over social tradition and institutions, conventions and customs.²⁴ Moreover, the demonstration of regulated sexuality and fertility appears to have become a cross-cultural indicator for modern subjectivity in which social regulation is replaced by self-regulation. Yet ethnographies of modern contraceptive practices illustrate how 'tradition' is not actually replaced by the 'rational' actions of modern subjects; rather, 'tradition', social convention and expectations are often reworked and reinforced in new ways. In this way, social and cultural values and practices, rather than pure individual self-interest, continue to inform and are incorporated into contraceptive and related sexual and reproductive practices.

In the context of urban Greece, Heather Paxson argues that the model of rational action:

is unhelpful in understanding sexual behaviour and fertility-control practices. Sexual relations are profoundly shaped by cultural pressures and, in Greece, sexual responsibility for men and women includes upholding asymmetrical gender relations. This gender asymmetry is inseparable from the meanings and practices of sex and love. (2002: 316)

Therefore, she argues, 'conception, pregnancy, birth and other aspects of reproduction are not immutable events, given in nature but are understood through culturally specific meanings of gender, kinship and procreation and are realised through power-laden relationships' (2004: 9). She illustrates how modern contraceptive practices occur in a context of gendered ideals and relationships imbued with ideas of affection, love and desire. Elisa Sobó's (1995) poignant study of women 'at risk' of HIV in the United

²³ See Kerzter (1995) and Greenhalgh (1995) for a detailed description of the functionalist definition and application of culture. Kerzter states that 'culture is treated as a grab bag of non-demographic, non-economic characteristics that influence behaviour without them being susceptible to economic and demographic explanation' (1995: 29).

States similarly found that women's cultural expectations about intimate relationships required them to practice unsafe sex in order to satisfy these values, this going against 'rational' behaviour based on self-interest. She states 'Love and the trust it involves, rather than money, is the immediate root of unsafe sex' (1995: 101) (see also Luker 1976; Holland et al. 1998). In London, Sophie Day (2006) showed how female sex workers did not use condoms with their boyfriends precisely in order to differentiate, in terms of love and trust, these relationships from paid sexual encounters.

As discussed earlier, rational actor models correlate modern contraceptives with women's reproductive autonomy and social advancement, profoundly altering gendered relationships. Yet contemporary and historical ethnographies of contraceptives have illustrated that gendered ideals and relationships have not radically changed and that, often, modern contraceptives are incorporated into existing gender dynamics – a change itself (see Paxson 2004; Fisher 2006; Holland et al. 1998). Moreover, traditional methods do not necessarily reinforce gender inequality. For example, withdrawal, the main method that led to fertility decline in Europe, is a traditional method associated with male authority and yet it depends on joint motivation and mutual cooperation between partners, which is more characteristic of modern companionate marriage (Hirsch 2003; Paxson 2004; Schneider and Schneider 1995; Fisher 2006). Some even suggest that withdrawal is, in fact, a rational action of modern subjectivity since it requires self-sacrifice, rational choice and mutual cooperation (Hirsch 2003, Paxson 2004), though there is no indication that the popularity of withdrawal is increasing in the UK or other 'modern' contexts. Modern methods can also have 'traditional' results; some authors have argued, for example, that women's spheres of autonomy have actually decreased with female controlled modern contraceptives (Holland et al 1998; Collier 1997; Schneider and Schneider 1995). In Sicily, the pill threatens the ideal of a modest, faithful and chaste woman as it removes the penalty for sex (Schneider and Schneider 1996), while in Greece, contraception adds to the burden of women's reproductive accountability (Paxson 2004). Older contraceptive methods can be used in modern ways and modern methods can reinforce conventional gender relations in new ways, which suggest a more complicated relationship between contraceptive methods and gender.

²⁴ Various authors have detailed the relationship between modern contraceptives and new subjectivities see Paxson (2004) for Greece, Ali (2002) for Egypt, Schneider and Schneider (1995) for Italy, Hirsch (2003) for Mexico, Collier (1997) for Spain, Adams and Pigg (2005) for a cross cultural account.

These authors suggest that rather than using 'traditional' and 'modern' as analytical categories, we should recognise that they are cultural concepts used to describe, evaluate and make claims about everyday experiences, relationships and practices. Jane Collier's (1997) study of kinship, parenting and love in Los Olivos, Andalucia, focused on the ideas and practices available for people to monitor, assess and regulate themselves and their activities over the last twenty years. People used the idea of 'modernity', including 'modern' contraceptives, to reject older generations' values and practices and to frame themselves as 'thinking for themselves'. She shows how the ideas of 'modern' and 'traditional' are used to narrate and interpret success and failure within a wider system of inequality. In Los Olivos people adopt a 'modern' subjectivity, 'thinking for themselves', which shifts the discourse of inequality from inherited to achieved status. Yet this does not represent a change or more choice than before but rather a new set of constraints; one criterion is not replaced with another, but a wealth of contradictory images are drawn on to evaluate themselves and to negotiate relationships.

Heather Paxson (2004) shows, for Greece, how ideas about traditional fertility practices are not so fatalistic and modern practices are not so rational and under control as imagined by Greek women; it is the interplay of both modern and traditional viewpoints that allows people to make sense of their lives:

Greeks ascribe events to fate in order to carry on in a world not under their immediate control. They do not act because it is their fate to do so; rather fate – which can in modern settings be shorthand for the emotional, moral and material factors seen to impinge on people's (supposedly) otherwise rational action – allows them to cope with events that do not accord with their ideals (2004: 95).

These studies suggest that 'tradition' is not replaced by the rational action of 'modern' subjects; rather 'tradition', social convention and social expectations continue to determine contraceptive practices and are often reworked and reinforced. Similarly, this study of the pill situates the rationales and practices of pill use within the social and cultural context that informs their meaning rather than adopting pre-determined analytical categories.

‘Natural Facts’ in Anthropological Theory

Discussions with the women in this study demonstrated that their decisions were far from self-interested rational actions disembedded from social relations and institutions but rather entangled in wider conflicting social, cultural and gender concepts and relationships. Their decisions, actions and experiences drew on gendered, situated social and cultural meanings and they constantly referred to the notions of ‘nature’ and ‘choice’ when defining, describing, interpreting and evaluating their pill use in their everyday lives and relationships. The following sections provide a summary of the extensive nature/culture and sex/gender debates in anthropology, analyzed in terms of how they relate to the ways in which the women in this study talk about the pill.

The discussion and attempted definition of ‘natural’ and ‘biological’ facts has a long intellectual history in anthropology which is most apparent in kinship studies. Franklin (1997), Strathern (1980, 1992a) and Schneider (1984) have traced and critiqued the ways in which nature has been taken-for-granted in kinship studies. They highlight how anthropological theory presumed that natural facts were ‘out there in reality’ and constituted an implicit universal basis upon which all societies built their social relationships and structures. They exposed how social relationships and structures apparently ‘rooted in’ biology and nature were in fact premised on Western folk models and knowledge practices. The following outline of the discussion of natural facts in anthropological theory takes these recent critiques as its point of departure. It concentrates on the debates about natural facts found in the recent anthropology of gender and kinship. The analysis of natural facts has diverged in the two subfields of feminist anthropology and the new kinship studies, with the former focusing on the relationship between sex and gender on the one hand and the latter on nature and culture. This analysis aims to reunite the study of kinship and gender by showing the way in which the natural facts of femininity are implicated in each subfield.

Many of the analytical insights about natural facts are drawn from anthropological studies of new reproductive technologies. New reproductive technologies follow after the pill chronologically in terms of their development, but these studies nonetheless provide useful analytical precedents for understanding the pill. This study engages with the insights of anthropological studies of reproductive technologies in formulating a critical analysis of the natural facts of femininity. It therefore addresses a lacuna both in

the literature on contraceptive practices and an absence of modern contraceptives from new reproductive technologies. Studies of contraceptive technologies have tended not to account for the technological dimensions of modern contraceptives on ideas of social roles and the body which this research foregrounds. Studies of reproductive technologies focus more on complex and exclusive assisted conception methods over more everyday technological interventions into reproductive life. They have also focused on kinship and the implications for the relationships between parents and children and, hence, the analysis of gender emphasises the achievement of maternal status.

The feminist critique of anthropology in the 1970s questioned male domination, patriarchy and female subordination as cross-culturally universal phenomena. Several analytical dichotomies such as nature/culture, public/private, production/reproduction were employed to understand universal female subordination (see Rosaldo and Lamphere 1974; Reiter 1975; Ortner 1974; Rosaldo 1974). The most renowned example of this approach is Sherry Ortner's (1974) analysis of gender symbolism which aims to illustrate how hierarchical sexual difference takes on constitutive meaning within a symbolic system. Ortner argues that women are subordinated cross-culturally because they are associated with the universally devalued domain of nature which is controlled and transcended by superior culture. Women are more closely associated with nature due to pregnancy and child-rearing whereas men are associated with culture and are therefore superior to women. Marilyn Strathern (1980) critiqued Ortner's argument by demonstrating how the idea that culture transcends nature is a Western knowledge practice and not universally salient. Henrietta Moore (1988) argues this binary opposition of male and female focuses on a single set of gendered relations defined by roles in reproduction, and does not account for other gendered relations, such as siblings and parent-child relations. For Moore, Ortner also does not address the historical and geographical differences between women in one culture as well as across cultures. Although it has been heavily critiqued, Ortner's work represents a disciplinary shift away from structural-functionalist analyses of sex categories and gender toward a cultural and symbolic analysis of how gender difference and inequality are constructed. This shift represents an epistemological break in the treatment of natural facts as the basis of the difference between men and women.

The same edited volume, *Women, Culture, and Society* (1974), that included Ortner's article also set out the critique of universal analytical categories and the binary opposition of male and female sex categories based on biological roles in sexual reproduction. Instead of assuming that biological sexual difference translated into universal sex categories and roles, binary sex categories and associated gender roles were not assumed to be a priori, predictable or fixed but rather as being constituted through culturally-specific social and symbolic processes that produce difference and inequality. The assumption of universal binary opposition was seen as ethnocentric, reductionist, and ahistorical (see MacCormack and Strathern 1980; Moore 1988, Moore 2003). The search for universal explanations of patriarchy and female oppression was replaced by the analysis of culturally-specific conceptualisations and definitions of gender (Moore 1988; MacCormack and Strathern 1980; Ortner and Whitehead 1981; Errington and Atkinson 1990).

This analytical shift meant that analysts started to distinguish between sex and gender. Gender was defined as the 'cultural elaboration of the meaning and significance of the natural facts of biological differences between women and men' (Moore 1999: 149). Sex represented physical biological difference between the sexes. Carsten (2004), Errington and Atkinson (1990), and Moore (1999) argue that this analytical distinction aimed to demonstrate that whatever physical sex was, cultural elaborations and perceptions of sex were not universal, inevitable or predictable. This allowed anthropologists to analyse how different cultures construct the difference between men and women and the relation of this to other axes of difference and why those differences are constructed in a particular way (see Moore 1994).

The examination of how different cultures construct the difference between women and men and how they constitute gender were the subjects of ethnographic studies that demonstrated that biological sexual difference did not universally translate into gender difference (see Strathern 1980; Errington 1990; Herdt 1994).²⁵ These studies showed that women and men had various roles in reproduction and gender that did not neatly map onto Western ideas of biological sex. It became clear that gender roles and ideologies are not singular or static but that they are often multiple and changing as in

²⁵ See Carsten (1997) and Brenner (1998) for ethnographies examining how gender difference is constructed in different cultural contexts.

the cases of parent-child or sibling relations or of the third-sex (see Errington 1990; Herdt 1994; Moore 1993; Peletz 1996).²⁶

Carsten (2004) argues that the analytical separation of sex and gender eventually leads to a theoretical impasse. Though it appeared to liberate analysis from universal biological determinism, it was problematic as it naturalised biological sex and placed it beyond inquiry. Jane Collier and Sylvia Yanagisako (1987) offered a way out of this impasse by problematising the category of biological sex as a natural fact. They questioned the implicit biological determinism of separating sex and gender since natural difference remains implicit in these analytical categories that, themselves, start with a definition that is rooted in unquestioned biological difference. Instead of assuming natural sexual difference implicit of sex, they suggest examining what biological facts do and do not explain about gender; questioning the biological facts of sex themselves. Collier and Yanagisako argue that:

Having recognised our model of biological difference as a particular cultural mode of thinking about relations between people, we should be able to question the 'biological facts' of sex themselves. We expect that our questioning of the presumably biological core of gender will eventually lead to the rejection of any dichotomy between sex and gender as biological and cultural facts and will open up the way for an analysis of the symbolic and social processes by which both are constructed in relation to each other (1987: 42).

They, therefore, redefined sex as a social product and argued for an examination of the 'symbolic processes [that] make these domains appear self evident and, perhaps, even "natural" fields of activity in any society' (1987: 35). From this perspective, the category of biological sex is seen as a product of the Western folk cultural model that tacitly informed anthropological analytical categories.

In a similar vein, Judith Butler (1990, 1993) and Thomas Laqueur (1992), drawing on Michel Foucault (1984), argue that sex, gender and sexuality are socially and historically constructed and that biological sexual difference is, in fact, an effect of gender. Thomas Laqueur (1992) illustrates how social and historical forces changed ideas about gender, which were reflected in the social construction of biological sex categories that transformed a one-sex model to a hierarchical two-sex model. Judith

²⁶ These studies of the production of gender difference fed into and contributed to studies of the construction of social difference and identity, yet these studies have been criticised for presuming that

Butler (1993) problematised the category of sex by reversing the relationship between sex and gender so that gender socially elaborates biological sex. In *Bodies that Matter* (1993) she outlines how the materiality and givenness of sex is a produced and naturalised effect of gender and how gender organises difference and produces categories that are encoded as pre-existing natural difference.

The separation of sex and gender and the critique of these categories illustrate how gender and sexual difference, and the analysis of these, are not universal, inevitable and taken-for-granted, thereby problematising the idea of natural facts in anthropological theory. This change in perspective was paralleled by similar theoretical developments in anthropological studies of kinship. The biological determinism and the natural facts of kinship theory came under similar critique that eventually transformed the study of kinship (see Schneider 1968 and 1984). Carsten (2004) has argued that these debates have resulted in the marginalisation of kinship and yet hold the possibilities for its refashioning.

David Schneider's (1960) cultural analysis of American kinship critically examined the presumed natural facts of kinship theory. Schneider argues that sexual intercourse is the core symbol of American kinship that links conjugal and cognatic love by merging the orders of nature and law, thus making the family a natural unit. The biological facts of the family and kinship are powerful cultural resources with symbolic qualities. That is, 'they represent something other than what they are, over and above and in addition to their existence as biological facts' (1984: 116). The biological facts of kinship symbolise love and 'diffuse, enduring solidarity' and are therefore an effect of social facts and not the reverse. Later, in *A Critique of the Study of Kinship* (1984), Schneider argued that the natural facts of kinship are informed by the 'ethno-epistemology of European culture'. Anthropological kinship theory, he said, conflated the Western folk model of social relationships 'rooted in' and 'based on' the biological facts of sexual reproduction with universal theories of kinship.²⁷

gender difference had ontological priority over other forms of difference (Moore 1993; Collier and Yanagisako 1987; Strathern 1980).

²⁷ Schneider noted two implicit Western assumptions in kinship theory: 'The Doctrine of the Genealogical Unity of Mankind', stating that genealogical relations are the same everywhere, and 'Blood Is Thicker Than Water', defining kinship as the relationships arising from sexual reproduction and hence arguing that social relations are 'rooted in' and 'based on' biological facts.

Schneider's critique not only brought to light the implicit ethnocentrism found in kinship theory and categories, it also revealed how anthropological theory and categories framed the causal relationship between nature and culture and the social and the biological. Schneider's examination of natural facts lay the groundwork for revitalising kinship studies by questioning the biologically determinist and functionalist assumptions of anthropological theories and opened up new ways of analytically relating nature and culture and the social and the biological (see also Franklin and McKinnon 2001; Franklin 1997; Carsten 2004). Framing biology as a cultural system and biological facts as symbols that generate cultural meaning led to an examination of the cultural meaning and symbolic systems of nature and biology.²⁸ In addition, the identification of implicit Western ethno-epistemological categories in anthropological theories made Western folk models, cultural categories and knowledge practices, particularly those related to biology, an area of anthropological investigation, thus drawing attention to the special status of nature and natural facts in Anglo-American culture.²⁹

Franklin and McKinnon (2003) and Franklin (1997) have both noted that biology and nature, and their substance and codes, are broadly and poorly defined in anthropology, presumably because they have been implicit and largely taken-for-granted.³⁰ In recent years the symbolic density of substances and codes of nature and biology have received much attention in kinship studies. The work of Marilyn Strathern (1980, 1992a, 1992b) has gone a long way in exploring the definition and density of the concepts of nature in Anglo-American culture and in anthropological theory more generally through a detailed examination of the multiple definitions of nature and its complex relationship to culture in Anglo-American knowledge practices. She defined nature as a domain that is intimately linked with the domain of culture. Nature and culture are in this model relationally defined and the relationship between them constantly shifts since culture controls nature and yet nature is prior to and determines culture:

²⁸ Carsten (2004) has noted how, after Schneider's critique of kinship, social institutions such as marriage, family, inheritance and so on, traditionally associated with kinship studies, were incorporated into studies of gender.

²⁹ Marilyn Strathern (1992a), Mary Bouquet (1993), Sarah Franklin (1997) and Rebecca Cassidy (2002) have all shown that this presumption of 'natural facts' as defined after nature is particularly English and forms an integral part of English knowledge production.

³⁰ See Franklin (1997: 50-57) for an analysis of Schneider's sweeping use of the terms 'nature' and 'biology'.

At one point culture is a creative, active force which produces form and is structured out of a passive, given nature. At another, culture is the end product of a process, tamed and refined, and dependent for energy upon resources outside itself. Culture is both the creative subject and the finished object; nature both resource and limitation, amenable to alteration and operating under laws of its own. It is rather like a prism that yields different patterns as at times either nature or culture may be seen as the encapsulated or encapsulating element. (Strathern 1980: 179)

The relationship between nature and culture in the West/England/Euro-America is not static. It is, rather, a continuous process of transformation of one to the other, a changing hierarchy in which meanings shift in relation to one another depending on the formulation of control between them. Strathern (1992a) argues that the very construction of the notion of culture implies that the relationship between nature and culture is an artifice that is further legitimated by grounding itself in nature.

In *After Nature* (1992a), Strathern explores further the complex co-production of nature and culture. She illustrates how ways of organising knowledge about the natural world are intertwined with ideas about the structure of society. There is a continuous tension between culture and nature, as society claims to descend from nature but at the same time departs from nature through socialisation. Culture is, therefore, both departing from and related to nature. As domains, culture and nature appear autonomous, internally-regulated and antithetical, yet they are relationally defined through their opposition. This relational opposition is a productive tension that makes both domains knowable; they play off one another as they illuminate and mask the other. In other words, nature makes culture evident and each domain depends on the other to demonstrate their contexts, boundaries and effects. Culture is built up of or after elements that are not itself, including especially nature: 'It [culture] incorporates the idea that, in working upon and modifying the natural world, human artifice must at the same time remain true to its law and to that extent imitate it' (Strathern 1992: 3).

Strathern refers to this complex relationship as a 'merographic connection': domains can be part of something else, but nothing is ever a whole as it can be re-described from another perspective as something else:

Consider: domains such as 'culture' and 'nature' appear to be linked by virtue of being at once similar and dissimilar. What makes the similarities is the effort to 'see' connections; what makes the dissimilarities is the 'recognition' of difference. Difference thereby becomes apparent from a simple fact of life: it is

a connection from another angle. That is, what looks as though it is connected to one fact can also be connected to another. Culture and nature may be connected together as domains that run in analogous fashion insofar as each operates in a similar way according to laws of its own; at the same time, each is also connected to a whole other range of phenomena which differentiate them – the activities of human beings, for instance, by contrast with the physical properties of the universe. The second connection makes the partial nature of the analogy obvious. It presupposes that one thing differs from another insofar as it belongs to or is part of something else. (Strathern 1992a: 73)

Merographic connections are exemplified in the hybrid character of kinship which is a composite of the social relations of kinship, that is socialised nature, and relations derived from nature. Kinship is constituted through the borrowing, shifting, connecting and disconnecting of nature and culture. The merographic relationship between nature and culture is made increasingly explicit by reproductive technologies, as they seem to openly make and unmake kinship facts. Reproductive technologies literalise and instrumentalise the interplay between social and biological facts (see also Cannell 1990; Franklin and McKinnon 2001; Thompson 2005; Ragoné 1994). Surrogacy, in-vitro fertilisation and donor insemination make explicit the hybridity of the supposedly “natural facts” of kinship to Euro-Americans.

Several ethnographies of reproductive technologies have detailed how biological and social facts are foregrounded and backgrounded in practice in order to make or unmake kinship connections. Helene Ragoné’s (1994) study of surrogacy in the USA shows how surrogates and intending parents downplay biological and genetic elements of motherhood while emphasising social aspects of motherhood in order to legitimate and normalise intending mothers’ claims to motherhood. Sarah Franklin’s (1997) study of women’s experiences of in vitro fertilisation (IVF) illustrates how technology, a form of social mediation, is transformed to be ‘just like nature’ and nature and technology become mutually substitutable in the creation of kinship. Charis Thompson’s (2003) study of surrogacy and IVF showed how different, contradictory social and biological models of relatedness are used and emphasised to decide who is related and how.

These studies illustrate that the relationships and boundaries between nature and culture are contested and permeable as reproductive technologies disassemble and reassemble the biological and social facts of kinship in novel combinations. These reformulations of kinship were often directed towards the conventional ends of becoming parents and making families and children, thus reinforcing normative categories (Cannell 1990;

Ragoné 1994; Thompson 2005; Becker 2000; Franklin 1997). This ‘recombinatory logic’ is not wholly new; previously anthropologists of English kinship have shown how people choose to stress different modes of relationality according to particular circumstances (Edwards and Strathern 2000; Edwards 2000; Firth 1959; Strathern 1984).

³¹ Yet what is new about this ‘recombinatory logic’ is the changing understandings of biological facts and the explicit agency involved in using natural facts (Carsten 2004; Franklin 2003; Thompson 2005).

The history of “natural facts” in the recent anthropology of gender and kinship shares a similar analytical trajectory. The idea that gender and kinship are based on “natural facts” that are ‘out there in reality’ is the product of a particular Anglo-American cultural model which has been imposed onto other systems of thought. Rather, natural facts are cultural constructs and symbols and their content and composition requires examination and elaboration. In anthropological studies of kinship and of gender, the critique of “natural facts” has reshaped the field, and natural facts themselves (their production and effects) have become a site of anthropological investigation.

The Power of “Natural Facts”

The anthropological and ethnographic investigation of “natural facts” has developed in two main ways: theorists have examined their symbolic and productive power (Franklin and McKinnon 2003) and how they function as the bases for truth claims, and naturalise difference and inequality in Western knowledge practices (Delaney and Yanagisako 2000; Franklin 2003). The analysis of “natural facts” by feminists and kinship theorists showed that biology and nature are cultural resources that are used to make sense of social categories, roles and relationships and therefore act as powerful bases in the making of truth claims. In this way, they are part of knowledge practices that classify, differentiate and legitimise difference. This section outlines how natural facts, as potent cultural constructs, constitute meaning and difference and how this capacity has been transformed with recent bio-technological innovation.

The classificatory and constitutive power of “natural facts” has been examined by Carol Delaney and Sylvia Yanagisako. In *Naturalizing Power* (2000) they argue that

³¹ There are some historical precedents for individual choice in family and kinship relations in England (see Firth 1959; Wilmot and Young 1986 and Strathern 1981)

naturalisation, making social facts appear natural, is a symbolic activity that produces and legitimises difference and inequality. The power of natural facts is to render certain relations and situations 'natural, inevitable, even god given' by acting as the explanatory schema for the order of things. In other words, identities and relationships that are 'rooted in' and 'based on' nature appear as inevitable unquestioned 'facts of life'. 'Natural' difference and inequality, the productive effects of biological discourse, are legitimated as inevitable and taken-for-granted by the natural 'order of things'.

Sarah Franklin et al. (2000) similarly argue that nature and natural facts have constitutive power as they are conceptualised as being real, self-evident and categorical. Naturalisation is, thus, a classificatory process that generates and legitimises difference. The classificatory and constitutive power of natural facts produces the essential constitution of the world, the principles by which it is ordered and produces 'the effect of being self-evident'. Delaney and Yanagisako (1995) illustrate this with regard to gender:

Men and women became defined by and identified with what they contributed to procreation. In contemporary Euro-American belief, reproduction has been reduced to its natural character and is associated with women; women have been defined by and conformed to their reproductive role. ... Gender definition and value have been inherent in the Western theory of procreation, but procreation is not just about the natural; it includes an ontological dimension. (1995: 9)

The association of women with their biological role in sexual reproduction illustrates how naturalisation legitimates certain identities, classifications, forms of difference and inequality.

As discussed in the previous section, the advent of reproductive technologies instrumentalised the relationship between nature and culture as nature and biology became increasingly 'technologically mediated and amenable to reconstruction' (Franklin 2003: 100). With advanced new reproductive technologies, explicit technological manipulation of natural facts blurred the boundary between the biological and the social, with consequences for the co-production of nature and culture and therefore the constitutive power of natural facts. This raises questions about what is nature and whether it continues as a potent explanatory schema for the 'order of things'.

Paul Rabinow (1997), Donna Haraway (1991) and Marilyn Strathern (1992a) have argued that bio-technologies have altered the relationship between nature and culture

and thus the potency of natural facts. This is because the ability to construct nature through technology 'contaminates' nature with culture, undermining nature's legitimacy to orchestrate the 'order of things'. This potentially has implications for knowledge practices as it becomes difficult to think of nature without culture and collapses their relational opposition, which in turn has consequences for the classificatory power of natural facts. Donna Haraway (1991) argues that nature and culture are imploding as nature no longer comes prior to culture since the social is no longer modelled after nature when it is rebuilt with technology. Paul Rabinow (1996) claims that in the new relations of 'biosociality' nature is increasingly modelled on culture and that the social relations descended from nature no longer express nature, instead they are being 'remade through technique'. Marilyn Strathern (1992a) argues that nature is potentially losing the capacity to be seen as a separate and distinct domain due to technological modifications and it therefore becomes 'flattened'. In a 'post-plural' context, the merographic connections between nature and culture and nature's ability to ground knowledge and model relations dissolves and the self-evident capacity of the natural domain vanishes.

These theorists suggest that the literalisation of nature through technology displaces the natural domain and its classificatory power. Recent ethnographies of reproductive technologies, however, have shown how nature and natural facts continue to ground meaning in practice (Edwards and Strathern 2000; Franklin et al. 2000; Thompson 2005). Moreover, nature and natural facts retain the capacity to affect distinction, classification and differentiation. Edwards and Strathern (2000), Franklin et al. (2000), Franklin (2003) and Thompson (2005) all argue that divisions and combinations of nature and culture continue to be employed to understand 'the order of things' and social difference. Franklin et al. (2000) maintain that nature is a 'distinctively powerful and transformative idiom' which is 'continually reinvented in the processes of naturalisation, de-naturalisation and re-naturalisation as a means of grounding the orders of meaning and practice we understand as culture' (2000: 19). Though nature and culture are blurring and acquiring each other's characteristics, the distinction between them is revised with generative and constitutive effects. Nature is not flattening or imploding, but rather is repeatedly reinvented and continues to shape and ground the production of meaning and practice (Dow 2010).

Sarah Franklin et al. (2000) suggest that the challenge raised by bio-technology is the following: 'How might we need to re-conceptualise the nature-culture axis as a classificatory process if nature as a referent system cannot secure the ground it once did as a taken-for-granted limit point of horizon? ... How is nature being re-created in the space of its own displacement?' (2000: 10). They argue that a processual model of nature captures the ways in which nature continues to make meaning and produce classificatory and differentiating effects. A processual model 'emphasises the movements enabling ideas of the natural to signify with the notable fluidity, contradictoriness and power that is their distinctive feature' (Franklin et al. 2000: 19). Though natural facts are more fluid and flexible, they remain a powerful idiom:

while nature and culture are increasingly isomorphic, in that they are acquiring each other's powers, their distinctiveness continues also to remain crucial. We argue that the category of the natural remains central to the production of difference, not only as a shifting classificatory category but through processes of naturalisation, de-naturalisation and re-naturalisation (Franklin et al. 2000: 9-10).

Franklin's (2003) study of new genetics exemplifies how biological and social facts are remade to generate and ground identities and relationships. She argues that new uncertainties about biology created by genetic technologies mean that biological facts are associated with innovation and change rather than fixity and continuity. The changing and variable meaning of nature makes it hard to examine the role of biology in making meaning and practice. She found that natural facts are central to new ways of weaving together identities and relationships, even when kinship and gender are shorn of their natural moorings. Franklin argues that: 'Increasingly, the biological refers to "a combination and division phenomena" that not only requires new metaphors, *but also comes to embody them*, producing an interesting reproductive process. The biological increasingly refers to mixtures of the biological and the technical. ... Like kinship, biology is increasingly "after nature"' (2003: 69; original emphasis). She illustrates this with new genetics in which biology is assembled from different orders according to the logic of the totality not found in the parts. The logic of the totality of new genetics is to reduce risk to the child, which is biological and therefore open to instrumentalisation, but also social in terms of the related sense of responsibility, obligation and hope. New genetics, as in Franklin's example of the assisted genealogy of pre-implantation genetic diagnosis, instrumentalises the partial connections between the social and biological by building on biological models of kinship open to social mediation (Franklin 2003). Here

technology reframes and intensifies the merographic connections between social and biological facts yet the distinction between them makes instrumentalisation possible.

Charis Thompson (2005) examined the reframing of nature and culture in the everyday practice of an assisted conception clinic. She shows how donor egg in-vitro fertilisation (IVF) and gestational surrogacy challenge biological motherhood by separating the genetic and gestational aspects of motherhood, thus creating several candidates for biological mother. She maps the strategies used to delineate the mother as couples, doctors and third parties pry apart biological motherhood into its separate components.³² In this study, the natural facts are strategically used to delineate relatedness when there are different, contradictory social and biological models available. Different modes of biological relatedness are used in the 'sorting and classifying of some things and not others as the biological facts of relevance' (2006: 198) and the making of socially meaningful categories.

Franklin's and Thompson's studies illustrate how biological and natural facts remain powerful cultural resources for grounding social categories. Thompson (2005) further argues that strategically naturalised social categories establish moral and epistemic taken-for-granted, that is 'the rendering of states of affairs and facts in a scientific or biological idiom and the means by which aspects of the site are rendered unproblematic or self-evident in the sense of seeming "natural"'. (2006: 81). Nature and biological facts are conflated with normality and therefore remain evaluative: 'What is normal is often stabilised by what is natural ... what is normal and normative also helps fix what is naturalised' (Thompson 2005: 81). This strategic naturalisation illustrates how nature continues to ground social categories and to guide meaning and practice. These strategic and normative uses of nature suggest a shift in thinking from kinship being 'fixed' by natural facts towards a model in which naturalness is the achieved outcome of 'doing' nature.

Sarah Franklin and Susan McKinnon's (2001) and Janet Carsten's (2004) overviews of new kinship studies outline the new ways in which 'natural facts' ground meaning and practice, but they also stress that these do not represent a radical departure because they pursue traditional kinship relations, reinforce the dichotomy between nature and culture

³² Thompson argues that contingent combinations of reproductive intent, financial investment and genetic contribution are used to trace maternity through the various bodies producing the baby.

and do not challenge hegemonic truth claims. What is new about nature and natural facts, Carsten suggests, is 'the very explicitness of the moves by which people are able to define who is kin and who is not, and what kinds of kinship count and what kinds do not ... If explicitness and a more or less visible reshuffling of the elements of kinship are what strike us most readily about kinship's new forms, then it is worth asking why they should jar. What is startling here is the very obviousness of the moves to exclude or include' (2004: 180). These recombinations of natural facts are not necessarily new, but what is novel is the explicit capacity to strategically use natural facts. Sarah Franklin et al. (2000) termed this explicit and strategic reshuffling of the indeterminate parts of kinship as 'strategic agency' where 'there is a lot of picking and choosing going on at the level of which information is accepted as useful knowledge, what kinds of authority are relied upon, and how individual decisions are reached amidst often conflicting individual, marital and familial priorities' (2000: 74).

With reproductive technologies people have the necessary agency in achieving and 'doing' nature to claim or disavow descent and relatedness as they are offered new ways to draw out distinctions and to reinforce old ways of claiming identity (Franklin 1997; Franklin and Roberts 2006; Thompson 2005; Ragoné 1994). Yet the distinction between social and natural facts remains fundamental to meaning-making and their continuing classificatory power. By framing the pill as a technology that intervenes in the social and biological facts of reproduction, I can explore how it affects the natural facts of sexuality, reproduction and gender. If the pill explicitly prises apart sex and reproduction, how do these women understand their gendered roles to be constituted and grounded? Are the natural facts of reproduction still relevant for gender? If so, how is nature and biology operationalised in relation to the constitution of gender difference?

The Natural Facts of Femininity

The previous sections outlined the discussions about natural facts in the anthropology of kinship and of gender and the recent theoretical developments in the analysis of 'natural facts'. An important part of these discussions and theoretical developments has depended on emphasising the particularities of the Anglo-American concept of nature that has, to a large extent, informed anthropological theory. This section details how 'natural facts', particularly those of sexual intercourse and reproduction, are significant

to contemporary English notions of femininity, what I term 'natural femininity'. By 'natural femininity' I mean to suggest that femininity in England is organised around the core symbols of sexual intercourse and reproduction and is, therefore, like kinship and gender, a hybrid of biological and social facts. Many of the characteristics of natural facts described, such as their capacity for being connected merographically and their constitutive and classificatory power, are, therefore, applicable to the domain of femininity.

Those working in the new kinship studies have observed how the assembling and disassembling of the codes and substance of biological and natural facts generate and ground identities and relationships, and much the same point applies to contemporary negotiations of femininity. In their narratives, the women in this study elaborated on the social and biological facts of femininity, demonstrating its hybrid nature. These facts related to a model of reproduction that informs ways of relating and naturalising gender identities. Natural facts were critical to the construction of femininity as they provide the form and content of a cultural model which posits fundamental differences between the sexes, which are in turn used to legitimise and normalise statuses, roles and norms for women.

They described how using the pill disrupts the naturalised association of sexual intercourse with reproduction and therefore challenges the construction of natural femininity. (Though the pill does not permanently break the link between sex and reproduction but, rather, this link is temporarily weakened and, after using the pill, it can be reinstated). Like abortion, the pill 'subverts the fertile union of men and women, either by denying procreative sex or the differentiation of male and female sexuality. This prospect threatens the union of opposites on which the continuity of the social whole is presumed to rest ... [and] represents an active denial by women of two essential conditions of female gender identity: pregnancy and the obligation of nurturance that should follow' (Ginsburg 1989: 216). With the pill, femininity is no longer inevitably tied to the natural facts of procreative sexual intercourse. Thus, the pill makes explicit that the natural facts of femininity are not inevitable but, rather, open to social mediation and are, therefore, more 'social' than 'natural'. On the pill, moreover, the biological facts of sexuality and menstruation that define natural femininity are no longer self-evident and become a question of choice. In this way, the pill displaces the core organising symbol of sexual intercourse and reproduction at the heart of 'natural

femininity' and, therefore, naturalised gender difference. The natural facts of femininity as 'rooted in' and 'based on' natural sexual difference do not hold firm.

This ethnography of pill users demonstrates how the natural facts of femininity are being actively remade as women use nature to make and remake new and old identity claims and re-constitute natural femininity. The following ethnography shows that, as with other reproductive technologies, even though the pill makes explicit the cultural construction of the taken-for-granted natural facts of femininity, the women I spoke to strategically used natural facts to ground identities and relationships by disassembling, reassembling and remaking nature. Natural facts and the relations between biological and social facts are strategically mobilised by women grounding femininity and gender difference in the idea of nature. This demonstrates that nature retains the capacity to effect self-evident classifications and differences and natural facts remain a powerful cultural resource for grounding social categories in new ways. Yet in the process, femininity is no longer understood by the women in this study as a fixed, inevitable state but as an ongoing achievement, the outcome of an active 'doing'. This problematises the pervasive idea that women using modern contraceptives have been liberated from 'traditional' models of naturalised femininity. Instead, their uses of the pill show that they actively attempt to inhabit these models in new ways.

This displacement of the natural facts of femininity described above is paralleled by profound changes in the social roles of women in the United Kingdom.³³ The 1980s and 1990s were characterised by economic turbulence, high inflation, high unemployment, recession and employment restructuring that led to a shift in employment patterns from manufacturing to the service economy. This resulted in a change in the gender composition of the workforce. The increased demand for different types of labour resulted in an influx of women into the labour market, mostly in part-time work (Equal Opportunities Commission 2006; Scott 2004; McRae 2004). Since 1975, male employment has fallen and women's economic activity through employment has increased by seventy percent. Susan McRae (2004) argues that this new economic and employment structure has provided unprecedented opportunities for highly educated

³³ It is important to note that there are historical precedents for high levels of single migrating people with low fertility rates due to late marriage and delayed child-bearing in north-western European societies. This suggests that apparently new family forms, gender relations and fertility patterns are not as novel as is sometimes assumed (Schofield and Wrigley 1989; MacFarlane 1978).

women who are increasingly employed in professional and managerial positions since the 1980s and early 1990s:

By 1997, one-third of employed women worked in managerial, professional, and associate professional occupations, a rise from one in five in 1980. Many of these women have remained childless or delayed childbearing until after establishing their careers. Each of these demographic trends is concentrated among middle-class, highly educated women; adoption of such career strategies had led to 40 percent of births being to women aged 30 and older and projections of 25 percent childlessness by the year 2010. It has also led to slow but discernible inroads being made by women into the top jobs in Britain. (McRae 2004: 6)

In London, many of these young women in managerial and professional jobs tend to live alone and this has resulted in the rapid rise of one-person households to levels unknown in previous decades (McRae 2004; Hall et al. 2004). This professional and domestic arrangement was typical of my respondents.³⁴

This emergent demographic category is part of wider changes in family formation and structure that challenge the idea of the naturalised traditional family. The traditional family is based on a standard functionalist theory of family life in which it is an adaptive unit that mediates between individual and society and is an essential function and prerequisite for survival (Cheal 1991). Therefore family structures are adapted to meet the needs of society and in industrial society it is the nuclear family (Parsons 1960).³⁵ According to this functional definition of the family, the nuclear family serves to socialise children and stabilise adults based on naturalised sex roles: an employed husband/father and home-based wife/mother to care for the child. Therefore, reproduction is the natural basis for family life with the conjugal relationship and naturalised gendered roles at the centre.³⁶ Historical and feminist research has

³⁴ It is important to note that the benefits accrued to some women do not affect all women who have entered work. The majority have entered part-time work which means lower rates of pay and poor promotion prospects; there have also been few changes in domestic responsibilities.

³⁵ This supposition has been criticised, as the nuclear family has been a distinguishing feature of English family arrangements for centuries (Laslett 1960, Stone 1978, Schofield and Wrigley 1989). Moreover, historical demographers have shown that marriage duration was short (marriage is now more stable than before even with high divorce rates) because it was often broken by the death of a partner and remarriage was very common; in a quarter of marriages one spouse was widowed [when?]. Historical pattern of high infant and child mortality and fostering also made parent-child relations tenuous. The idealised nuclear family was therefore often a composite family of remarried spouses, stepchildren and orphaned or abandoned children and could be short-lived and unstable. Incidentally, this also reflects the absence of social welfare provision.

³⁶ The nuclear family is informed by an ideology of modernisation with implicit gender relations (see Talcott Parsons (1960) in which it is the unit of production and reproduction and motor of industrialisation and demographic transition.

questioned the nuclear family and suggests instead distinguishing between the family as a social and economic institution and the family as an ideology (Barrett and McIntosh 1982):

The symbolic importance of the family cannot be underestimated, for it goes beyond political allegiances of left or right and has arguably come to be seen as the most important institution of modern industrial society. The problem, however, is that it is seen to be grounded in reality rather than as a symbol of system or ideology (Gittins 1993:59).

Therefore it is important to differentiate between the family as an ideal form and the lived realities of family life.

The last thirty years has seen a decline in the traditional 'two parents plus dependent children' family and the rise of more complex and diverse households and family types.³⁷ Cohabitation is on the increase and is associated with a rise in births outside marriage; this phenomenon is accompanied by rising divorce rates and an astronomic increase in lone-parent families and one-person households.³⁸ Scott (2004) succinctly summarises the recent changes in households and families:

The numbers marrying have halved, the numbers divorcing have trebled, and the proportion of children born outside marriage has quadrupled. People are marrying later and having fewer children than was the case in previous generations. Lone parents now head about a quarter of all families with dependent children. The rapid increase in cohabitation among unmarried couples is one of the most spectacular ways in which traditional family life is changing in Britain. (2004: 69)

These wider changes are made manifest by the fact that one in three children are now being born outside marriage and that many have more than two sets of parents and grandparents (McRae 2004).³⁹ Beck writes:

³⁷ The 1950s and 1960s ideal family is now an anomaly (McRae 2004) and the occurrence of increased and younger marriage in the 1960s was historically unique (Lewis and Kiernan 1996).

³⁸ See McRae (2004), Allan and Crow (2001) and Ringer (1997) for further details about these demographic changes. Lesthaeghe (1995) has termed these changes the 'Second Demographic Transition' characterised by an accelerated divorce rate, the end of the baby boom and a sharp decline in fertility due to the pill in the 1970s. This was followed by an increase in cohabitation and in the number of children born outside marriage between 1970 and 1985, while in the mid-1980s (the third stage), there was a plateau in the divorce rate with an increase in pre- and post-marital cohabitation and an increase in one-person and single-parent households.

³⁹ For some of these changes, an association between certain family types (such as teenage mothers, divorcees, and lone parents) and economic disadvantage is salient.

These changes are not new; what is new, though, is that they have moved from being marginal to normal. The 'traditional' family lost its normative position as alternative arrangements increased and proliferated: 'With a bit of exaggeration one could say "anything goes". ... Marriage can be subtracted from sexuality and that in turn from parenthood; parenthood can be multiplied by divorce and the whole thing can be divided by living together or apart' (Beck 1992: 116; quoted in Scott 2004: 76).

McRae (2004) comments that this does not signify a decline in the family but, rather, its diversification as people continue to value family relationships.⁴⁰ These changes are partly attributable to women's increased and changing economic participation which has altered the distribution and nature of work in households and the family, and partly attributable to shifts in morality and legislation.

Several theorists argue that these demographic changes have arisen from changes in sexual morality associated with increased access to modern contraception, abortion and divorce. Since the 1960s progressive legislative reforms in relation to contraception, abortion and divorce have separated sex from marriage and (later) parenthood from marriage. The introduction of the pill in 1964 and the Family Planning Act of 1967 made contraception easier to access and more reliable. The same year, the Abortion Act allowed the safe and legal termination of pregnancy, though on restricted grounds. Two years later, in 1969, the divorce laws were liberalised in the Divorce Reform Act by making 'irretrievable breakdown' an acceptable grounds for divorce.

Lewis and Kiernan (1996) argue that the separation of sex from marriage and, later, marriage from parenthood has decreased the institutional support of the 'traditional family'. They identify a new morality that permeates the progressive legislative reforms in contraception, abortion and divorce. This new morality is based on the idea that sex is a form of personal expression of love and mutual respect that should not be externally regulated by institutions (see Chapter Five). Sex was, therefore, no longer exclusively associated with marriage. Moreover, doctors, theologians and birth-control activists maintained that modern contraception made it possible to separate sex and reproduction and, hence, it was not necessary to confine sex to marriage and the family. In addition the no-fault divorce was a means to secure better relationships and to not prioritise

⁴⁰ Historian Lawrence Stone (1975) reminds us: 'From these facts [historical marriage and household trends] can be drawn one very firm conclusion about the premodern family, namely that it was, statistically speaking, a transient and temporary association, both of husband and wife and of parents and children' (Stone 1975: 46). And even when the nuclear family form was a realisable norm in the late

marital stability over personal wellbeing, love and mutual respect. These reforms did not initially have immediate repercussions on the traditional family as the increase in premarital sex in the 1960s was accompanied by a tendency to marry and not divorce. But from the 1970s onwards marriage declined, or was replaced with cohabitation and divorce rose along with the number of one-parent families. There was also an increase in births outside marriage that further separated marriage from parenthood. Elizabeth Beck (1992), Jeffery Weeks (1981), and Anthony Giddens (1992) argue that this undermined the traditional equation of sex with procreation and its containment in marriage and that the separation of sex, marriage and parenthood, which no longer characterise everyday concepts of the family.

A combination of legislative reforms in divorce, abortion and contraception provision, radical advances in reproductive technologies and macro-economic change have resulted in new possibilities for women. The male breadwinner model, based on ideas of naturalised sexual difference, is being replaced by the two-income family norm, with about two-fifths of mothers in part-time jobs.⁴¹ Yet women continue to do the majority of domestic and childcare work. Economic and familial changes suggest that the roles, expectations and aspirations of women within and outside the family have changed. The natural equation of sex, reproduction and parenthood and naturalised roles limited to the family does not capture the more complex and contradictory roles and relationships of contemporary women in the United Kingdom. Expanded feminine possibilities create a range of different, contradictory yet simultaneous roles, demands and expectations with which women must negotiate and balance.

In Faye Ginsburg (1989) study of abortion activists in Fargo, North Dakota, she charts how rapid socio-economic change in the United States challenged the assumed social roles and life trajectories of women as their individual experiences no longer coincide with existing cultural norms of femininity. She argues that in this changing context there is no longer a commensurate model of femininity (1989:13). As the possibilities of motherhood and waged work increase so do the options and expectations of women, this creates a gap between individual experiences and cultural ideals as there are limited cultural models available for structuring and making sense of this experience. In her study of abortion activists, she shows how women reformulate existing cultural

nineteenth it was also accompanied by the rhetoric of degeneration and crisis, particularly around changing women's roles (Jagger and Wright 1999; Showalter 1992).

⁴¹ Two-income families now represent 62 percent of all couples with children (McRae 2004).

resources to accommodate their culturally anomalous experiences and 'continually adjust the boundaries of those spheres to fit the shape of new experiences in their lives that seem at odds with the available interpretations of gender' (1989: 12-13). In so doing, they create provisional solutions to their existential disorder, rework gender ideologies and generate new paradigms of 'being female'. In her ethnography, she elaborates on how women attempt to transform the cultural meaning and social organisation of reproduction, the last unambiguous symbol of femininity, to manage these contradictions. Both anti-choice and pro-choice activists are redefining female identity as they both cope with the common problem of balancing waged and reproductive work and, though they appear in opposition, both formulate female identity as an achievement rather than a natural destiny.

In such transforming context, authors such as Ginsburg (1989) and Paxson (2004) argue that femininity is increasingly reduced to reproduction as 'the last unambiguous symbol of [an] exclusive female arena'. Reproduction remains an intense site of concern because economic and demographic changes have decreased the differentiation between women's and men's roles. Getting pregnant and being a mother is, therefore, an increasingly significant form of gender distinction. In her study of motherhood in urban Greece Heather Paxson found that: 'Motherhood ... becomes increasingly important for establishing gender, for distinguishing (working) women from (working) men. As women's and men's roles converge, biologically grounded reproductive difference is increasingly highlighted. ... In this sense too, the establishment of modern women's gender proficiency may, paradoxically, depend more fundamentally than ever on achieving motherhood' (2004: 74). Reproduction as the 'the last unambiguous symbol' of femininity makes contraceptive practices even more relevant to our attempts to examine the constitution of femininity in the current technological and social context.

The ability to divorce, to vote, to get educated, to work and to be financial independent does not challenge the centrality of reproduction and motherhood to women's lives nor the division of labour on which reproduction was based. In urban Greece and the United States, having children remains the ultimate goal in female adult status that competes with educational and professional opportunities and demands. This ethnography will demonstrate that in London, like urban Greece and small-town USA, women are strategically and tentatively rewriting the meaning of being a woman, using existing

cultural resources to cope with contradictions between ideas of femininity and their lived experiences.

The “crisis” in femininity that Ginsburg (1989) describes and I will further explore in this thesis relates to changes in the wider political economy that have transformed gender roles and relationships. Several theorists tracing the impact of these changes in male roles and identities have illustrated the implications for understanding masculinity in anthropology, particularly questioning it as a taken-for-granted and unmarked category (see Gutmann 1997 for overview). These studies on the construction of masculinity and male identities found that, rather than being taken-for-granted and unitary, masculinity is complex, variable and contested (see Brandes 1980; Connell 1995; Gutmann 1997; Herzfield 1995 and Peletz 1994). Hence, there is no unitary male perspective but a more complex and fluid set of ideas and practices about how masculinity relates to the division of labour, family relationships, child-rearing and sexuality (Gutmann 1997) as well as how masculinity is a naturalised category (see Connell 1995). They point to the over-dichotomised difference between men and women and outline the dialectic relationship between masculinity and femininity that have little meaning except in relation to each other (Gutmann 1997; Peletz 1994). Gutmann (1997:402) states “one can never study one gender without studying the other” and hence studies of masculinity and femininity are not analytically discrete. Though this thesis primarily focuses on the constitution of femininity there is an implicit dialogue with masculinity.

I argue that femininity is part and parcel of the Western folk model of sexual intercourse and reproduction that organises gender and kinship and is, therefore, structured by the same logic of natural facts as that described in the previous sections. This section has detailed the organising symbol of sexual reproduction in Anglo-American kinship and gender in order to illustrate how the pill literalises the “natural facts” of sexual reproduction and displaces the biological and social facts natural femininity. This displacement is paralleled by concurrent politico-economic and demographic changes that have simultaneously disrupted the social facts of natural femininity.⁴² These particular technological and sociological transformations affect the everyday

⁴² It is important to note that the research was carried out two years prior to the 2009 credit crunch in the context of very high rental and mortgage levels in the London area.

negotiation of femininity as they inform the assumptions and expectations that make taking the pill a desirable course of action.

The Structure of the Thesis

This thesis will show that the decisions and practices of the women I spoke to around their use of the contraceptive pill should not be understood only in terms of a model of human behaviour that is posited on self-interest and rationality. Instead, I will argue that these decisions and practices cannot be divorced from the relational contexts in which they occur. I will also consider whether the interview respondents related the pill to wider social institutions and conventions and if so, how. In addition, I will explore the pharmaceutical practices of the pill that distinguish it from other contraceptive methods.

The structure of the following ethnography is based on how the respondents talked about the pill, moving from their most explicit and future-oriented motivations of pill use to the less articulated and more implicit motivations that have direct consequences in daily life. Each chapter reiterates, from a different angle, the main theme of the thesis, namely that the incorporation of the pill into daily life both destabilises ideas about natural femininity yet is also part of the provisional solutions to the contradictions inherent in contemporary femininity. The women I spoke to continue to aspire to and work towards achieving natural femininity by strategically disassembling and reassembling the natural facts of femininity in both conventional and new ways. These strategies aim to balance and coordinate often conflicting social and cultural expectations as well as to realise femininity itself. In so doing, they change the meaning of natural femininity from something understood as fixed ('being') to something achieved ('doing').

Chapter Two presents the methodology of this thesis, namely multi-sited research, clinic-based ethnography and the collection of personal narratives. This chapter also describes the research setting(s) and situates them in their historical, social and institutional contexts. It then reconstructs the research process, introducing fieldsites and respondents, such as mother and baby groups, pharmaceutical companies and other departments of the NHS.

The ethnography starts with the inconvenience the women I spoke to repeatedly go through if they want to use the oral contraceptive pill which demonstrates the importance of the pill to them. Chapter Three focuses on the clinical encounters between medical practitioners and the women trying to get the pill. It is based on fieldwork carried out in the clinic and describes the routine clinical encounter and the procedures that determine eligibility. These procedures are part of the process of objectifying a woman. Yet these women indicate that they are not simply acquiescing to their objectification, they are actively participating in it in order to achieve the desired outcome of getting the pill, though this is jeopardised by different assessments of side-effects and risks. This chapter critically reflects on the power relationships between the practitioner and the client, a precondition for being on the pill, and examines the degree of agency in situations in which women are relatively powerless. It sets the scene for the following ethnography and also introduces the central themes of the thesis, namely the active deliberation these women undertake when they use the pill to balance the contradictions of femininity.

The next chapter moves on to pregnancy because its avoidance is often the most explicit reason given for taking the pill. Examining this claim illustrates that it is much more complicated than might appear at first sight. A closer analysis reveals that it is more appropriate to describe women's motivations as having to do with getting pregnant at the right time rather than simply not getting pregnant. Pregnancy and motherhood are life-altering for a woman. This life-changing event is regarded as natural and has a specific gendered character but, as they see it, should be controlled to coincide with the right financial, relational and physical conditions in order to demonstrate maternal love. The 'natural destiny' of motherhood, therefore, continues to define femininity, yet motherhood is redefined by them as an achievement, which depends on the reproductive control engendered by the pill. This chapter emphasises how, by using the pill, the women in this study reconstitute the idea of motherhood at the heart of natural femininity.

Having shown the complex inter-relationship between the pill and ideas of femininity, the following chapters explore some of the implicit benefits of the pill that are far from peripheral for the women in this study. Chapter Five describes how respondents took the pill to have pleasurable sex in longer-term companionate relationships. This is contrary to the public discourse that presupposes that the separation of sex and

reproduction results in sexual promiscuity. Rather, contraception choice is linked to the experience of sex and unfolds and forms part of trajectories of companionate intimate relationships. These accounts are then related to the ideals of intimacy expressed by these women to illustrate how companionate ideals are mobilised in practice. The chapter also exemplifies how the pill is discussed in such a way as to reconstruct the naturalised association between sex and reproduction, in contrast to the assumption that the pill ruptures this connection.

Chapter Six describes how women in this study took the pill to regulate and manage their menstruation, an embodied symbol of natural femininity. The chapter examines how menstruation was considered undesirable, disruptive and inconvenient and how many of these women used the pill to optimise their periods in order to allow them to perform different social roles of contemporary femininity. I then examine why the majority of the women I spoke to chose to continue to menstruate despite the fact that they could use the pill not to. This chapter highlights the unique pharmaceutical character of the pill.

The final ethnographic chapter, Chapter Seven, uses the accounts of the pill and the female body to critically reflect on the social and symbolic processes facilitated by the widespread availability and use of pharmaceuticals. First I detail the bodily and biological control enabled by the pill, so that its use is seen to enhance and optimise the body in ways that parallel the self management and self discipline practices associated with pharmaceutical technologies in advanced liberal democracies. I then describe the ambivalence about control and choice that challenge self management and self discipline practices and suggest a more complicated gendered engagement with pharmaceuticals.

This introduction has outlined how anthropologists of gender, kinship and reproductive technologies have shown how the concept of nature in Euro-American culture is used in different ways and has particular and sometimes contradictory effects. One of the particular effects that I will focus on in this ethnography is how nature is linked to power and social difference, specifically gender difference. Anthropologists studying gender and reproductive technologies have demonstrated that one of the central ways in which nature is linked with power is through the idea of “natural facts”. “Natural facts”

are important in providing the bases for Euro-American folk models of reproduction that inform ways of relating and naturalising gender identities. Natural facts are critical to the construction of gender as they provide the form and content of a cultural model which posits fundamental differences between the sexes, which are in turn used to legitimise and normalise different statuses, roles and ideologies for women and men. This ethnography focuses on how nature and natural facts are used to reproduce particular norms, ideologies and statuses, by delineating the complex relationship between nature and femininity for contemporary British women as seen through the ways they talk about their most intimate experiences of natural femininity. In attempting to capture the complexities of these experiences of embodied femininity, we also need a more sophisticated model of human agency. Again, this can be achieved by focusing on nature and natural facts, as the way in which they are used embody the very contradictions, contingencies and complexities of these women's experiences.

The ambivalence and contradictions implicit in nature (and choice, the counterpart to nature) as well as the re-inventing of nature through choice suggest that femininity is constituted through 'merographic connections', that is, part natural, part achieved. The social and the biological facts of femininity can be differentiated from one another but also connected to each other and to a whole other range of phenomena (Strathern 1992a: 73). Femininity is also merographic in that it has a necessarily partial character, as women's different social roles differ from each other yet at the same time belong to each other. Femininity can be seen as composed of hybrid feminine subject positions based on achieved or naturalised social roles. Hence, femininity is constituted through the borrowing, shifting, connecting and disconnecting of these differently grounded positions. The experiences of the women in this study of taking the pill make explicit the artificial, creative nature of natural femininity.

The pill challenges cultural models of natural femininity through creating several options for femininity by separating out its different biological and social aspects. In this way, the pill intensifies the merographic connections between social and biological facts of femininity by affecting nature's ability to model relations and roles (Strathern 1992a; Franklin 2003). As will be shown here, natural facts continue to delineate femininity when several contradictory social and biological models are available. These practices are not a radical departure from conventional femininity as they reinforce the

nature/culture dichotomy and do not challenge hegemonic truth claims, however, what is new is the explicit way women define what is feminine and what is not.

In descriptions of the pill, biological and social facts are variously foregrounded and backgrounded in order to make or unmake femininity in everyday practice. Different facts are used to legitimise and normalise different norms, ideologies and roles of gender. It is the continuous tension between achieved and naturalised aspects of femininity and their relational opposition that demonstrates the contexts, boundaries and effects of femininity. This contradiction and ambivalence in the facts of femininity means that differently constituted feminine subjectivities can be inhabited, balanced and kept in play. The composite character of femininity as well as the slippage between domains makes a singular or static femininity an impossibility.

Chapter Two

Studying the Pill

This chapter outlines the methodology adopted for the purposes of the research as well as sketching the historical and institutional settings that shape the particularities of the data collected and the resulting analysis. I adopted a methodological approach that foregrounds the voices of the women I spoke to in order to understand the cultural values and social conditions that shape their assumptions about and experiences of the pill. The previous chapter outlined how studies of contraceptive practice have emphasised theorists' analytical categories over those of the users themselves, which points to a disjuncture between theory and everyday practice. Ethnography was selected as the most appropriate method for this study because its inductive approach stresses the emic, everyday, taken-for-granted meanings and knowledge practices of actors (see Gupta and Ferguson 1997). Analysing the language that these women used to talk about how and why they use the pill affords insights into the cultural values, ideas and practices and the institutions and relationships that shaped these experiences of being on the pill.

As I suggested in the Introduction, recent ethnographies of reproductive technologies provide an analytical framework that is salient for understanding the pill, but also a guiding set of methodological precedents. The most characteristic features of these different ethnographies' methodological approaches is the fact that they are primarily clinic-based studies that also involve supplementary fieldwork (carried out in additional sites where different actors, agencies and technological processes intersect) and the collection and analysis of individual narratives. This chapter details this general methodological approach before going on to outline the particular methodology adopted for this study, including details about gaining research access, the fieldwork itself, data analysis as well as the obstacles encountered that restricted the scope of the study. The chapter also describes the historical and institutional settings of the primary and secondary fieldsites.

This chapter also details the collection, nature, analysis and use of the contraceptive narratives that inform and populate the following chapters. These narratives illustrate how the women I interviewed talked about the pill in such a way as to reflect on many

different areas, concerns and domains of their lives. The simple question, 'why did you start to you take the pill?' triggered a series of thoughts, experiences and concerns about a range of social domains and relationships. The question of why this single question provoked such eloquence provides the framework for this analysis and suggests that the pill is a taken for granted part of everyday life, but rarely talked about. Here I will give a detailed description of these narratives, which are an artefact of ethnographic interviews undertaken in a clinical setting, in order to help situate the accounts that follow.

Methodological Precedents

The research undertaken for this study centres on the pill as a cultural artefact and therefore differs from ethnographies which start with a territorially-bounded community. I adopted a methodology, common to ethnographies of reproductive technologies, that places technologies at the centre of fieldwork. Ethnographies of reproductive technologies are characterised by clinic-based studies, where different actors, agencies and technologies overlap, and which inevitably radiate out into multiple other related sites. This type of fieldwork allows for the collection of personal narratives from differently positioned actors.⁴³

These ethnographies centre on a primary fixed location from which clinical services and technologies are provided and follow related social trajectories, such as patient groups, procedures, patients and regulatory bodies. They are therefore multi-sited and open-ended (see Martin 1987; Davis-Floyd 1992; Franklin 1997; Becker 2000; Franklin and Roberts 2006; Rapp 1999; Thompson 2005; Gibbon 2006). These methodological approach illustrates how technologies are produced and consumed at the intersections of different actors and processes which occur at different sites and no single location or actor can represent (Rapp 1999; Appadurai 1986; Gupta and Ferguson 1997). It also enables the mapping of the connections and overlaps between sites, encounters and practices that make meaning (Marcus 1994; Martin 1987; Rapp 1999). This research adopted a similar methodological approach.

⁴³ Anthropologists in this emerging field have noted the limitations of this methodology. Franklin (1997) raises the question of whether these types of ethnography are 'preliminary innovations' or simply 'a number of unsatisfactory connections'.

Sarah Franklin (1997) argues that multi-sited fieldwork parallels the ‘more piecemeal, discontinuous, fragmented and incoherent “lifeworlds” inhabited by participants’ (1997:15). Engaging with several sites reflects the range of actors and relationships (involving people such as practitioners, partners, family and friends) that directly influence individuals’ experiences and interactions with technology (Becker 2000; Franklin 1997; Inhorn 2006; Franklin and Roberts 2006; Thompson 2005; Gibbon 2006). Encompassing multiple sites also captures indirectly involved actors and relationships that affect the experience of technology, such as pharmaceutical companies, regulatory bodies, policy makers, lobby groups and the media. A potential problem with this approach, however, is that there are limitless potential sites. Marcus (1994) and Appadurai (1986) suggest that following a specified ‘object’ limits the possible sites and makes the linkages between these sites clear.⁴⁴ Following an ‘object’ as it moves across different sites and contexts allows for an interpretation ‘that acknowledges its embeddedness in several different layers of social meaning and practice’ (Franklin and Roberts 2006: 75).

This aim to recognise and incorporate the range of sites, actors and processes involved in making meaning around an object can be anchored by a primary fieldsite. In studies of reproductive technologies, clinics serve as relatively self-contained physical spaces where several actors, agencies and processes overlap and intersect in the management of technologies and the production of meaning. Charis Thompson (2005) notes: ‘Clinics combine lived lives with scientific and technical practice, making it hard for an ethnographer to ignore the centrality of the intersections between lives and technology’ (2006: 170). Clinics are, therefore, an ideal starting point for an ethnographic study of the pill. Fieldwork in clinics is ethnography in that ‘it is still a process of collection, transcription, analysis and representation’ (Franklin and Roberts 2006: 80). Clinics are locations for conducting participant observation of the clinics themselves, of their procedures, lab work and consultations, as well as for recruiting respondents. Each clinical site has social particularities such as its bureaucracy, its physical location, its private or public setting and its charging policy (free, subsidised or private) that determine the composition of the clientele. By analysing this composition, differences

⁴⁴ Appadurai’s (1986) analysis of the social life of things demonstrates how things have biographies and how it is analytically useful to trace those journeys during which they gain and lose meaning in different settings. Van der Geest (2002) has subsequently applied this approach to medicines. He argues that medicines have social lives and suggests tracing their meaning through their production and marketing, prescription, distribution, consumption and their physical and social effects on users.

in class, ethnicity, income, education, scientific literacy and religious convictions can be discerned and examined. We can also see how different groups attribute distinct meanings to the same process thereby providing alternative and competing rationales to the universalising claims of biomedicine. This can also provide insights into 'stratified reproduction' (see Rapp 1999). From the primary fieldsite of the clinic other relevant and related fieldsites, processes and actors can be more easily identified, studied and related.

Fieldwork related to reproductive technologies also characteristically uses personal testimonies and narratives (see Thompson 2005; Rapp 1999; Franklin 1997;). Charis Thompson (2005) argues, in relation to surrogacy, that testimonials are useful 'to understand how undergoing these technologies may or may not transform the women and how technologies figure in and enable their self making' (2005:183). Jeanette Edwards (2000) has also suggested that testimonies and narratives give respondents the authority to speak and to contextualise their ideas in their own lives as well as to make connections across domains. Testimonies and narratives stress emic values and categories and reveal shared assumptions and ways of knowing the world that are central to ethnography. Moreover, the social and cultural values of physical experiences are expressed in such narratives. Iris Young (1990) argues that: 'Meaning subsists not only in signs and symbols, but also in the movement and consequences of action; experience carries the connotation of context and action... Talk about experience expresses subjectivity, describes the feelings, motives and reactions of subjects as they affect and are affected by the context in which they are situated' (1990:13). With multiple sites and actors, testimonials can be collected from actors with no direct experience of the technology as well as those of different ages and at different stages of the technological process – would-be, just starting, in-the-middle, refusing, successful and failed users. Assorted testimonials provide a range of perspectives that deepen our understanding of the different layers of shared cultural meanings and practices.

This research broadly follows the characteristic features of the ethnographies of reproductive technologies outlined above. The research was based out of a single clinical site from where several related sites were identified and studied; and the personal narratives of different actors were also collected.

Accessing the Field

The principal research for this ethnography was conducted in a specialist centre for contraceptive services, the Margaret Pyke Centre (known as the Pyke by people who use it/work there), funded publicly as part of the NHS. Accessing an NHS clinical site involved satisfying high entry requirements in terms of ethical and executive approval. However, once access was gained, incorporation into the Pyke's activities was relatively easy. There were, though, some unexpected benefits and limitations to this choice of fieldsite. A notable inconvenience was the extensive ethical approval process I had to go through for the Camden and Islington NHS Local Research Ethics Committee (REC hereafter). Ethical approval was mandatory because an honorary contract, which transformed me into a NHS employee, was a legal requirement. The ethical approval process, from the time of identifying the clinic to starting fieldwork, eventually took over eight months to complete.

The ethical approval process began when I met with senior staff at the Pyke in order to present the proposed research at a monthly staff meeting. The senior staff then provided me with written confirmation of their approval which was subsequently submitted to the REC with a detailed research application and relevant accompanying documents. The accompanying documents included patient information sheets, consent forms and procedures, interview protocols for clients and staff and recruitment leaflets and posters (see Appendix Two). The application was submitted to a REC Committee composed of area and ethics specialists and laypersons who regularly assess applications. Applicants are welcome to defend their applications in person and whilst I nervously awaited my audience, a veteran applicant told me that no one is approved without amendments being made. True to form, the Committee had several concerns about confidentiality and participant observation in the public areas of the clinic. These concerns were addressed by agreeing to place a highly visible poster stating that participant observation was taking place and asking clients uncomfortable with this to notify reception. After making this amendment, amongst others, I received official ethical approval and the honorary contract. The final hurdle was to obtain approval from the Occupational Health department indicating that I was fit to work and not a danger to either staff or clients.

A condition set by the REC committee was the mandatory written consent of all respondents. Each interview had to be preceded by a consent procedure that described the research, encouraged respondents to read the patient information sheet, emphasised confidentiality and anonymity measures, requested permission to record conversations and explained the secure storage of information. After this lengthy procedure, the respondents were requested to sign the consent form that I countersigned and kept at the clinic. Though lengthy, the consent procedure proved helpful in reassuring respondents about the measures being taken to guarantee their confidentiality and anonymity and created a 'tell-all' atmosphere. Because of this I decided to use the same procedure in non-clinical fieldsites. In this thesis, the anonymity of all respondents is maintained by means of the use of pseudonyms and by altering any descriptive information that identifies a particular individual.

The REC committee placed another restriction that limited the research as the Pyke management did not approve my request to directly observe consultations since this was thought to prolong sessions and because I would be taking the place of a fee-paying trainee. Since I managed to establish good working relationships with the staff, who would have been happy to accommodate me in my wish to observe their consultations, this lack of approval effectively prevented my access. Later requests to observe consultations were again blocked. As a result, the encounters between the client and the service provider were not directly observed. In addition, I was unable to interview respondents under the age of sixteen as this required additional ethical review since it raised legal questions and Criminal Records Bureau check.

The Primary Fieldsites

Although this research was multi-sited and involved several clinical and non-clinical fieldsites, the majority of the fieldwork was based at a primary clinical fieldsite, the Pyke, from which other secondary fieldsites emerged. That fieldwork was conducted in four publicly-funded, specialist contraceptive services centres in London between January 2006 and January 2007. Fieldwork began in the Pyke, as mentioned, a single stand-alone contraceptive services centre that is a direct service provider but also oversees and coordinates eleven community-based contraceptive centres and coordinates the sexual and reproductive health services of the Camden and Islington

Primary Care Trust catchment area.⁴⁵ Three of these community-based contraceptive centres were also fieldsites for this study. This section describes the primary fieldsite including its history and institutional and regulatory setting.

History of the Pyke

The Pyke is located off Tottenham Court Road, a busy commercial high street in central London. The central location of the Pyke is not due to the demand of local residents but to the historical development of birth control provision in London. In the past, the area was a low-income residential neighbourhood where early birth control pioneers, including Margaret Pyke, undertook their philanthropic work.⁴⁶ Today, in the same vicinity, there is a Marie Stopes clinic that provides private and NHS contraceptive and abortion services as well as the Mortimer Street Clinic and the Bloomsbury Clinic that provide sexual health services. The location reflects the fact that the provision of contraception in London is structured more on historical demand than according to contemporary needs (The London Health Observatory 2008).

The location and name of the Pyke are indicative of its strong associations with the British birth control movement. This movement is represented by iconic personalities, such as Marie Stopes, Lady Denman and Margaret Pyke, who played an important role in the advancement and mainstreaming of family planning provision from the 1920s onwards (see Leathard 1980; Latham 2002). The key catalytic moment in the emergence of the birth control movement occurred in 1924 when John Wheatley, the then Minister of Health, published Circular 153 which forbade municipal maternity centres from providing contraceptive information and services (Jeger 1962). In response, in 1930 leading figures from the suffragette movement, such as Lady Denman, formed the National Birth Control Council (NBCC) uniting all the birth control organisations under one banner in order to promote contraceptive services. Within the NBCC, Margaret Pyke was responsible for mobilising volunteers. In 1931 Wheatley's ban was overridden by the next Minister of Health and local councils were permitted to provide contraceptive advice to mothers endangered by further pregnancies (Leger 1962). The

⁴⁵ The community contraceptive services are Belsize, Gospel Oak, Crowndale, Bloomsbury, Goodinge, Hornsey Rise, Holloway, Highbury, Angel, Finsbury and the City.

⁴⁶ The birth control movement was closely aligned with the British eugenics movement and birth control was seen as a means to end the cycle of poverty and deprivation. By enabling lower birth rates amongst the poor, they hoped to prevent further 'degeneration' of the British population (Leathard 1980; Latham 2002).

NBCC actively ensured the implementation of this new measure and in 1932 began to run specialist clinics subsidised by local councils.

In 1939 the NBCC became the Family Planning Association and in 1954 Margaret Pyke became its chairperson. Between the 1930s and the 1960s there was only patchy availability of contraceptive information and services and these were provided by private specialist services not by the NHS. As outlined in the previous chapter, the introduction of the pill in the 1960s radically changed this situation. In 1966 a model training centre for family planning was established in memory of Margaret Pyke. Later, her son, Dr David Pyke, established the Margaret Pyke Memorial Trust, a charitable trust, in the headquarters of the Family Planning Association at 27 Mortimer Street (close to the current location of the Pyke clinic).⁴⁷ The Memorial Trust was initially self-financing and used client fees to cover its running costs. In 1976 the NHS incorporated all private family planning clinics, including the Pyke, as part of the policy for the free provision of family planning. The Trust continues to provide education, training and research on contraception alongside the NHS clinical services.⁴⁸

Institutional Structure of the Pyke

Today, the Pyke and its affiliated community services provide a range of sexual and reproductive health services for the surrounding area and for the Camden and Islington Primary Care Trust (PCT) catchment area. In 2007, it provided these services for a population of approximately 217,000 in Camden and 190,584 in Islington.⁴⁹ The population of the boroughs of Camden and Islington is socially and ethnically diverse covering both deprived inner-city areas and more affluent suburbs.⁵⁰ In addition to serving the residents of Camden and Islington, the Pyke and its affiliated centres have open access for non-residents for all services with the exception of cervical screening.

⁴⁷ Many of the pioneers' descendants continue to be associated with the field. Lady Denman's children and grandchildren continue to give the birth control movement support and Margaret Pyke's son went on to become a consultant physician.

⁴⁸ Current staff would often refer to their connection the pioneers.

⁴⁹ These figures are taken from the Camden Primary Care Trust Annual Report 2007/2008 and Islington Primary Care Trust Annual Report 2006/07; both Camden and Islington PCTs come under the Strategic Health Authority for London that was established in July 2006 replacing the former North Central London Strategic Health Authority.

⁵⁰ There are distinct health inequalities in this PCT, a fact that is best demonstrated by different life expectancies. The national average life expectancy is 75.2 years for men while the life expectancy in Camden is 73.5, in Haringey 74.6 and in Islington 74.

The Pyke and its affiliated centres represent one of the two delivery mechanisms for contraceptive services in the UK. Contraceptives are provided either through a specialist contraceptive service (i.e. a family planning clinic) or through general practitioners, both of which provide contraceptives free-of-charge. Clients are self-referred and can opt for either service, unlike other specialist services that require a GP's referral. For the women in this study, deciding which service to choose depended on several factors: problems registering with a local GP, the degree of confidence they have in their GP, habit, commuting routine and/or complications requiring specialist care. Many women have used both systems. GPs remain the main source of contraceptive advice and supply and in 2000 it was estimated that three-quarters of women received contraceptives from their GP, and that nearly nine out of ten contraceptive prescriptions made out by GPs were for oral contraceptives (Botting and Dunnell 2000).

There are marked differences in the two delivery mechanisms. Firstly, GPs are expected to provide general contraceptive advice and supplies whereas family planning clinics provide specialist advice and procedures. Many GPs and practice nurses do not have specialist training in family planning. Eighty percent of GPs have had some training but for two-thirds of that group this was undertaken in the 1970s. Practice nurses, on the other hand, are more likely to have been recently trained (FPA 1999). Secondly, general practices and specialist services are financed from different national health budgets and therefore have different financial limitations. General practitioners are self-employed and contracted by the NHS and receive an item-of-service payment for every patient consulting about contraception. There are no limits on the amount of services or commodities supplied. In contrast, the staff and supplies of a specialist service are set in the PCT's annual budget which has implications for the services provided. The Pyke, for example, is an open-access service; however, since it has a set financial allocation it experiences budget limitations. In one instance the Pyke's senior management decided not to provide expensive pills such as Yasmin and Dianette because of these budgetary constraints.

Many women in this study were surprised at the difference in treatment between GPs and the specialist centres. For example, a pill-user who was taken off the pill by her GP because she was categorised as 'at risk' was surprised when, at a later visit to the specialist service, she was re-prescribed the pill. Many of the specialist practitioners with whom I worked had disdain for GPs because they felt they lacked a nuanced

understanding of the different contraceptive methods and were just prescribing the same pill to women uniformly rather than responding to specific needs. Many staff had horror stories about GPs not properly assessing women or putting them on contraceptives when they exhibited high risk factors.

Alongside contraceptive counselling and free contraceptive supplies (including condoms), the Pyke provides a range of services including the fitting and removal of intrauterine contraceptives and contraceptive implants; counselling and referrals for male and female sterilisation; pregnancy testing; pregnancy advice and referral; cervical screening; advice and referrals for sexually transmitted infections (STI) screening; specialist young people's sexual health services; psychosexual counselling and advice on menopause, pre-menstrual syndrome, menstrual problems and breast problems.⁵¹ The more popular services are general contraceptive counselling, contraceptive re-supply, the fitting and removal of long-acting reversible contraceptives (LARCs) and cervical screening.⁵²

As a specialist contraceptive service, the Pyke exclusively provides contraceptive and other reproductive health services five days a week. The working day is divided into three sessions, each conducted by a team of nurses and doctors. The team is comprised of a team leader, usually a senior nurse with advanced training, along with two doctors and three nurses with specialist family planning training. One nurse is allocated the role of Advice Sister and exclusively attends walk-in clients; the rest of the team attend appointments. Appointment-only evening sessions are held on Monday, Wednesday and Thursday nights with a skeleton team of two to three nurses and a doctor. Additional staff, both nurses and doctors, conduct specialist sessions for LARCs and complicated procedures which are carried out along with regular services.

The Pyke runs a two-tiered access system in which a client can either book an appointment in advance or attend the walk-in service. They offer sixteen ten-minute booked appointments slots and four twenty-minute appointment slots are allocated for

⁵¹ The types of services available have been reduced with the closure of the surgical area; the Pyke no longer provides terminations for pregnancies, infertility assessment and treatment or sterilisation services.

⁵² It is difficult to ascertain what are the most popular services and how these relate to national statistics. Data regarding referral information, age, GP's details, home address, ethnicity and method of contraception and services used gathered at each client's visit is not processed due to lack of resources. Piles of completed but unprocessed 'service statistics' forms line the walls of the basement alongside the records of the early victims of HIV/AIDS. In addition, the national statistics on contraceptive services are

new patients in order to complete a detailed history and examination. Appointments must be made for inter-uterine device (IUD) and implant insertion, complicated procedures and psychosexual counselling. Running the two modes of access in parallel often leads to confusion and frustration amongst clients as appointments are given priority while 'walk-ins' wait to be seen by the Advice Sister. The system is not explained clearly and it can appear as if some clients are receiving preferential treatment. Consultations frequently overrun and there is often a mounting backlog of frustrated waiting clients. This situation is particularly acute in the early morning, at lunchtime and after work.

The floor above the clinic is also a hive of activity; here we find the administration of the PCT contraceptive service for the entire Camden and Islington area along with research and training activities. These activities are managed by the Margaret Pyke Memorial Trust and include Basic Training for the Diploma of the Faculty of Family Planning and Reproductive Health Care (both the theory and clinical practicum) and Special Skills Training in LARCs for doctors as well as placements for nurse training and Special Skills Training for Nurses for the fitting of intrauterine devices. The medical training ensures a steady flow of trainee nurses and doctors participating in consultations as part of their practicum; this prolongs consultations and slows down the services. The Memorial Trust also conducts medical and clinical research and trials relating to reproductive health technologies such as the HPV vaccine and new contraceptive pills. The staff's familiarity with research enabled me to integrate easily as they were accustomed to in situ researchers. Though the duration of my research was seen as overly long.

In addition to those providing services and ongoing research and training, there are several staff who coordinate the human resources, supplies and administration for eleven community-based services. These community-based contraceptive services usually consist of two-hour sessions provided within existing NHS health centres on set days. None of the community-based services are stand-alone and the contraceptive sessions are one of several different services provided. A rotation system, alternating a nurse and a doctor from the Pyke, is used to operate the community sessions. Some of these are led by highly experienced and qualified nurses. The community services only

also inaccurate because they do not account for the contraceptives provided by general practitioners who provide the majority of the contraceptives used in the United Kingdom.

provide a walk-in service for a set quota of clients, and who are seen on a 'first come, first served' basis.

The staff pointed out the difference between the clients attending the Pyke and those attending the community services centres. The location of the Pyke means that their clientele are predominantly well-educated, professional, relatively affluent women who work in the area but reside elsewhere. This contrasts with the community services centres where clients are local residents, representative of the general class, ethnic and religious make-up of the particular neighbourhood.⁵³ I attended the sessions of three community services centres for six months to complement my ongoing fieldwork at the Pyke.

All the sessions I observed were gendered spaces, the staff and the clients being predominantly women. Simply walking into any of the service centres, one immediately gets the sense of entering a female space. There were a few male staff – four doctors and two administrative staff and there were no male nurses. Few men attended as clients and if they did so, it was for psychosexual counselling. On the rare occasion that a man did enter the clinic he was usually accompanying a female client, about to ask for free condoms or was simply in search of directions.

The Regulatory Context of the Pyke

The Margaret Pyke Centre is wholly financed and managed by the NHS and is therefore situated within a host of ancillary institutions and agencies that guide and determine the type and structure of the service provided. In 1976 the Pyke was incorporated into the NHS, under the jurisdiction of the Department of Health. As part of the NHS, the Pyke became located within a dense network of mandatory policies, protocols, management styles, clinical guidance and financial restrictions that continue to affect its staff and services. As for the NHS as a whole, the Pyke has been affected by the upheavals generated by over a decade of disjointed health reform, the recent appearance of additional regulatory bodies and new government policy, in particular the first National Sexual Health Policy.

⁵³ One community services centre that served a predominantly British Bangladeshi population worked with the help of a resident translator.

Everyone in the United Kingdom is eligible for free healthcare at the point of use,⁵⁴ independent of class, profession, income and ethnicity. The NHS brings hospital services, general practitioner services (doctors, pharmacists, opticians and dentists) and community-based services (e.g. community nurses, midwives, health visitors) under a single organisational umbrella. The NHS provides the direct delivery of comprehensive health services in England and is almost wholly financed by means of central taxation. The Department of Health oversees the NHS activities in England through the ten Strategic Health Authorities (SHAs).⁵⁵ The Strategic Health Authorities supervise 152 Primary Care Trusts (PCTs) that provide both primary and secondary care in their respective areas and which ensure the local implementation of national health policy and strategy.⁵⁶ Eighty percent of funding for the NHS is directly allocated to the PCTs who determine and provide the locally tailored health care, including GP practices, walk-in centres, dentists, pharmacists and opticians. The PCTs also manage secondary health care (covering hospitals, mental health and ambulance services) in collaboration with other health and social care providers. The majority of contraceptive services are provided through the primary care services of the PCTs.

Since 1997, the NHS has undergone continuous complex organisational and financial restructuring. Under the leadership of each of the last five Secretaries of State for Health there have been new reforms aimed at increasing the quality and cost-effectiveness of the NHS.⁵⁷ These reforms have focused on decentralising health priority setting and budget allocation to primary health care providers, adopting market based principles and shifting to performance and results based management. The quality and delivery of primary health care, managed by the PCTs, is the focus of a complicated and disjointed reform process. These reforms have led to the reorganisation of health authorities and to the establishment and dissolution of national supervisory and regulatory bodies.

⁵⁴ The NHS runs in parallel with a private healthcare system that is predominantly paid for by private health insurance and which represents a small proportion of the health services used during the time of fieldwork.

⁵⁵ NHS SHAs are directly accountable to the DoH and the NHS Chief Executive has a direct management line to SHA Chief Executives.

⁵⁶ The NHS is divided into two parts: primary and secondary care. Primary care represents the first point of contact and is predominantly delivered by independent agencies such as GPs, dentists and pharmacists. Secondary care is acute health care and can be elective care – planned specialist care following on from a referral from a primary care centre – or emergency care. PCTs oversee the provision of primary care and commission secondary care.

⁵⁷ Frank Dobson (1997-1999), Alan Milburn (1999-2003), John Reid (2003-2005); Patricia Hewitt (2005-2007) and currently Alan Johnson.

In 2006, when I was conducting fieldwork, another round of reforms was introduced that redefined health authority patterns. These organisational changes, particularly the establishment of new GP contracts and the restructuring of salaries, were, however, not properly costed and this led to a national deficit of £547 million. As a result, funds that had been allocated for improving services such as sexual health were redirected to cover the costs of the reform, stringent financial measures were taken, cutting patient services and freezing recruitment, to ensure that the NHS could balance the books overall. This organisational restructuring combined with a financial clampdown resulted in a recruitment freeze and the micro-management of supplies at the Pyke, crippling service provision. During the period of fieldwork several of the community-based sessions were cut. This was due to the financial cuts implemented by Camden and Islington PCT and the restructuring of the Pyke's services in line with the new National Sexual Health Strategy. The restructuring of the Pyke was intended to generally reduce the number of community sessions while enhancing a select few community services centres to address current strains on the service. For example, at present IUD procedures can only take place at the Pyke, which generates an excessive demand for limited slots. However the planned enhancement of selected community-based services, would allow them to be able to provide these services as well.

A decade of reform has also led to the proliferation of various regulatory and supervisory bodies that oversee services at the Pyke. The DoH is responsible for the development, implementation and monitoring of government policy and regulations concerning health and determines resource allocation.⁵⁸ In turn, these policy and management frameworks influence local health authority and service providers' activities and spending. Much of the work of the DoH is conducted through the Arm's Length Bodies (ALBs), stand-alone national organisations that regulate specific functions of healthcare, establish and improve national standards and support NHS services.⁵⁹ The ALBs' Executive Agencies cover particular business areas such as the NHS Purchasing and Supply Agency (NHS PASA), which is responsible for purchasing goods such as the pill, and the Medicines and Healthcare Products Regulatory Agency (MHRA), which is responsible for ensuring that medicines such as the pill are effective and safe. These two agencies determine which contraceptives the Pyke provides. There

⁵⁸ Devolution has led to decentralisation and self-administration of the NHS in Scotland, Wales, and Northern Ireland.

⁵⁹ ALBs vary in size but normally have boards, employ staff and publish accounts. They are accountable to the Department of Health and sometimes directly to Parliament. Most ALBs also receive substantial funding from the Department of Health.

are also independent special health authorities, such as the National Institute of Clinical Excellence (NICE) (which has now become National Institute of Health and Clinical Excellence – NIHCE), and, that appraise the cost-effectiveness of treatments to ensure that they are appropriately prioritised and recommend which contraceptives to promote accordingly.

In 2005 the DoH published a new national health policy, *Choosing Health*, which stressed balancing clients' informed choice with cost-effectiveness.⁶⁰ An example of this new emphasis can be found in 2006 when NICE observed that thirty percent of unplanned pregnancies were due to contraceptive user error, a problem which could be addressed by increasing the uptake of long-acting reversible contraceptives (LARCs). Only approximately eight percent of women aged 16–49 use LARCs compared to the twenty five percent who use the pill.⁶¹ NICE recommended the promotion of LARCs in place of user-dependent contraceptives like the pill as a way of increasing the cost-effective use of resources. These recommendations may impact on the Pyke because they could lead to an increase in LARC referrals, but since no new facilities or qualified personnel are provided to deal with this rise in demand this could put further strain on the other existing services. The above mentioned recommendations are also reflected in the plans to enhance community services.

The Pyke staff are also under pressure to deliver services according to the priorities of the National Sexual Health Policy. In 2003, the Independent Advisory Group on Sexual Health and HIV (made up of sexual health professionals) was established to advise the DoH on the implementation of the 2001 National Sexual Health and HIV Strategy. The National Sexual Health Strategy was the first of its kind and identified key areas to be addressed through a 'comprehensive and holistic model'.⁶² The model focuses on three levels of service provision. The first level is the basic provision of sexual health to be

⁶⁰ *Choosing Health* sets out the principles for improving public health by supporting individuals to make informed and healthier choices and to this end has incorporated the suggestions of the 2001 National Sexual Health Strategy. Those objectives of the National Strategy with policy backing have been transformed into a Primary Care Service Framework that outlines the necessary requirements for a PCT to provide an enhanced primary care system, including appropriate processes, service inputs, staffing competencies and so on. Sexual health now falls within the ambit of Primary Care Service Frameworks.

⁶¹ See National Institute of Clinical Excellence, 'Guidelines: Long-Acting Reversible Contraceptives' (2006).

⁶² 'Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancies, illness and disease' (Department of Health 2001).

carried out at GPs' surgeries and walk-in centres. The second level is an enhanced level of care that includes basic provision and some specialist provision such as IUD/IUS fitting; enhanced genito-urinary (GU) STI treatment; HIV counselling, testing and treatment and training for doctors and nurses. The third level is a specialist provision of sexual health care that provides all of the above plus expertise in research, education and training. The Pyke is currently working to enhance its services and to integrate its sexual health care in order to become a third level service provider.

Secondary Fieldsites

The historical, institutional and regulatory context of the Pyke suggested other possible fieldsites for consideration. Several secondary fieldsites, linked in some way to the primary fieldsites, were pursued as well so as to include elements of the logistical supply chain, alternative modes of provision and regulatory bodies such as the FFPRHC Basic Training Diploma. Several potential secondary lines did become additional subjects of research, but other sites proved impossible to access in spite of my attempts to do so.

The logistical supply chain, including the source manufacturers and procurement agents, represented a critical part of the pill's social trajectory. The logistical supply chain covers both different sites and actors involved in the production, licensing, procurement and distribution of the pill. During my fieldwork, I followed the logistical supply chain from the Pyke to one of the source manufacturers, Schering, to the procurement agent for the Camden and Islington PCT. On several occasions I met with the representatives of Schering and visited the company's UK headquarters for the marketing of their oral contraceptives. The conversations and visits were highly formal and restricted. I complemented the data gathered from these visits with an analysis of the patenting, licensing and drug development practices. I also analysed ethnographic artefacts such as advertisements, packaging and patient information inserts. In addition, I met with the logistical supply chain intermediary, the procurement department of the Camden and Islington PCT, which procures, distributes and monitors the contraceptive provision within the PCT. The unit vigilantly monitors the safe distribution of the pill from NHS sites as well as ensuring sufficient in-date stocks. Much of this data has not been included in the thesis as further research is needed to link this material with the contraceptive narratives.

As it became apparent that many women used both specialist contraceptive services and general practitioners to obtain contraceptives, I expanded my research to include a general practitioner's surgery falling within the same area as the three community-based service centres covered. I sent a letter of enquiry to thirty local GPs outlining my research objectives, explaining how I had received ethical approval and requesting their participation. I followed the letters up with phone calls and this eventually elicited one positive response from a GP who was morally opposed to contraceptive provision, particularly emergency contraception. My attempts to interview first-generation users of the pill, currently in their 70s and 80s, were also unsuccessful as my attempt to access the group of women through several local charities for the elderly were denied.

After several months of clinic-based fieldwork a pattern amongst the respondents became clear – the majority were pre-parturient. This inevitably raised the question of what happens to pill users when they have had children. I therefore approached several pre-natal and baby groups in the Camden and Islington area to work with new mothers in order to find out about their views on and experiences of the pill. I interviewed new mothers who were attending baby and toddler groups in the same areas as the community services where I conducted supplementary fieldwork, using the same consent procedures and methodology. The baby groups were organised by the local National Childbirth Trust (NCT) coordinator and were usually composed of local women who had attended the same pre-natal classes. The new mums had monthly coffee mornings where they discussed how they were coping with the demands of mothering and swapped tips. The NCT group played a unique role, as they saw it, in providing a venue for new mothers to share their experiences, anxieties and concerns without appearing neurotic. The baby group, Hippobabies, was organised by the local church. There were two two-hour sessions a week, one for babies and one for toddlers. Both the NCT and the church-based baby groups were in high demand, over-subscribed and praised by their users. These were important sites for sociality for these women as much of their prior relationships based on educational and professional acquaintance had been restructured by having a child (see Chapter Four).

Fieldwork

I carried out daily participant observation both in the public areas of clinic as well as the areas accessed only by staff of the Pyke for over a year. I also spent between two to four months, two days a week, in each of the three community services centres. Long hours were spent sitting alongside clients in the waiting areas and chatting with staff at reception during their breaks. I helped prepare test packs for other research projects and attended the often bewilderingly technical monthly staff meetings. Sometimes during a quiet period staff requested my help in non-public activities such as putting together new medical folders, repackaging condoms, putting prescription stickers on all types of contraception and entertaining small children whose mothers were undergoing procedures.

Sometimes my involvement improved services by providing an additional pair of hands. However, I also frequently delayed practitioners with my persistent questioning. On one occasion my presence met resistance when a nurse thought I was observing her work and aggressively confronted me before complaining to the management. However, this nurse was reputed to be 'difficult' and the complaint was not followed up. In the end, in fact, this incident brought me closer to the other staff.

My regular appearance at the service, the monthly staff meetings, social events and chats around the kettle resulted in my rapid acceptance within this small community of service providers. As I became more acquainted with the staff, I conducted a series of in-depth open-ended formal and informal interviews with them. Formal interviews included the consent procedure and were recorded for later transcription. I also interviewed other Pyke staff including the administrators, managers and directors. The participant observation I was engaged in and the close relationships I developed with the service providers exposed me to the informal hierarchies, solidarities and disputes (along with the mechanisms used to resolve them) as well as the details of particular consultations. They also involved me in the joys and sorrows of people's personal lives. Again much of this data is not covered here because the thesis focuses on the contraceptive narratives of the pill users. My research experiences confirm that clinics are 'elite' fieldsites (Franklin and Roberts 2006) with high entry requirements in terms of formal approval processes and ongoing consent procedures. However, I found that once 'approved' I was easily and readily incorporated into the daily routines.

The staff were helpful with other aspects of the research and frequently informed clients about my research during their consultations and this led to a number of valuable interviews. The staff also expressed concern about the narrow focus on the Pyke and encouraged me to include the community services centres, sometimes trying to facilitate my research there, with varying degrees of success. Their ongoing commitment to their work was a constant source of motivation and inspiration. For instance, an elderly nurse who continued to practice after her retirement often recounted sobering stories about preparing the corpses of the women who had died from unsafe abortions prior to the 1967 Abortion Act.

In addition to the interviews with staff I also interviewed clients attending the services as well as their friends and a few partners. My initial attempts at recruiting participants through posters and leaflets were ineffective and I soon realised that a more direct approach was required. Once recruited, all the client respondents were interviewed individually in a variety of settings. Many interviews took place in available consultation rooms. Some clients deferred interviews, which were later carried out in public spaces such as pubs and restaurants. I also interviewed many respondents at their workplaces; these included the BBC, the Home Office and various well-known companies. When I became more familiar with the women I conducted follow-up interviews and life histories at their or my home. These interviews varied in length from half an hour to three hours.

I initially interviewed current pill users recruited at the clinical fieldsite and later expanded my research to include former pill users and women who had changed their contraceptive method when it became apparent that that the narratives of the pill were closely interwoven with other methods (see Chapter Five). The clinic-recruited respondents often facilitated interviews with their female friends and occasionally with their partners. When several clusters of female friends were able to be interviewed separately this permitted me to trace shared ideas. Rayna Rapp (1999) comments that the possibilities for potential research subjects are 'ever-expanding', yet in actual fact the respondents set the limits on these possibilities. I was keen to include female friends, partners and family members, to conduct group interviews and participate in their daily lives and I made such requests at the end of interviews. However, in general, respondents were not keen to involve their partners and families. Eventually only two

male partners participated, two others having cancelled at the last minute.⁶³ I therefore expanded my general request to include male friends, a few of whom participated. The paucity of male respondents and of respondents' relatives limits the following analysis in some respects. Difficulty recruiting relatives could be due to the distance of respondents' homes from London or concern about their families knowing about their personal lives. It is also possible that they were concerned about confidentiality. This reticence on the part of informants in incorporating me into their lives beyond the clinic could be partly related to the continuing silence that surrounds the subject of sex and contraception. It should also be mentioned that by basing the research in a contraceptive service I did not encounter women who were clearly opposed to contraception that could have provided a useful juxtaposition as demonstrated in Faye Ginsburg's (1989) study of perspectives of pro- and anti-choice activists in North Dakota.

All the initial pill users' interviews followed a similar format to ensure that the information obtained was comparable. The standard interview started with the consent procedure which proved to be a blessing as the formal promise of confidentiality freed up respondents to share intimate and personal accounts of their contraceptive and sexual practices.⁶⁴ These intimate portraits were verified throughout by means of double-checking the sequences of events and dates which were then confirmed again in subsequent meetings.

The interviews were open-ended and semi-structured by means of a series of prompts covering types of contraceptives used, knowledge about the pill, effects and experience of taking the pill and routines. Initially the research topic may appear to be somewhat forced as it was not something the respondents claimed to think about or have anything to say about on a general basis; however, through the course of the research it emerged that they did in fact have much to say about the pill. I usually started the dialogue by helping informants sketch their contraceptive and sexual history in the form of a chronological narrative, which was then used as the basis for the subsequent interviews

⁶³ Several ethnographies of reproductive technologies have noted difficulties in recruiting male partners (see Inhorn 2006 and Rapp 1999).

⁶⁴ Marcia Inhorn (2006), who has worked on infertility in Egypt, also found formal consent procedures beneficial: 'For them in both my studies, informed consent forms seemed to put them at ease once they realised that the interviews were private, confidential, and ultimately anonymous. In fact, many informants expressed their gratitude for an opportunity to speak to me confidentially, in the hospital rather than their homes, about often painful and private subjects that cannot be openly discussed in public, even with close family and friends' (2006:26).

and life histories. The life history sessions were aimed at gaining a better understanding of their contraceptive use within the broader context of their lives.

The majority of the following ethnography was elicited from the contraceptive narratives. These narratives centred on mapping a chronology of contraceptive episodes from the informants' sexual and contraceptive 'debut' up until the present. As the contraceptive narratives were sketched, digressions and points of interest were elaborated on. There were many evident blanks, much revising of dates and events and some ad hoc embellishments. It was clear that these were not rehearsed stories but rather narratives formed during the course of the conversations. It was often the first time respondents had pulled together seemingly discrete contraceptive episodes and emotional, relational and sexual events into some sort of interrelated structure. This process proved revelatory for many. Although the pill was the centre of the conversation, the discussion often led to reproductive, sexual, relational and professional narratives. Sexual histories related to a particular partner or a particular period often triggered memories of forgotten contraceptive experiences. Janet Hoskins (1998) suggests that narratives are a formative process in which people fashion identities by marrying multiple social identities (daughter, worker, lover) and agendas, creating cohesion between fragmentary experiences and situating them within available social and cultural meanings. Therefore, these contraceptive narratives are partly idiosyncratic and partly social and provide an interesting insight into the relation between the two. During the course of these conversations, the respondents narrated their lives (and, to some extent, themselves) through the pill, the pill acting as a tool used to access muted social and cultural meanings (Appadurai 1986; Kopytoff 1986; Hoskins 1998). As Hoskins (1998) comments, objects, like the pill, often become a prop, 'a storytelling device, and also a mnemonic for certain experiences' (1998: 4), such as femininity.

An open-ended semi-structured approach was also helpful because of the potentially sensitive nature of the research project which required flexibility in order to allow people to respond in their own manner and in their own time. Moreover, such flexibility gave respondents the opportunity to present themselves and their stories in their own language, in terms of their own values and to evaluate their own experiences and practices. The contraceptive narratives approach, like life histories, emphasises subjective evaluations of experiences, choices, interactions and processes (Mandelbaum

1982) and gives a historical perspective (Ellen 1984). It encourages respondents' to reflect on their own ideas, contextualise them within their lives and allows them to freely make connections across domains, thus revealing what connections are possible and thinkable.

The respondents also had questions; they were keen to know about my motivations and experiences, my thoughts and opinions. This often led to the question of whether I was using the pill. I explained that I had stopped taking the pill ten years before due to 'unbearable side-effects'. However, persistent questioning along these lines prompted me to participate in the clinical trial of a new contraceptive pill that was being carried out at the Pyke. During the second half of my fieldwork I started to take an experimental combined oral contraceptive pill in order to gain firsthand experience. In a sense this was embodied participant observation in which my experience echoed those of my respondents as I too began to adjust my body to the contradictory demands of my daily life.

Contraceptive Narratives

The contraceptive narratives collected from the pill users constitute the heart of this ethnographic account of the pill. They are the product of dialogues between the respondents and me within the clinical setting and therefore a particular type of artefact. The contraceptive narratives began with the required ethical consent process, which resulted in the respondent signing the consent forms and me turning on a tape recorder. In this highly staged environment, I asked a single starting question: 'When did you start to use the pill?' As the respondent answered this question, I began to draft out her contraceptive history on the back of the consent form. This process could range from twenty minutes to four hours, as the respondent elaborated on a particular contraceptive episode, the rationale for why she started, her interactions with parents, lovers and service providers, the experience of getting the particular method as well as the experience of taking it, as well as descriptions of what other events were occurring at that point in her life, which she felt were relevant to her decisions and actions. Changes in and cessations of contraceptive methods were marked on the chronologies, including when they occurred and why they had happened. In general, the interviews lasted for about an hour and a half to two hours. Sometimes prompts were used to encourage

respondents to expand on certain topics or to review previously discussed episodes which were then discussed from another angle.

The contraceptive narratives are more like contraceptive histories collected from self-selected respondents at both the Margaret Pyke and three community based centres. They were often conducted in free consultation rooms. My introduction, the consent process and location, positioned me as a clinic-based researcher and may therefore have conveyed a sense of the implicit dynamics of clinical relationships (which will be discussed in more detail in the following chapter). My direct association with the clinic and public health services placed me in a particular relationship to the respondent, in this way the narratives are products of a clinical encounter. I would suggest that the narratives may represent the clinical histories that the respondents would have liked to give during their consultations with practitioners. The interaction with the ethnographer represents an opportunity to explain themselves and how integral the pill was to them. It was as if they were often unable to express their perspective in the carefully performed clinical history, described in the next chapter, of the actual clinical consultation where they felt there would be a risk of not securing their prescription if they were entirely forthcoming. This suggests that the contraceptive narratives were a kind of repressed narrative of the encounter that was experientially present, had meaning for the respondents and was crucially linked to the setting. This may also be the case in other clinic-based ethnographies of new reproductive technologies such as Charis Thompson's (2005) study of assisted conception and Rayna Rapp's (1999) of amniocentesis.

Through these contraceptive narratives, the respondents were able to tell stories, to give meaning to their experiences of the pill and to place it in the context of their lives, as well as to relate it to wider cultural and social themes. The narratives I collected were similar to Klienman's (1988) 'illness narratives' insofar as he describes them:

The illness narrative is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long-term course of suffering. The plot lines, core metaphors, and rhetorical devices that structure the illness narrative are drawn from cultural and personal models of arranging experiences in meaningful ways and for effectively communicating those meanings. Over the long course of chronic disorder, these model texts shape and even create experience. The personal narrative does not merely reflect illness experience, but rather it contributes to the experience of symptoms and suffering (49).

According to Kleinman, the meaning of illness encompasses the culturally shared symptoms that reflect the relations of body with self and bodily processes with cultural categories, their cultural significance and values associated with those symptoms and the personal and social context. Through 'illness narratives' people share the complex inner language of distress and disability, how they live with them and the broader consequences in daily activities, careers and relationships. In this way, the narrative links the social world with inner experience. Illness narratives are not accounts of what is actually happening but rather reflect the significance and values associated with illness in the creation of life histories. Moreover, Kleinman suggests that retrospective narratives have a moral purpose in reaffirming the core cultural values that are seen to be under siege, as well as the reintegration of social relationships that structural tensions have intensified.

The idea of illness narratives is dependent on the distinction between illness and disease. Illness, for Kleinman, is the subjective account of experience, explanation, appraisal and response to or treatment of symptoms and suffering, which are culturally bounded and shape the ways we behave. This is distinct from disease, in which illness is recast in terms of disorder within a specific taxonomy and nosology for the purpose of diagnosis. In the process of seeking medical attention, health professionals deal with disease and mechanical breakdown, attempting to find a technical fix for dimensions of illness which are often social and moral. It is important to note that, for Kleinman, the illness narrative was a clinical, almost therapeutic, construct to assist medical practitioners access the polysemic and multivocal experience of illness within the medicalised setting of the clinic, in order to better address the concerns and needs of patients that are often lost in the traditional clinical case history.

Gilbert Lewis (2000) contrasts medical case histories, a standard format of complaints, investigation and treatment, that selectively focus on specific 'relevant data' for judgement and diagnosis in which the patient and the details of the patient's circumstances do not feature, with illness narratives. For Lewis, illness narratives are more of a 'documentary' than a conversation that is concerned with one person's experience and the representation of events through their eyes. The illness narrative outlines how things seem to the person who lives through them, connecting the inner experience with the social world. He notes that they are more cultural than social as

they do not account for others watching and acting in a particular illness experience and episode, yet they also contain the interviewer's view who transcribes them.

During this research sixty-nine contraceptive narratives were collected, some of which were also the result of follow-up interviews and life histories with particular respondents. Each interview was recorded and included as part of the fieldwork notes taken on a daily basis. Of the sixty-nine interviews collected, twenty respondents' accounts were transcribed. These were selected on the basis of length and availability of repeat interviews. The twenty interviews were analysed based on the striking commonalities in the narratives and the similarities between respondents. This focus on similarities was aimed at drawing out and making explicit the shared meanings given to the experience of the pill, the typical placement of these meanings within the context of life and how they relate to wider social and cultural themes. The quotations given in the thesis are typically interview responses. This analytical focus on similarities has resulted in a sense of homogeneity between the respondents' accounts. In addition, the clinic-based narratives were often one-off and there was no opportunity to compare responses, which led to a relatively homogenous group of narratives of young professional women for analysis; little scope for examining difference such as educational attainment, class and ethnicity and limited examination of significant relationships, such as family, friends and lovers.

The primary focus on narratives and ethnographic interviews in this analysis relies on respondents being gatekeepers to their own experiences and in the accounts that follow this experience is extracted from everyday life, context and interactions. It is recognised that these narratives in themselves are the product of the clinical encounter, which set the parameters of the analysis. These narratives are not only produced in the clinic but they also did not leave the clinic, so in a way, remain unrelated to other 'narratives', practices, settings and relationships (though narratives of the lifecourse, of intimate relationships and of work were discussed at length in the course of these encounters). The focus is on the intimate and the personal over the public, relational and collective histories. And in this way, the narrating process mimics and complies with the silence about the pill outside the clinical spheres.

The resistance of respondents to incorporate me and my questions about the pill into their wider lives discussed earlier and the prevention of these narratives travelling

outside the clinic is indicative of the silence about the pill, despite it also being a taken for granted part of their lives. Yet the narration of the pill did provide the opportunity to explore aspects of life that may not organically surface elsewhere. Jenny Hockey has suggested that interviews provide 'situated moments in which people engage with aspects of life which may not surface elsewhere. They allow past and present to be accessed via the present and create space for what has been left unsaid and what remains invisible' (2002: 214). As such, the staged narratives are necessary for the identification and definitions of key terms, themes and issues related to the pill, as respondents made clear when they noted that the pill was not something that was talked about regularly, even though in the course of our discussions it appeared to be a necessary and taken for granted part of everyday life.

Methodological Limitations

The methodology that was adopted, like any methodology, had its limitations. Three recurring methodological concerns were: how to ensure the validity and consistency of the data; how to address the bias of doing 'anthropology at home' and ethical concerns about how to answer questions without 'contaminating' the data. Concern about how to ensure validity and consistency in individual interviews was constant. Individual interviews with often unrelated respondents prevented the natural checks of validity and consistency available in a 'traditional' fieldsite. This issue is particularly relevant when dealing with the sensitive and charged topics of sex and reproduction.

Respondents might conceal certain behaviours and decisions or deliberately change their stories if they felt embarrassed or ashamed. I therefore checked all the accounts for internal consistency during the interview process by asking them to elaborate information, by returning to points and by rephrasing and reintroducing questions later in the interview. The considerable length of the interview made it difficult to maintain distortions as it is hard to consistently misrepresent for extended periods of time. In the follow-up interviews it was possible to double-check inconsistencies. As suggested earlier, some respondents used the interviews as an opportunity to tell a previously untold story, often recounting particularly fraught experiences of abortions and endometriosis, and in these cases the interviews became confessionals. Respondents were generally honest about not remembering details and some later sent emails to provide supplementary information.

The silences and gaps in the conversations were revealing and highlighted another methodological concern regarding doing 'anthropology at home', which presents particular problems. Firstly, the respondents and the researcher share assumptions and these can pass by unquestioned during the course of a conversation. Charis Thompson (2005) has noted: 'Although an ethnographer who is working within a familiar culture is less likely to impose an internal but ultimately irrational symbolic or functionalist coherence on that culture than if he or she is faced with the exotic otherness of a far off culture, there is a temptation to confer truth values that are in line with preconceived categories' (2006:16). This had, at least in one instance, been the case for me, as I realised when, a few months after finishing fieldwork, I read an article about recent legislation on reproductive health care and had the shocking realisation that I had forgotten to discuss sterilisation, the most effective form of contraception and one that is uniquely placed in the UK legislation. It would have been useful to include it to further explore ideas about bodies. Sterilisation was a blind spot for me but it is interesting that respondents, both pill users and practitioners, also shared the same blind spot and never perceived it to be a contraceptive option either. Sterilisation did not seem to register on the contraceptive horizon of any of the research participants, or on mine.

All fieldwork requires entering and affecting people's thoughts and lives. During the interviews I made a great effort to not influence or lead the conversation. However, the issues dealt with involved highly personal and sensitive areas and had medical implications for the respondent. The respondents therefore often had questions and wanted advice. Occasionally, I was asked questions concerning reproductive physiology – e.g. 'When is my fertile period?' – or about the functioning or effectiveness of the pill – e.g. 'Does Ecstasy have an impact on the pill?' – or about their own experiences – e.g. 'Am I normal?' Though these questions conveyed a general ambivalence about the pill and the ability to adjust the body at will, they also posed a methodological and ethical dilemma because I was unsure whether to answer in a way that was in accordance with their ideas so as to not 'contaminate' the data or to correct their misunderstandings by providing accurate information. When situations like this occurred I would try to continue the interview, answering questions depending on the accuracy of my own information or referring the informant to the relevant practitioner.

Data Analysis

The data analysis focused primarily on the contraceptive narratives that I collected. All the respondents who volunteered to participate in the research had different motivations. Many respondents talked about how they had never had a space or opportunity to elaborate on their contraceptive, reproductive and sexual experiences. Often they had a story to tell, whether it was of painful and humiliating periods or of secret abortions. In these broad contraceptive narratives, the respondents conveyed much humour, sadness, heartache and joy and long dormant secrets about unplanned pregnancies and abortions and hidden anxieties, aspirations and expectations concerning their futures were revealed. These emotional, funny and tragic contraceptive narratives form the heart of the ethnography.

Each respondent individually shared their knowledge and experiences of the pill, their contraceptive and reproductive decision-making, their expected and desired futures, their ideas about their bodies and their sexual and intimate strategies along with details about the wider demands experienced in their lives, yet there were striking commonalities between their accounts. These commonalities reveal the shared concepts and knowledge practices that existed in spite of the fact that the respondents were unknown to each other; the ethnography is presented in such a way to show these similarities.

Over the course of fieldwork, I collected ninety-one recorded interviews with different actors as well as follow-up interviews and life histories for fifteen current or former pill users. The sample included people of different ages, people with different contraceptive careers and people requiring different clinical services. It also included new users, intermittent users, continuous users, contraceptive switchers and non-users. This data was complemented by fieldnotes taken during one year's participant observation at the Pyke and at three community-based services centres and secondary fieldsites. These go to make up the data set that informs the following ethnographic analysis.

Selected interviews and life histories of pill users were transcribed. The analysis of these transcripts was fruitful because even though the respondents were interviewed individually there were striking commonalities in their experiences, the language used

and their areas of concern. The transcripts were systematically coded according to keywords that were then cross-checked across the whole sample for commonalities and differences. Four questions indirectly guided the analysis: (1) what do the assumptions and expectations about the pill reveal about these women's lives? (2) why was taking the pill a desired course of action? (3) how did women integrate the pill into their practices? and (4) in what context did the decision to take the pill occur? The analysed transcripts were cross-checked along with the other sources collected. This process drew out shared ideas about the pill, the clinical encounter, pregnancy and motherhood, sex, intimacy and the body, as well as ideas about nature and femininity, discussed in the following chapters.

This methodology and analysis has affected the way the ethnography is presented here. The ethnography is presented through short related quotes from different respondents, which illustrate particular themes. This presentation style stresses the similarities amongst the respondents' ideas. My analysis draws out women's shared areas of concern such as accessing the pill, planning pregnancy, sexual and intimate relationships, managing menstruation and controlling the body. However, it provides a fractured picture of the respondents and the context in which these opinions were expressed.

The structure of the thesis is based on how respondents talked about the pill and reflects the sequence in which the topics emerged from them. Underlying the different areas of the respondents' concern was a persistent and shared anxiety about how to control an 'unruly' female body that continually threatened their social performance within the current political economy. The respondents at the Pyke were well-educated, professional women in demanding roles who were using the pill strategically in order to adjust their bodies and selves to the contradictions of this 'uncharted territory'.

The following ethnography of the pill is based on respondent's stories and verbatim quotes. The transcriptions are the source for all the quotes in the text. The verbatim quotes are in original speech, even when grammatically incorrect, and I have tried to use punctuation to convey how the speech was delivered rather than to achieve grammatical convention. I have added words in squared brackets where it has been necessary to make the meaning clearer.

Chapter Three

Getting the Pill: An Ethnographic Account of a Family Planning Clinic

She was back. As soon as she walked through the door there was a collective groan from the reception staff. They remembered this particular client as she had been very difficult a few weeks earlier. On her previous visit she had asked to see a doctor immediately as her husband had accidentally taken her pills on a trip, so she had missed her pill and they had had sex the previous night.⁶⁵ I watched as, according to normal procedure, she was registered by the staff and told to wait. She kept returning to reception demanding to know how long she would have to wait, the staff calmly responding with their typical reply: 'We do not have many nurses today, so we cannot say how long the wait will be, but there are such and such a number of clients in front of you'. After some time had passed, she asked the reception staff to issue her regular prescription – they responded that she first had to be seen by a nurse. She then demanded to see the manager; in streams of tears she shouted that she might be pregnant and that the reception staff would be responsible. The reception staff, as well as the rest of the waiting clients, looked away in shocked silence. When she returned to her seat the reception staff secretly moved her up the waiting list. When she approached the counter for her second visit, the reception staff kept pushing the others forward to serve her. In the end, Lisa, an experienced and battle-weary receptionist with over sixteen years experience behind the counter, stepped forward and in her most dulcet tones asked, 'How can I help?'

In a specialist contraceptive service that sees over five hundred faces a week, you remember very few of them. Only a few women stand out and these are because there is some sort of incident, typically either an emergency or some kind of hostile behaviour. This particular client had been in a few weeks prior to this visit as a walk-in patient without an appointment and was now asking for a repeat prescription of her pill. This is a common request that can be easily accommodated; what was less common about the incident was her distress. According to the client, her bag, like so many clients' bags, had gone missing with her pill strip inside and she was desperate to replace the prescription. At the Pyke, there is an epidemic of missing bags containing pill strips.

Every day a handful of clients claim that their bags have been lost or stolen.⁶⁵ I suggest that the 'lost bag' scenario is a strategy often used by clients who want to mask the fact that they have miscalculated the pill cycle of 28 days when matching it against calendar time while ensuring continued access to the pill. This was one of the many strategies used by the women that I spoke with to get the pill.

During the course of clinical encounters the women I spoke to used a variety of strategies to get the pill. These ranged from adopting passive and compliant behaviour, to rewriting personal and family medical histories, to misrepresenting important clinical information and downplaying side-effects and risks. This chapter explores how the women who participated in this study negotiate clinical encounters with medical practitioners, focusing particularly on their strategies to get the pill.

Getting the pill requires organising a visit to the clinic and participating in a clinical encounter on a regular basis; the fact that so many women are prepared to go through this inconvenience demonstrates the importance of getting the pill for them. This sets the scene for the following chapters, which examine why these women went to such great lengths and took such extreme measures to get the pill.⁶⁷ It also introduces a recurrent theme that runs throughout the thesis, namely their desire for more control over their bodies and lives within the conventions of social relationships and institutions. This provides a different angle on the assumption that the pill frees women from social constraints. Rather, the pragmatic negotiation of clinical bureaucracy necessary in order to get the pill makes explicit the immediate social constraints that define the experience of being prescribed the pill.

The chapter opens with Louise's account of getting the pill which exemplifies the complex interactions she has undertaken every six months for the last nineteen years. I then examine the coordination of different types of timings necessary to secure an

⁶⁵ Only a clinical assessment of where she was in the pill cycle could determine whether she was 'at risk' of pregnancy or not.

⁶⁶ Both the clinical staff and I are doubtful that so many bags actually go missing and that so many women carry their pills in their bags. Women in this study describe a series of prompts they use to remind themselves to take the pill on a daily basis, usually when they wake up or go to sleep. They undertake several measures to ensure that taking the pill becomes part of their habitual routine, such as placing it next to their toothbrush or moisturiser. When they fail to remember to get a repeat prescription they sometimes invent an excuse to cover up their oversight. Or else there has been a petty crime spree.

⁶⁷ Due to constraints set by the Camden and Islington Research Ethics Committee and the Pyke management, I was not permitted to directly observe any consultations; the analysis presented here is, therefore, based on the practitioners' and clients' accounts of the clinical encounters.

appointment to get the pill. This is followed by sketching the routine clinical encounter and procedures that determine eligibility, particularly registration, medical history-taking and physical examinations, before going on to document the consequent objectification of women as clinical objects. The subsequent section illustrates how the women I spoke to do not acquiesce in this process, but rather actively participate in clinical encounters by developing strategies to achieve a particular clinical outcome. However, disagreements between the practitioner and the client, particularly those related to the assessment of risks and side-effects, jeopardise the success of these strategies, and reveal the implicit institutional power dynamics that determine women's access to the pill.

Louise's Story

I first met Louise, a thirty-four year old smartly dressed freelance writer, at one of the community-based services and when I handed her the research leaflet she explained that she was simply too busy to participate. A few days later I received an email from her saying that she had changed her mind. When we sat down in a local pub after work she told me that she had changed her mind because she did not want any young woman to go through what she had experienced. She thought one of the major problems facing young women who want to use contraception was the family planning service itself, particularly the practitioners. In the United Kingdom, medical practitioners exclusively mediate access to the pill. Therefore, access is arbitrated through a clinical encounter with a medical practitioner at a general practitioner's surgery or a family planning clinic.⁶⁸ Any study of the pill must, therefore, consider the interrelationship between the managed and regulated world of the clinic and the lived experiences of the users. In the clinic, practitioners use clinical procedures and processes, such as registration, assessment and follow-up, to determine eligibility for and therefore prescription of the pill.

Louise grew up in the suburbs of London and recently moved in with her long-term boyfriend. She told me how she started using the pill at the age of seventeen in 1987 and she has taken it continuously ever since. She explained that when she decided to

⁶⁸ Women who want to use the pill or any contraception can refer themselves or be referred by a medical practitioner. In other words, a woman can choose to go to her local GP or to a specialist contraceptive service, popularly known as a family planning centre. This is unlike other NHS specialist services where the GP is the first point of contact and refers the client.

take the pill at seventeen she felt 'brave' and grown up, but when she saw the nurse she became 'defensive' and 'secretive'. She thinks this may have been because of the insecurities she thought typical of a young adult but it has characterised every clinical encounter since. Louise described how she feels when at the clinic:

What I relay to you is my experience the first time but I can tell you it is how I feel every time I go to a family planning, which is like a little girl. I do appreciate when you are there a nurse has to deal with 101 people who have all have their own opinions about contraception and because of that they have to deal delicately with everybody. And they always have to go through the same rules. I appreciate their principles but over time I go there I absolutely detest it. With the exception actually now moving to Islington, though I hate the concept of not having an appointment, they are much more relaxed in the attitude to contraception than I ever had before. In all my years, it has always been a very much older nurse that was me looking after me, I just suppose I felt like a little girl, a little intimidated by the process. I hate being asked when is your last period even though I know it is always on a Friday. I sit there like a nervous wreck.... I think that I have quite a relaxed attitude to contraception but every time I go in to a clinic I become this little girl, feeling intimidated by the whole process, feeling like I am going to be told off because I don't know when my pill pack will run out, I can't remember if I meant to take the pill for one day or two days, all silly things like that. It just makes me feel intimidated, the whole process. I can't stand it.

Louise describes how, when she saw the nurse, she felt like a child who was silly, intimidated and nervous and she had to be brave. She uses the metaphor of a child-adult dynamic to describe what she sees as an unequal power relationship of the clinical relationship. Louise has been enduring what she sees as an infantilising experience for almost twenty years. Yet these encounters are necessary because she does not want to have children as this is not a lifestyle she currently wants. Louise became unintentionally pregnant at the age of sixteen and had an abortion at ten weeks; she then immediately started to take the pill. In addition to preventing unintended pregnancy, she also uses the pill to manage her periods. She sees the pill as a way to manage her private and public life, yet this was threatened at each encounter with the practitioner.

Louise expressed her sense of frustration about the situation because she feels her contraceptive choice should be hers, as it is her body. In her opinion practitioners do not have the right to make such critical decisions about her body and her life. She told me: 'My contraception, my body, just give it out. And I am also very concerned about that now I am about to turn thirty-five at some stage someone will ask me whether or not, or question whether I should be on the contraceptive pill. I feel it's my choice'. She

explained to me that 'they always have to go through the same rules' that have the effect of making her feel she is 'just another person, another number'. She felt irked that a practitioner, who treated her like a 'number' rather than as an individual with specific needs and circumstances, can make life-altering decisions on her behalf:

Every time I went I always get the [pill], 'what day do you get your period?', 'do you smoke?' and they wouldn't be able to do anything about it but I would have to go through that process every six months. It is none of their business. No disrespect to the person who issues me the pill but they are not knowledgeable enough about me as an individual to start dishing out individual advice. They only go by their tick boxes, so their job dictates that they have to go 'oh, you smoke', 'oh you are over thirty five', and I can't be bothered.

She described the way that practitioners follow the rules 'like clockwork' which suits her because 'I just go through the motions and make my own choices'. In this way, she transforms her frustration into strategic actions to balance what she sees as an unequal power relationship.

Though the routine encounters were infantilising, Louise was fully aware that if she presented herself as 'very passive and defensive', like a child, she would get the pill. She found this humiliating but effective. She also carefully selected the information she shared with the practitioner. For example, she was a heavy smoker and over thirty, which combined together put her 'at risk' and theoretically made her ineligible for the pill. She hid this information: 'I smoke and I don't tell the family planning people because again I know they will start to challenge my decision to take the pill'. When she started to attend a new clinic she debated whether to tell them she smoked but decided not to because 'I don't tell them what they don't need to know as far as I am concerned'.

For Louise, the pill had beneficial effects that enhanced her life, which were endangered by the unequal relationship with a practitioner. In her account, she explained her attempts to regain some power. Like several women I spoke to, she concealed clinically significant facts as she felt she understood the risks from smoking and considered them less serious than the risk of an unplanned pregnancy. In other words, her priorities and interests did not reconcile with those of the practitioner. She justified this by telling me: 'I feel family planning clinics are just part of a process, a mechanism for distribution, it is not somewhere I would get advice from'. She therefore rejects the assumption that their practitioners are appropriately equipped to make decisions about her body and life,

though they could. Louise's story exemplifies many of the accounts of the clinical encounter as well as the strategies adopted to access the pill. These strategies suggest a sense of feeling both powerful and powerless at the same time.

Making an Appointment, or, Rather, Managing Time

Louise's story provides insights into the clinical encounter itself, but the complex navigations of social interactions to get the pill start well in advance, most notably in arranging an appointment. The 'lost bag' scenario discussed earlier is accepted as a convenient untruth adopted to mask the fact that clients have miscalculated pill time, a cycle of twenty-eight days, in relation to calendar time. Conversations with practitioners and clients suggest that pill time and calendar time are often conflated and used interchangeably even though there is a significant difference between them. If calendar time and pill time are conflated, a typical six-month prescription, used for six cycles, results in a discrepancy of fifteen days. And this does not take into account the common practice of skipping the seven-day break between pill strips, which can lead to a further forty-two-day discrepancy. These miscalculations are just one example of the several timescales that the women I spoke to have to manage.

The women in this study are constantly negotiating the different and often competing time systems of the clinic, the pill and the intersection between them. Charis Thompson (2005) identified three interrelated time systems in her study of an infertility clinic: bureaucratic, menstrual and chronological time. These resonate with the time systems used at the Pyke. 'Bureaucratic' time is the linear time of working hours which is marked by appointment schedules, calendars and waiting times. Menstrual time relates to the menstrual cycle specific to each individual woman (though it is often treated clinically as a universal 28-day cycle). In the Pyke a lot of time is spent reconciling bureaucratic and menstrual time in order to arrange smear tests, schedule IUD insertions, prescribe emergency contraception, determine when to start the pill and assess the impact of a missed pill and the possibility of post-coital contraception. Chronological time refers to the age of the client, whether she is a 13-year-old who has to be treated according to the Fraser Guidelines,⁶⁹ a 35-year-old smoker who wants to continue on the

⁶⁹ Under British Family Law, anyone aged 16-18 has the right to consent to treatment. Young people under 16 can consent to medical treatment if they are judged to have sufficient maturity and to understand what the implications and risks of the treatment offered are. Doctors can, therefore, provide contraceptive advice and treatment without parental consent providing certain criteria outlined in the Fraser Guidelines

combined pill despite the clinical risks involved or even a 50-year-old woman who has been advised to stop taking the pill. Menstrual and chronological time influence the direction that a clinical encounter takes as well as the responding strategies of the clients.

In addition to the clinical time systems described, the pill has a unique time system of its own of twenty-eight days that overwrites and standardises the individual's menstrual cycle and which must be coordinated with bureaucratic and chronological time, in calculating when to start, when to change, when to stop and when to get an appointment to ensure continuity of supply. The women in this study constantly coordinated the different time systems in order to ensure both access to and the efficacy of the pill. The clinic's and the pill's time systems also had to be balanced with the time systems relating to the progression of the life-course such as educational and professional advancement and the imagined reproductive trajectory (see Chapter Four).

These conflicting time systems also had to be coordinated with the time demands of work. These respondents continuously fretted over how to harmonise the heavy time demands of work with the bureaucratic, menstrual and chronological time system of the clinic, the pill's timing and the longer-term time of the life-course. Their narratives are filled with their constant worries about how to schedule appointments that do not disrupt their work schedule but are aligned with pill and clinical time. They frequently complained about the impossibility of getting to see their local GP and therefore they used the Pyke's walk-in service before or after work. Client numbers rose sharply early in the morning, at lunch time and in the early evenings as women poured into the Pyke for the purpose of obtaining a simple repeat prescription. Coordinating clinic time and pill time with their work schedules is only the start of the socially mediated process to get the pill.

Objectification through Registration, Histories and Examinations

These women experienced the passing of time before and in the clinical encounter itself as dragging, especially in contrast to the fleeting encounter with practitioners. The wait

are met. These include the young person understanding the professional's advice; not being able to be persuaded to tell their parents; and their being judged likely to have sexual intercourse whether or not they secure access to contraception. If they are to receive contraceptive treatment, this depends on the

for a consultation was unpredictable and varied from fifteen minutes to an hour and a half, often aggravated by the lack of a full contingent of staff.⁷⁰ Managing time and enduring the long wait are only the starting blocks of the short but critical consultation with a practitioner, the gatekeeper to the pill. Clinical consultations are typically only ten minutes long and follow a set formula based on predetermined national clinical protocols.

Most days at the Pyke were characterised by a crowd of clients waiting, many of whom had walk-in status and therefore lower priority than those with appointments. As noted in the previous chapter, there is a two-tiered appointment system at the Pyke. The top tier is a pre-booked appointment system and the bottom tier is an open-access walk-in service. They operate simultaneously except in the evening sessions and at the community clinics. Pre-booked appointments are given priority and all the staff on the clinic floor take these visits. The 'walk-ins', clients who walk in off the street and do not have an appointment, wait to be seen by the advice sister or by any other member of staff on the clinic floor when there are no appointments. Running the two systems concurrently often leads to confusion and frustration amongst clients as it is unclear what is happening and it appears that some clients are being seen quicker even though they arrived later. This creates tension and aggravation and the often silent elongated waiting is punctuated by the leafing through of glossy magazines (donated by a local publishing company), 'death stares' at the staff and knowing nods between waiting clients. The quiet of the waiting area contrasts with the noisy bustling of staff as they desperately try to attend to clients in a timely manner.

Prior to receiving any consultation, all clients must have a medical record with their personal details and be registered within the Pyke's administrative system. Once completed or updated, these medical records are kept onsite and retrieved as and when necessary. New clients are registered and a medical record is created with an accompanying client number. Returning clients' existing records are retrieved upon their arrival when they supply their client number. The medical record stores the client's details such as name, date of birth, address, GP's address and date of last menstruation. It also documents previous consultations, clinical procedures and outcomes. The

judgement being reached that they will not suffer physically or mentally from this. Young people under 16, like all NHS patients, also have the right to confidentiality.

⁷⁰ See Chapter Two for a discussion of the employment freeze that reduced the number of staff at the Pyke during the fieldwork period.

practitioner uses the record to guide the consultation and as a prompt for clinical procedures, particularly history-taking and physical examinations.⁷¹ The priority given to the medical record by practitioners converts an individual woman into a set of numerical and biological categories and attributes, or as Louise put it, 'tick boxes', for clinical evaluation. As Thompson (2005) has argued these simple bureaucratic routines are part of a process through which women are defined as objects for clinical services.⁷²

After finding time for an appointment, registering at reception and surviving an often interminable wait, clients are then called by their first name by a practitioner, either a specialist nurse or doctor, to go to a consultation room. The term 'practitioner' is used by all staff to refer to both nurses and doctors. Medical practitioners at the Pyke do not overtly distinguish themselves as nurses or doctors to the clients. The nurses and doctors often use their first names, dispense with formal titles and wear casual clothes that make them indistinguishable from one another. Clients often mistake highly-trained and experienced nurses for doctors and young doctors for nurses. This makes for an informal and relaxed atmosphere. However, the practitioners at the Pyke do have hierarchies of expertise that are demonstrated and understood amongst themselves.

In the consultation room the client specifies why she is there and then the practitioner directs the encounter accordingly.⁷³ During the consultation the primary task of the practitioner is to provide for the contraceptive needs of the client by obtaining the necessary information to assess her risk, conveying her risk status and then addressing additional questions and concerns. The role of the client is to provide personal and embodied knowledge by means of a clinical history, something which would otherwise be inaccessible to the practitioner. This follows a similar pattern to that found in other ethnographic studies of clinical encounters (for similar descriptions see Day 2006; Gibbon 2007; Franklin 2007; Rapp 1999). Rapp's (1999) study of genetic counselling

⁷¹ Guidance is also used for auditing purposes in case of complaint and malpractice.

⁷² Several other anthropologists have noted the importance of medical records. Robbie Davis-Floyd (1992) noted that American women on labour wards do not try to read their medical records, betraying a sense that they have no right to the information. She also noted that the bureaucratic procedure creates a distance between the information about the women and the women themselves. Practitioners have exclusive access to the medical records and information which makes them holders and guardians of special knowledge, legitimises their authority and, by shutting women out, defines a sphere of 'authoritative knowledge' (Davis-Floyd 1992). In Sophie Day's (2007) ethnography of the Praed clinic the medical records 'were almost a "second" body accompanying a patient around the clinic and so I tried to carry them with me when I too saw a "patient". They constituted the clinic as much as the other bodies of patients and staff, and provided a sense of historical continuity in the context of frequent staff changes and building moves' (2007:18).

around amniocentesis screening found that routine clinical consultations had three objectives: firstly, for the practitioner to convey information; secondly, for clients to provide individual and family history that is then organised according to the practitioner's protocols and, finally, to answer questions and concerns. This closely corresponds with the accounts given of consultations at the Pyke.

During the consultation, the practitioner assesses whether a woman is eligible for the pill according to whether her profile fits within a set 'normal' biological parameters. The client's profile is compiled through the two standard procedures of clinical history-taking and physical examination. The practitioners use these procedures to extract personal embodied information from the client and convert it into standard biomedical information that can be measured and assessed in order to determine eligibility. All practitioners follow the national standard clinical guidelines for the prescription of Combined Oral Contraception set by the regulatory body, the Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit, to assess eligibility (see FFPRHC 2003).⁷⁴ The guidelines outline the required procedures for conducting a comprehensive personal clinical history and physical examination. The guidelines take a 'holistic approach' that is defined by a comprehensive clinical history:

Clinical history-taking and examination allow an assessment of medical eligibility for COC use. In this context, the clinical history should include medical, sexual, family and drug history, as well as details of reproductive health and previous contraceptive use. With this information, clinicians can advise women appropriately on their contraceptive options, taking account of both the medical and social factors (FFPRHC 2003: 209).

The guidance places history-giving and history-taking at the centre of the consultation.

According to the guidance, to assess eligibility the practitioner requires a range of biomedical information relating to the client's age, last menstrual period, medical history, family history, drug history and (often) obstetric and sexual history. The

⁷³ Practitioners must follow the set of national and clinical protocols set by the FFPRHC for each contraceptive method.

⁷⁴ The Pyke has developed additional guidelines in the form of the Patient Group Directives (PGD). The PGDs represent a tool used to guide and standardise consultations and procedures across the service. They provide protocols for a range of activities such as prescribing combined pills, POPs, injections, pain-killers and local anaesthetic without having to refer to a doctor. Previously these activities required a doctor's approval and slowed down the service. With the PGDs in place, nurse-prescribers are able to provide more clinical services, such as assessing eligibility, that go well beyond their previous remit. However the cases that require specialist attention because they surpass the PGDs protocols are referred to the doctor on duty or on call.

medical history looks for indications of arterial disease, migraines, thrombo-embolism, liver disease and breast cancer. The family history aims to identify genetic predisposition to conditions such as arterial disease, deep vein thrombosis and breast cancer.⁷⁵ The drug history examines current and former medication use to identify conditions or drugs that have contraindications. Sexual and obstetric histories are also taken to assess sexual risk behaviour. For each history the practitioner asks a series of questions prompted by the medical record and the client responds with her personal and embodied knowledge. The practitioners assess the responses in order to identify potential personal or genetic risk factors that could prohibit pill use. The clinical histories are accompanied by two mandatory physical examinations for body weight and blood pressure.⁷⁶ This specialised meaning of 'histories' in clinical context differs from the ways that women themselves frame their own contraceptive histories. The contraceptive narratives collected in this research, which were based on open questions, no time limitations and focused on individuals' areas of interest raised different concerns in contrast to the time-limited closed questions of the clinical history.

The clinical histories and physical examinations exclusively focus on extracting relevant biomedical information from the clients for clinical evaluation of normality. Practitioners assess the information for biomedical indicators of elevated risk that could bar pill use such as age, smoker status, obesity (defined as a Body Mass Index greater than 30), hypertension, focal migraine, personal or family history of breast or liver disease, deep vein thrombosis, stroke or heart disease and/or diabetes. Each risk factor is assessed and forms part of the client's overall risk profile that governs her eligibility for the pill and determines what method of contraception is offered. Practitioners stressed the importance of doing a good history because, if an accurate history is not compiled, they noted bluntly, the client 'could drop dead'.

Clinical histories and physical examinations represent as another process of objectification by which women are converted into objects for clinical services. Through the histories, practitioners extract and change clients' personal and embodied information into biomedically relevant indicators to assess risk. They pick out the physical and biological facts from the social and cultural 'noise' of clients' responses, which then form the basis for assessing eligibility. The client is converted into

⁷⁵ Sahra Gibbon (2006) points out that family histories make biogenetic links explicit.

⁷⁶ Practitioners often also use the clinical histories as an opportunity to do health promotion for safe sex and quitting smoking.

biomedical data that is organised according to existing clinical and biomedical categories in a set range. In this way, the system of assessment treats women like objects or numbers. Having said this, the experience of objectification did vary depending on a particular practitioner's 'bed-side manner'. Moreover, practitioners did not see their assessment practices as a process of objectification but rather as best assisting the client to make an informed and safe contraceptive choice.

This system of assessment and corresponding objectification is typical of a biomedical approach that privileges scientific rationality, according to which what is real can be objectively observed, measured and quantified into clinical facts that serve as the basis for diagnosis and treatment (Lindenbaum and Lock 1993; Helman 2000). Observable and quantifiable clinical facts are, in this way of thinking, biological or physical and can be located within a range of physical biological parameters. Cecil Helman (2000) identified this approach to medicine as typical of western biomedicine in which:

Health or normality are defined by reference to certain physical and biochemical parameters, such as weight, height, circumference, blood count, haemoglobin level, levels of electrolytes or hormones, blood pressure, heart rate, respiratory rate, heart size or visual acuity. For each measurement there is a numerical range – the 'normal value' – within which the individual is considered normal and healthy. (Helman 2000: 80)

By treating women as a set of biomedical indicators, they can be assessed as 'normal' – i.e. having no cardio-vascular, liver or breast disease, being a healthy weight, non-smoking and with a healthy immediate family – and therefore eligible for the pill. In the clinic, being on the pill required being 'normal' and normality was biologically defined. Rapp (1999), Thompson (2005) and Gibbon (2006) have outlined how clinical procedures yield biomedical information by transforming clients' information into categories suitable for biomedical assessments of normality. Practitioners at the Pyke similarly are looking for biomedical indicators of normality and abnormality as categories on which to base their assessments. In addition to assessing risk, taking and analysing clinical histories also helps to establish practitioners' specialised knowledge, expertise and authority.

Once a client is assessed and judged to be 'normal', based on her presented and decoded biomedical information, she becomes eligible for the pill. The practitioner prescribes the pill and advises the client when to start taking it and what to do if she misses a pill, as

well as warning her about side-effects, benefits and contraindications (such as taking antibiotics,) and promoting safer sex. An initial three-month supply of the pill is prescribed, usually the 'first line option' of a monophasic-combined pill, and, more specifically, often Schering's inexpensive Microgynon.⁷⁷ The client is encouraged to return after three months for a follow-up if she is a first-time user or after a further six months if she is an established user and then every twelve months thereafter if there are no problems.⁷⁸ At subsequent visits the practitioner will review whether the client is happy with the method, if there are any side-effects and if there have been any changes in her medical, family and drug history. This is followed by routine physical examinations for blood pressure and weight. The frequent clinical encounters required – a minimum of twice a year until recently – make the clinical procedures, system of assessment and objectification a predictable and learnt routine which, as a consequence, the clients can strategically manipulate.

Clients' Strategic Participation in the Clinical Encounter

In accounts of routine clinical encounters, the practitioner appears to lead the procedures and interactions as they have authoritative specialised knowledge to assess eligibility. However, like Louise, many of the women I spoke to did not passively accept this implicitly unequal relationship of assessment, even when they appeared to acquiesce; instead they actively and strategically directed the encounter to ensure access to the pill. Typically, they had clear objectives in the clinical encounter: Tania told me that 'The only thing you are thinking about is getting your pill and going' and Mary echoed this, saying, 'There was no way he [the practitioner] was going to fob me off with anything else'. The time and effort of registering and waiting reflect the incredible determination of these women to get the pill.

Despite this determination the combination of routine procedures, clinical authority and being a 'good patient' left little space to direct the clinical encounter. Yet, it is precisely the standard and predictable, routine and clinical nature of the encounter that enabled them to learn what questions, indicators, behaviours and examinations to expect. Based

⁷⁷ Clients who do not experience side-effects often do not know the name or composition of the pill they take nor do they care to know. In these cases often the only thing they know is the colour of the packaging. It is only when they experience side-effects or perceived risk that they tend to recognise the different types of pill.

on their knowledge of the expected routine, objectification and their implicit compliant role in the clinical relationship they developed and deployed strategies to get what they wanted.

Many of the women commented on the repetitive and predictable routine of the clinical encounter with GPs and contraceptive services practitioners. Elizabeth describes how a routine clinical encounter proceeded: 'We had the quick blood pressure, weight, how you feeling generally, "do you smoke?", "no", "that's fine" and that was it. She knew I wanted the pill, went in and came back with the pill and that was it really. There wasn't really talk about anything else, she didn't even ask me about my sexual history or stuff or whether it was right for me on the pill'. She outlined how she could predict what the questions and procedures would be in order to get the pill. Rachel, a long-term continuous pill user of thirteen years, explained: 'When things were normal I could just roll up and get re-prescriptions on it and then I go in every six months or every year to do the blood pressure and the weight'. This habituated routine made it easy for her to get the pill.

Many of the women who faced no obstacles in getting the pill told me that they were accustomed to the routine and never thought to challenge it by asking questions or articulating problems. Tania had been using Lygnon, a triphasic pill, for nine years and experienced severe mood changes. She never thought to tell her practitioner because she did not think to question the routine:

But they said are you aware about, I can't even remember, all those normal questions, they took my blood pressure, took my weight, and put me on Lygnyon because I was a smoker and I said I smoked ten a week or something, like not that much. Yeah, I was an occasional smoker and that's what they said would be best. And that's honestly what I remember them saying, this is the best pill for you. I didn't question them at all, I was just happy they gave it to me to be protected.

Here, Tania describes how the routine was habitual, the procedures and her responses were rote and she did not think to ask questions. Tania unquestioningly accepted the routine and authority of the practitioner as these allowed her to achieve her principal objective. And she was not the only one – many respondents accepted the practitioner's

⁷⁸ During fieldwork in 2006 there was a change in the prescription guidelines for the pill allowing women who had been on the pill for an extended period without problems to be given a twelve-month prescription instead of a six-month prescription.

authority and expertise, particularly if there were no complications or threats to their eligibility. Francis, a continuous pill user for seven years, told me: 'I take advice of what they think and what's best'. Teresa, a continuous user for sixteen years, happily accepts the practitioner's assessment: 'I respect their judgement. As soon as anybody here suggested I didn't, I wouldn't. Straight away, I would let the judgement of the specialists here outweigh my own preference, even if I thought I feel alright, but if they said you probably really shouldn't, then I would stop it immediately. That is why I continue to take it'. In these examples the standard routine and relationship produced the desired result of getting the pill. The predictable routine was convenient and satisfied their needs; hence, they became accustomed to it.

This compliance partly relates to the fact that many women started the pill on their practitioner's recommendation. At nineteen Jessica had taken the morning-after pill three times when her GP recommended she start on the pill. She told me: 'If I had said that I don't want to go on it, she would of [*sic*] said "No, really you should really go on it"'. Immediately after having her second child at nineteen, Rebecca was recommended to start taking the pill. She explained: 'Yeah the hospital said to me, "don't you think you should do something this time?" because it had happened so quickly afterwards. I didn't want any more babies so I had to do something. I didn't want a coil or anything like. I thought the pill would be the best option'. Tina's GP recommended that she take the pill to reduce her menstrual pain: 'I think I just went to the GP because I was having bad pains. But, I think, I am pretty sure the doctor would have told me because I wouldn't have known at that age that that helped'. Jessica, Rebecca and Tina have now been taking the pill for six, ten and five years respectively.

The women I spoke to described how their acceptance of the practitioners' authoritative decisions was reinforced by the predictable routine of the clinical encounter itself. Tania, cited earlier, who did not ask questions, explained how the two dovetailed:

I hadn't realised that I could ask for different pills, you know what I mean, and when we go to the family planning clinic, or the doctor, "have you had any problems with the pill?" I never think of any problems when I am at the place because it's just one of these questions that comes out of nowhere. Well it's not coming out of nowhere really, but I can't relate any of the problems to it at the moment and it does not get discussed and I go on the pill but, now I realise... You go to the doctor and you say I have this, this and this, I get and I go, I don't even think. It is really strange because it is like a blip in the mind.

Tania implies that as the person in the role of client she cannot raise an 'out of nowhere' question, outside of the expected flow of information between client and practitioner. This suggests that within the consultation the client and the practitioner have specific roles – for instance, practitioners ask questions and make recommendations to which the client responds. On first reading, the compliance of the women I spoke to appears to demonstrate a lack of agency and control. Clients were expected to be civil, compliant and maintain the flow of expertise travelling from the practitioner to the client (see Thompson 2005; Gibbon 2007). Asking 'out of nowhere' questions did not conform to the expected client-practitioner relationship.

However, accepting authority and not raising questions, not highlighting problems and not challenging set roles ensures a smooth routine encounter that results in them taking the pill home. By acquiescing and conforming to the expected client role they achieve their objective. This can be seen as a strategy of self-presentation and many of the women felt they adopted a markedly different persona in the clinic from the social roles taken outside. Many clients described how they take on this 'appropriate' behaviour even though it often conflicted with their ordinary personality or their professional responsibilities outside the clinic. Staff frequently commented on the differences in clients' behaviour between the reception area and the consultation room. At the reception clients were demanding and aggressive whereas in the consultation they were civil, even deferential. From my place behind the reception counter, I also observed a notable difference between when women registered and returned from the consultation, they transformed from demanding services to being deferential and kind.

The combination of routine, clinical authority and being a 'good patient' leaves little space for a client to openly direct the practitioner and the clinical outcome. Yet, the women I spoke to did not simply submit to the practitioner; they used subtle strategies to direct the outcome of the encounter, such as adopting the compliant persona of a client, and therefore actively participated in their own objectification to achieve their desired objective. In her study of surrogacy in infertility clinics, Thompson (2005) termed the actions of the women receiving treatment as 'intentional subordination': 'subordinating the will to the structural power of another person or organisation to achieve some overarching goal. The power is not something that simply resides in the physician or institution, however, as this notion tends to suggest. The physician is a link in the chain that mediates access to the techniques. The patients do not so much let

themselves be treated like objects to comply with the physicians as they comply with the physicians to let themselves be treated like objects' (2006: 191). Although practitioners and clinical protocols took the lead in the clinical encounter, set the terms of engagement and determined eligibility, clients actively directed the encounter by suppressing their social personas in order to become passive clinical objects. Therefore not questioning the practitioner and being compliant was, in itself, a strategic practice that often helped them achieve their desired outcome.

In addition to 'intentional subordination', knowledge learnt through repeated clinical routine was also used to ensure access to the pill. The regularity of the clinical encounters enabled these women to learn what questions and examinations to expect. These women learn to think through medicine by presenting biomedical information in such a way as to purposefully direct the clinical evaluation. Rayna Rapp describes this process in the following way: 'Learning to think through medicine entails the re-coding of the body: its ills, systematic connections, and intergenerational history all take on new and specialised meaning' (Rapp 1999: 76). Having learnt how to interpret the culturally valorised biomedical categories of assessment, the women I spoke to could strategically present biomedical information for evaluation and thus guide the outcome of their clinical encounters.

Several of the women explained how they strategically altered the information they presented in clinical histories to ensure access to the pill. By adapting the information they shared they actively affected the outcome whilst appearing to be compliant, as was the case with Louise. Similarly, Emily, an intermittent user of the pill, omitted important information about her family history because she thought this would have reduced the likelihood of her getting the pill. She decided not to mention the fact that her mother was hospitalised with deep vein thrombosis, a high risk factor. Emily explained why she did this:

E: I know I ran into problems because I had to get my prescription filled over here and they wanted to change me off Femodene... They asked me if there was any history of blood clots in the family and I said no. My mother was after spending months in hospital [with thrombosis]. But I wanted Femodene, I knew it, I had used it and I trusted it.

V: So you lied to the doctor about your mum's thrombosis?

E: Absolutely I am sure she had it not because she was on the pill but because she smokes like a trooper. I had never smoked, I wasn't at risk, I knew more than the doctors.

Emily describes how she withheld biomedically valuable information during the clinical encounter as she thought this would negatively bias getting the pill.

Mary, a continuous pill user of sixteen years told me how she successfully combines several strategies in order to ensure access. She intentionally performs in the routine by mentally preparing a script containing tailored biomedical information. She told me:

With my GP it is so much hassle to get there, you kind of have to know, you almost have to have a script because he watches an egg timer, he is still writing up the notes from the last patient when you get in. You have five minutes, you have to go bang, bang, bang these are my symptoms so you kind of have to write a prompt. So I went in and said here is my calendar this is when it is happening, this is what is happening, I have kept a note for you, because what I can't do with is if you to tell me to go away and monitor things, I have monitored things and it comes down to this, pre-menstrual, yeah it looks like it is go on the pill.

In her prepared script, she considers the timings, numbers, and routine questions set by clinical guidance and this provides a way for her to have a degree of power and control in what she considers an unequal power relationship. The system of assessment and the practitioner could conflict with her desires, and therefore, she worked within the constraints of the clinical categories to achieve her goal. These strategies of omitting or tailoring information illustrate how the women I spoke to actively use their knowledge about the clinical encounter (including their own objectification), their understanding of biomedical categories and compliant behaviour to achieve their desired ends.

In their accounts of consultations the women I spoke to described the different strategies, from 'intentional subordination' to overtly concealing clinically important information to scripting, all of which depend on 'learning' the routines and expected roles of the clinical relationships. These various strategies are effective because they create the appearance of congruence between the values and expectations of the practitioner and the client. This congruence is maintained whilst the desired outcome was uncontested. Conflicts in assessing side-effects and potential risks often derailed clients' strategies as it revealed the difference between practitioners' and clients' objectives. This illustrates the limitations of patients' agency and the continuing institutional regulation of fertility.

Clients' Strategic Participation in the Not-So-Routine Clinical Encounters

Many accounts of the disputes in clinical encounters reported to me occurred when clients and practitioners had differing perceptions of side-effects and risks. Reporting side-effects or being categorised as 'at risk' raises 'out of nowhere' questions that disturb the routine and roles that underpin the strategic participation of the women I spoke with. Not-so-routine clinical encounters are situations where clients raised concerns about the side-effects, when there were conflicts over what was considered a side-effect or when the practitioner's risk assessment limited access to the pill.

When these women reported their experience of emotional or sexual side-effects during consultations they were, they said, often belittled by practitioners. Practitioners were more concerned with identifying and addressing bio-physical side-effects such as headaches and migraines, that is to say side-effects that affect a client's risk profile. This again suggests a biomedical bias, which prioritises biological and physical factors over psychological or sexual effects. The clients, by contrast, identified and evaluated side-effects based on what they consider to affect their normal bodily functions and social roles. Etkins (1992) and Nichter and Vuckovic (1994) argue that the identification and evaluation of side-effects are socially and culturally mediated and that a side-effect is defined by how it affects culturally important bodily processes and social duties (see Chapter Seven for a detailed discussion of side-effects). Hence, there is a tension between the definition and assessment of side-effects as interpreted by practitioners and by clients.

Kristen and Kate recounted to me their experiences of reporting side-effects. From their points of view they were not taken seriously and were made to feel unreasonable and overdramatic. Kristen had been on the pill for over ten years and had decided to start 'tricycling' to reduce her pre-menstrual headaches. Tricycling is when pill users do not take the recommended seven-day break between pill strips and, therefore, have no withdrawal bleed. She soon started to experience irregular and heavy breakthrough bleeding, which she immediately reported to her practitioner only to be told that this was not a side-effect. Kristen related how this made her feel: 'It just seems to be a rather extreme reaction when people keep telling you that it is not necessarily one of the side-effects that they would expect. So there is that feeling, here is me being a hypochondriac, that something else is wrong'. In this situation, she privileged her own

embodied assessment, which changed the patient-practitioner relationship and the apparent flow of control, only for it to be reinstated by the practitioner's refutation of her assessment. Similarly, when Kate started taking a new pill at the start of a long-term sexual relationship, she started to experience continual discomfort – this was dismissed when she reported it to her practitioner. She told me: 'I kept going back and saying this is happening, this is happening and they just said "No, I don't think it is to do with the pill, just carry on for another month."' I just had a weekend when I was in real pain and just thought this is ridiculous, what am I doing, I went in on Monday and said take me off this pill. If it is not that I will find out it's something else but it just seems strange that it only started with that [the new pill]'

Kate and Kristen's side-effects had serious repercussions for their personal and professional lives. Kristen, for example, suffered embarrassment as she bled through her clothing at work and they both had to take time off work to rest or to get medical attention. They had both reported self-assessed side-effects that were dismissed by their practitioners (later, both were diagnosed and treated for ovarian cysts). In sharing their embodied knowledge and stressing their assessment they challenged the conventions of the clinical relationship. They perceived the practitioner's response not as providing an expert solution to the problem but, rather, an attempt to reinstate the typical power relationship. They now question their practitioners' authority and expertise. Kate told me:

My last experience has put me off slightly because I thought someone should have said to me why don't you change. I am surprised, I am thinking about writing to them why didn't anyone think to say why don't you change. I was on it for five months and I went back literally once month with something. So because up 'til that point they had been brilliant... Every time I went back with a symptom they said it's unrelated, you think well how do you know it's unrelated surely you change the thing that is different and then see whether it continues. I am surprised, I don't know if they have a policy unless you ask to change.

Mary who also experienced problems on the pill and whose concerns were also dismissed told me: 'You don't always think that it is going to be the pill. You don't think your GP is going to give you something that is going to make you ill'. In these examples we can see how reporting side-effects changes the routine processes and relationships as women introduced their own categories of assessment based on embodied knowledge which conflict with the practitioners' biomedical assessment based on expert medical knowledge.

Side-effects are clinically defined as the pharmacological effects of a drug that are unrelated to its primary action, in this case preventing pregnancy.⁷⁹ The predicted side-effects of the combined pill are breakthrough bleeding, weight gain, breast tenderness, headaches, acne and mood changes (Guillebaud 2004; DFFP 2006) as derived from the physiological and psychological changes manifested during clinical trials (Etkins 1992). From a clinical perspective, side-effects do not necessarily generate risk and are therefore not significant; this view was shared by the Pyke's practitioners. Several of the Pyke's practitioners pointed out that the pill is unique because of the fact that it is prescribed to healthy normal population and its primary action tends not to be felt; only the side-effects are likely to be perceived.⁸⁰ A senior doctor (and national authority on the risks and side-effects of the pill) told me: 'With the pill they don't notice the thing that is better, which is they are not getting pregnant, but they do notice the side-effects. So it's very biased in their mind to the side-effects because they don't see the benefits as such, nobody views I am not pregnant as a benefit'. Practitioners commented that the most commonly reported side-effects were weight gain and unfounded anxieties about infertility, which they did not consider to be serious. The women I interviewed did note weight gain and fertility anxiety as well as other side-effects ranging from loss of libido, to flattened mood or volatile mood swings, to breast tenderness. Yet these side-effects were dismissed by practitioners as 'not serious' and one practitioner even told me: 'Women with side-effects are a pain in the neck'.

Another disruption to the clinical routine occurs when the system of assessment categorises a woman as 'at risk' and therefore ineligible to take the pill. According to clinical studies, there are few life-threatening or serious conditions associated with taking the pill (Oldfield 1998; Beral 1999). The associated mortality rate for pill users is low when there are no pre-existing problems, with two deaths per million users per year attributed to the pill for the age group 20-24, two to five deaths for the age group 30-34 and twenty to twenty-five deaths for the age group 40-44 (WHO 1998).⁸¹ The risks of

⁷⁹ In some cases, a known side-effect is the motivation for prescribing the drug as, for example, when a woman takes the pill primarily to enhance cycle control or reduce bleeding instead of for the purposes of the pill's primary action, preventing pregnancy. Julia, for example, had taken the pill infrequently but after her mother died from ovarian cancer she wanted to take the pill, despite all its side-effects and risks, because of the positive secondary side-effect that it reduces the risk of ovarian cancer.

⁸⁰ Women did notice relief from menstruation-related conditions such as heavy bleeding, pain and irregularity; some women also noted bad acne.

⁸¹ In a few cases, women can be at risk of myocardial infarction, a risk which increases with age, smoking and high blood pressure. Hypertension, smoking and age also increase the risk of strokes amongst pill users. Women on the pill have an increased risk of venous thrombo-embolism. The natural rate of 5 per

taking the pill are reduced when detailed clinical evaluations are taken. When 'abnormal' biomedical indicators are obtained from her clinical history and physical examination a woman is placed in the 'at-risk' category.⁸² Some risk factors such as high weight, smoking habits and blood pressure are changeable while some others, such as genetic history and certain physiological conditions, are permanent. In cases of permanent risk ineligible clients are offered an alternative method, such as the progesterone-only pill. In cases of impermanent risk clients are referred to the higher expertise of a clinician who is authorised to go beyond the standard medical protocols.⁸³ Yet, for many clients the risks of taking the pill were not considered as risky as life without the pill. For instance, Rachel, who has been on the pill continuously for thirteen years, never questioned the practitioner and passively went through the routine in order to get the pill. When she was denied the pill due to her changed risk profile, she no longer remained compliant and instead actively challenged the practitioner's decision and asked questions. This did not, however, result in the desired repeat prescription.

The reporting of side-effects or the identification of risk reveals the different priorities of the clients and the practitioners which are masked in the routine clinical encounters. For example, a serious potential health risk identified by the practitioner might not be seen as important as the potential consequences of an unplanned pregnancy for the client; or, alternatively, the uncomfortable or upsetting side-effect experienced by a client might be dismissed as a minor nuisance by the practitioner. The client-practitioner relationship becomes less cooperative and more complicated with the identification of and response to 'nuisance side-effects' and 'serious health risks'. In these examples, clients no longer fit into the normal biomedical categories and require the practitioners' specialised knowledge and expertise to find an appropriate solution to their problem.

100,000 per year increases to 30-40 per 100,000 per year for women on the pill (this rate increases even more with high BMI and smoking). There is also an increased risk of developing breast cancer as well as hepatocellular carcinoma. It can be seen then that while there are few risks when taking the pill, these risks are serious and hence require strict regulation.

⁸² Women are ineligible for the pill if they are considered to have elevated risk or when, in clinical terminology, the 'risks outweigh benefits' or generate an 'unacceptable health risk' (FFPRHC 2003). According to the FFPRHC (2003) guidelines in cases where women have hypertension, an elevated BMI, VTE or sickle cell or liver disease the risks of being on the pill outweigh the advantages and an alternative method of contraception is suggested. In cases of arterial disease, women should not take any hormonal contraceptive. In cases where women are smokers over 35, suffer from certain cardiovascular conditions or experience non-focal migraines or diabetes the advantages of being on the pill outweigh the risks unless they have two or more of these conditions. A possible alternative for women who smoke, with high BMI, focal migraines, high blood pressure and/or at risk of VTE is to take the progesterone-only pill.

⁸³ The Pyke tends to see more 'difficult' cases as the centre is staffed by internationally recognised contraceptive specialists and receives referrals from around the country.

Here the client must adopt more radical strategies, involving changing methods or practitioner, to achieve her objective.

The reporting of side-effects or the detection of risks disrupts the standard clinical routine and clients' strategic responses because the apparent congruence between the client's and practitioner's standpoints is unmasked and unequal relationships are laid bare. If the biomedical classification of a client is abnormal, a more nuanced pharmacological response is required from the practitioner. Often the reporting of side-effects or the identification of risk at the Pyke requires the offering of a solution. In responding to the particularities of side-effects and risks, practitioners demonstrate their expertise to meet the specific biomedical needs of a client. The practitioner interprets the side-effects as progesteronic and/or oestrogenic effects and then changes the oestrogen dosage, type of progesterone, type of pill or opts for another method altogether. The practitioner's specialist expertise is engaged and enacted exactly when the client shifts from being a standard clinical object to being a specific case that requires specially tailored diagnosis and treatment. Whereas, a clinical assessment of 'at risk' limits the client's strategic responses because the assessment is based on a biomedical category they often cannot alter. So, in not-so-routine encounters, the client's ability to act strategically is reduced.

Rachel, Elizabeth and Mary's accounts illustrate how the women in this study dealt with their 'at-risk' status. Rachel, mentioned earlier, was taken off the pill by her GP because of her high BMI which increased her risk of having a stroke. When she heard this assessment, she verbally (and almost physically) assaulted her GP. She had been taking the pill not only to prevent pregnancy but also to regulate her cycle and her moods and she was worried that her unregulated reproductive cycle would affect her work performance. At this point she was on a strict diet to lose the necessary weight to get back on her preferred pill. Elizabeth, a 24-year-old patent lawyer, had taken the pill for four months at the start of her first sexual relationship. Within six months of becoming sexually active, the pill affected her liver function, resulting in a rash, and she was taken off the pill. Elizabeth describes her experience: 'They came up with all these weird and wonderful things that they tried on me, one of the ones is that they said I had scabies, which isn't very nice and my boyfriend and my family all had to go through the treatment as well, so it was a bit, looking back on it, it was funny but at the time it was not great'. Since then she has tried various different contraceptive methods. Mary, a

continuous combined pill user for eleven years recounted when she reported her frequent focal migraines to a practitioner at the Pyke and described the practitioner's resulting horror. The concerned practitioner immediately told her she was 'at risk' and suggested she switch to a progesterone-only pill. She agreed but was severely disturbed by the fact that no practitioner had identified the risk earlier. In all these examples, the practitioners' assessment was final.

An 'at-risk' assessment limits and reduces the strategies available to women to influence the clinical encounter. Neither compliance, nor intentional subordination, nor altering information in the clinical histories, achieve the desired outcome when 'risk' is introduced. Not-so-routine encounters demonstrate the practitioner's authority and highlight the client's relative structural powerlessness, as they cannot affect the 'at risk' categorisation. Mary and Elizabeth accepted the assessment and alternative contraceptive methods offered and Rachel subsequently made the necessary changes to her lifestyle. A more radical response was to find a new practitioner and try to omit the 'offending' information, therefore ensuring continued access to the pill. This was the case for Louise and Emily, both cited earlier, who were considered 'at risk' and found new practitioners, where they omitted the prejudicial information in order to ensure continued access to the pill.

The Limits of Clients' Strategies in Clinical Encounters

The clinical consultation determines a woman's current eligibility for the pill and it is, therefore, the client-practitioner interaction that mediates access. These accounts of clinical encounters illustrate how both practitioners and clients participate in the outcome of these encounters. The clinical procedures for a risk assessment, namely clinical histories and physical examinations, are practitioner-led and clients respond strategically in order to influence the outcome. In the examples of standard clinical encounters clients exerted influence through 'intentional subordination' and the manipulation of biomedical categories.

This analysis of clients' strategic practices speak to ongoing debates about clinical relationships between patient and practitioner. Recently, anthropologists have responded to a tendency to overemphasise the practitioner's authority and underestimate the client's participation by demonstrating that such a view denies the fact that in reality

both the client and the practitioner participate in directing clinical outcomes within their respective constraints. Anthropological studies of clinical encounters suggest that these encounters do not involve a one-way transfer of authoritative knowledge from the practitioner to the client since the client also plays an active role in determining the course of the interaction and its outcome (for further discussion see Kleinman 1980; Helman 2000; Thompson 2005; Gibbon 2002, 2007; Rapp 1999). In the context of breast cancer care and management in the UK, Sahra Gibbon (2002) has observed that the needs and desired objectives of the client cannot be separated from the actions of the practitioners. The strategic responses described here illustrate that although practitioners have specialist authoritative knowledge, this knowledge does not entirely exclude clients.

The national requirement for a comprehensive clinical history makes it crucial to assessing eligibility and, therefore, central to the clinical encounter. It is through the clinical history that the practitioner extracts the client's embodied knowledge and converts it into assessable biomedical categories. Clinical histories require the participation of clients in order to integrate their personal and embodied knowledge into the assessment procedures. These clinical histories are verbal exchanges and create a space for clients to share in directing the outcome by providing, denying or adapting information and by manipulating the clinical history the client can actively influence both the assessment and the outcome. As seen in their accounts, the women in this study were keen to achieve the objective of getting the pill and actively edited their responses accordingly. They play down side-effects and potential risk indicators by reporting that they smoke fewer cigarettes than they do or by excluding aspects of their family's medical history thus making themselves more amenable to the normal biological parameters. There is, then, scope for clients to share information in such a way as to achieve their objectives. By actively fulfilling, or reporting that they fulfil, the categories of eligibility the clients actively participate in their objectification.

These processes of objectification are learnt in the process of repeatedly participating in clinical routines in which clients become familiar with medical protocols and categories and manipulate these to their advantage. I have argued that the women I spoke with were learning to 'think through medicine' (Rapp 1999: 76) in order to achieve their goals. These women are, nevertheless, actively orienting and adapting themselves as clinical objects in accordance with clinical standards and procedures. Through

bureaucratic and clinical procedures, the women I spoke to are made into and actively turn themselves into clinical objects.

The strategic manipulation of clinical histories also points to the expected behaviour of the client in the client-practitioner relationship, which is compliant, passive and accepting of the practitioner's authority. In responding to these procedures and displaying this behaviour, clients are 'intentionally subordinating' themselves in order to fulfil their objectives. These women are therefore actively 'subordinating their will to the structural power of another person or organisation to achieve some overarching goal' (Thompson 2005: 191). Many women actually 'intentionally subordinate' themselves when they enter into the clinical encounter as they adopt a comportment often at odds with their roles outside of the consultation setting.

As objectification leads to a desired goal, these women are actively involved in what is happening to them. Thompson (2005) argues that an individual's agency is not curtailed by being labelled and objectified as a client, since they may actually actively seek this status in the 'pursuit of empowerment and control' as they attempt 'to author and authorise' themselves: "The woman's objectification involves her active participation and is managed by her as crucially as by the practitioners, procedures, and instruments. Patient agency is not only incompatible with objectification but sometimes requires periods of objectification' (Thompson 2005: 185). In their accounts these women comply with expected behaviour, not asking unexpected questions and providing edited information for assessment. Though they may appear to be acquiescing to their own objectification, in doing so they are in fact demonstrating their agency. This provides a different view of agency beyond a definition limited to compliance or resistance in the clinical encounter.

The examples discussed in this chapter show how clients actively participate in and influence the outcomes of clinical encounters. These women are not 'helpless' nor 'victims' of objectification but actively participate and manage their own objectification in order to achieve desired ends. Moreover, it illustrates constraints on the practitioners, who do share certain values, theories, practices and behaviours that are inculcated in them during training and practice (Helman 2000; Klienman 1980; Lupton 2003; Luhrmann 2000). Medical training teaches a positivist scientific method that is reliant on numerical measurement of physicochemical and biological indicators and particular

ways of analysing situations and cases. This surface uniformity and objectivity of practitioners is contrasted with the idiosyncratic and lay perspective of the client. Practitioners have their own biases and are relatively limited and powerless in relation to their institutional and regulatory constraints.

Yet, these accounts of clinical encounters also suggest a more constrained view of patients' agency in the clinical relationship and its outcome. My analysis proposes that these women are strategising from a position of relative powerlessness. 'Intentional subordination' is a strategic point of power for clients but it is constrained by factors beyond their control, such as national medical protocols and clinic opening times. Moreover, during the manipulation of clinical histories and intentional subordination the clients are responding to set clinical procedures and categories which they must learn and strategically deploy. They have to adopt a role that is unfamiliar to them outside the clinical setting and must make a considerable effort to align with clinical practices, categories and time systems in order to get the pill. Also, although they could strategically edit their clinical histories, they could not manipulate the outcome of the physical examinations.

The women I spoke to are aware of their relative powerlessness in these encounters. The chapter started with Louise's comments about the imbalance of power, an imbalance resulting from the fact that the practitioners have the authority to make life-altering decisions about their bodies and futures by dictating whether or not they may take the pill. Rachel, who took the pill to prevent pregnancy and to regulate her menstruation, and who had recently been categorised as 'at risk', had similar thoughts:

And that is one thing that when I went to the doctor's and got hysterical with her. I really got angry with her, I said to her, it is my body and you are telling me what I can put into it. I have a real problem with that as she wouldn't give me what I need. I said I will sign a piece of paper if it means that you are worried about giving it to me because I am going to drop dead tomorrow. I will sign a piece of paper for it. I don't understand why you can't give me what I need. It was like I was coming off ecstasy and she wouldn't give me what I need. I think she was quite shocked, it was very funny. It is a big thing, I should be able to say what pill I want to go on. It makes me so angry. If I am responsible for managing two million pounds a year, managing people, I am surely responsible enough to be able to do decide what I put in my body. And that might kill me or give me a blood clot, that is a decision I can make, not the doctors. I don't understand where the power comes. I understand them having to do it, but they should bring in forms that say I understand the risks I am taking but I

specifically want to take this, and it is my decision. So long as people are informed about it they should be allowed to make those decisions themselves.

Rachel felt she was capable of making decisions about her daily and future life, yet she also recognised that practitioners could make the definitive decision about whether she could have this control or not. This angered her as their ability to influence her choices jarred with her control and influence in her life outside the clinic. Practitioners' authority over other bodies was often felt to be at odds with the social positions and roles held outside the clinic. Both Rachel and Louise felt that the practitioners had unwarranted authority to affect and control decisions about their bodies and lives.

The structural powerlessness of the women I spoke to in clinical relationships was most evident when they reported side-effects and when they were identified as 'at risk'. In the case of reported side-effects, clients' concerns were rarely seriously addressed and were often dismissed as 'cosmetic' even though they may have had serious repercussions on the performance of other social roles. In the case of an 'at-risk' assessment clients have limited options: to adhere to the alternatives provided by the practitioner or to seek a new practitioner. Again their structural position in the clinical relationship restricted their perceived ability to control their bodies and lives.

Yet the accounts of powerlessness occurred alongside a desire for the practitioners' knowledge and expertise about the pill and well-being. For some of the women I spoke to, the routine questions and examinations of practitioners created a sense of security and safety because they felt they were being monitored whilst using something potentially harmful. For them, the physical examinations (which they could not manipulate) were a particularly important part of their visit as it made them feel as if they were being objectively monitored (see Gibbon 2007). Mary told me: 'The doctor I have at the moment is very conscientious, always measures my blood pressure every time when I go ask for a new prescription, checks my weight, whereas others never really bothered'. Tina explained that examinations made her feel everything was alright: 'They are always very good they always weigh me and giving me the blood pressure, tell me to stop smoking, so what have you. I remember once vaguely going to one of my many GPs, ex GPs, and remember feeling quite being affronted that [he] didn't take my blood pressure. "Here you are, have that" I thought hang on a minute, I want a test to know if everything is okay'. These women perceived the physical examination as a form of assurance through which practitioners ascertain and exhibit their authoritative

specialised knowledge. This suggests that the women in this research are both ambivalent about the pill and the role of the practitioner.

These accounts indicate that the clinical outcome of getting the pill is the negotiated product of client-practitioner interaction. Yet the analysis of these clients' strategies to direct the clinical encounter demonstrates that such strategies are constrained by biomedically valued categories and institutional clinical guidance, rather than reflecting the clients' own priorities and interests. They are also based on a structurally imbalanced clinical relationship. In these clinical encounters, particularly the client-practitioner relationship, clients are exercising agency from a position of structural powerlessness which is both resisted and desired.

Conclusion

These accounts of the clinical encounter paint a picture of the complex social interactions necessary to get the pill. This regularly repeated encounter starts with the coordinating of different time systems to accurately set up the clinical encounter. Once the consultation has been arranged, the practitioner and client interact in such a way that the needs and desired objectives of the client are inseparable from the actions of the practitioners. The range of strategies deployed to get the pill play to the biomedical categories and clinical procedures that objectify clients and safeguard practitioners' specialised knowledge and authority. The privileging of biomedical categories and the expected roles create an apparent congruence between the clients and the practitioners.

The experiences of those women who were deemed 'at risk' or suffered side-effects make explicit the different and incongruent categories and expectations of clients and practitioners, as well as highlighting the greater powers of determination of practitioners, institutions and their regulatory structures. Although the women's strategies demonstrated agency to some extent, they were operating within a set of structural and institutional constraints, which they were largely powerless to influence. This analysis suggests that the pill does not represent a shift from social to personalised regulation of fertility, but rather that the regulation of reproduction remains socially mediated through clinical institutions.

The pill is described in public health literature as a tool of self control, autonomy and rational choice because it is a medicine that individualises and enables personal responsibility. Yet it is precisely because it is a medicine that it is guarded by biomedical institutions that determine who has access to it and when. Far from freeing women from external social institutions (such as marriage and kinship) that regulate fertility, the accounts analysed here illustrate how the women I spoke to must navigate the clinical procedures, categories and processes of the NHS and that these efforts are embedded within unequal clinical relationships. These accounts demonstrate the incredible efforts required on the part of these women in order to get the pill. The repeated inconvenience and the lengths they went to get the pill to illustrate how important the pill was for them. The following chapters explore why this was so.

Chapter Four

Pregnancy and the Pill

My standard question at the start of every interview, after outlining a contraceptive history with my respondent, was simply, why do you take the pill? The typical response was: to prevent pregnancy and several women commented they felt they were 'too selfish' to have a child now. This chapter explores this somewhat unexpected claim about selfishness, which suggests that having a child is seen to be selfless act rather than a selfish one. It also implies that pregnancy is not only about the potential child but about realising the social institution of motherhood, which is central to ideas of natural femininity. Here I examine why some of the women I spoke to think they are too selfish to have a child and use the pill to postpone childbearing. And I ask, what does this tell us about their ideas about pregnancy and motherhood and how this relates to their pill use?

This chapter explores these women's motivations to prevent pregnancy rather than analysing pill use through the kinds of demographic and economic approaches outlined in the Introduction, which understand the use of modern contraceptives as rational, autonomous and self-interested decisions free from the constraints of biology and social institutions. Here I consider whether the decision to prevent pregnancy with the pill is rational, autonomous and self-interested or bound within more complex social institutions and is a more relational decision, particularly in terms of thinking of the self and self-improvement as being in the service of others.

The following accounts of preventing pregnancy with the pill demonstrate that pregnancy and motherhood remain persistent and significant concerns for the women I spoke to as well as a structuring feature of their lives. The first section looks at the different ways women talk about pregnancy in terms of their anxieties about unwanted pregnancies and abortions, future plans and their actual experiences of pregnancy. The following section then outlines how their practical considerations in planning pregnancy sit alongside ideas of 'nature' that define their imagined reproductive futures and affect their 'rational' decisions. The chapter then explores how women used the pill to balance these seemingly contradictory considerations in planning pregnancy and its effects on

understanding 'natural femininity'. Similar tensions regarding other contemporary ideas of natural femininity are considered from different angles in the following chapters.

Reflections on Pregnancy and Motherhood

Pregnancy Anxiety

I arrived at Rachel's flat in the centre of town early one evening and was keen to catch up on events, as the last time we had met it had ended on a contraceptive cliff-hanger. Rachel is a tall, blonde, immaculately dressed woman in her early thirties. She lives alone in a fashionable area in a flat she bought when she moved to London to join a legal publishing house after several years in New York. When we first met, over tea on the terrace, she described how she had taken Femodene, a COC, continuously for thirteen years in order to control her extreme mood swings, to manage her periods to suit her demanding work schedule and to prevent pregnancy during the times when she was sexually active. Due to recent weight gain, apparently the result of her long working hours, her GP changed her pill to Cerazette, a POP. While on Cerazette she experienced volatile mood swings, physically assaulted her then boyfriend and verbally abused her doctor. She stopped taking the suspect pill and resolved to lose the necessary weight so as to return to taking her preferred Femodene. When we first met she also proudly told me how she had never had sex while off the pill or without advance knowledge of her partner's sexual history (see the next chapter). She compared her virtuous behaviour with the 'reckless' antics of her friends who often had to resort to emergency contraception and pregnancy tests.

On this occasion, she rushed me in to tell me her news. She recounted how, because she was no longer on the pill and did not have condoms around, she had had unprotected sex with her ex-boyfriend, how she had been wracked with pregnancy anxiety and had spent a frenzied morning hunting for the morning-after pill. Even after taking the morning-after pill she was still consumed with worry about being single and pregnant. She minutely detailed how she had contemplated whether she would have an abortion, how to do so, whether she would tell her ex-boyfriend, which friends could help, whether she could raise a child alone, what would happen to her career and what her friends, family and colleagues would think. As noted, the corrective measure of the morning-after pill had not quelled her distress as she anxiously awaited her period. Days

before it was due, when she could not stand the agonising wait any more, she took her first pregnancy test, which was negative. Even so she felt no relief until she started the early menstrual spotting. Rachel eagerly wants children in the future but the threat of this unplanned pregnancy had upset and disturbed her to a remarkable degree.

Rachel's story illustrates how pregnancy tests can be poignantly recollected liminal moments marking the divide between the two possible embodied states, of pregnant and not pregnant. Rachel's contemplations indicate that there are several possible reproductive futures. Pregnancy tests clarify and resolve this indeterminacy concerning women's physiological and, more importantly to them, social status but they also underscore the radical difference between one state and the other. The women I spoke to recounted how during the period of time between unprotected sex and the test they were fraught with uncertainty about themselves and their desired futures. In fact, many of the pregnancy tests appeared unwarranted as the women involved had been on the pill and had sometimes even also used condoms. They were also aware of the availability of free, legal and safe medical and surgical abortions.⁸⁴ Even so, an episode of unprotected sex was enough to trigger palpable anxiety. The threat of an unintentional pregnancy, for many, prompted immediate remedial responses involving post-coital contraception, popularly known as the 'morning-after pill'.⁸⁵ Pregnancy anxieties were, for many women, indicative of a profound ambivalence about pregnancy and revealed the implications of different possible reproductive futures.

Often it was the experience of pregnancy anxiety, pregnancy tests and taking the morning-after pill that prompted women to start on the pill. For example, Sita, a 24-year-old law student, started taking the pill after having resorted to taking the morning-after pill. Her recollections of this experience identify the source of her anxiety. She recalled: 'It was strange to deal with something that could have a large potential by just taking a pill like that. It seems, I don't know, I suppose it is equivalent to taking the pill,

⁸⁴ The British Pregnancy Advisory Service (bpas), Marie Stopes and Abortion Rights have commented that abortion services in the United Kingdom remain limited due to severe delays in obtaining a termination of pregnancy within the legal timeframe, while in Northern Ireland abortion remains effectively illegal. There are currently some pilot initiatives aiming to improve access by providing home-based medical abortions.

⁸⁵ The morning-after pill, Levonelle, is a form of post-coital contraception that can be used up to seventy-two hours after sexual intercourse. The sooner after intercourse it is taken, the more effective it is. It is 95 percent effective if taken within 24 hours and 58 percent effective if taken between 49 and 72 hours. Levonelle is now available from GPs, contraceptives services and pharmacists. If the seventy-two hour 'window' provided by the morning-after pill is missed, an emergency copper-T intrauterine device (IUD) can be inserted up to 5 days after intercourse to prevent pregnancy.

but it just seems different at the time... It is strange how normal it can feel, I almost feel guilty for not feeling more panicky about it all, making it a bigger thing'. Sita thought a potential pregnancy would be accompanied by a greater sense of awe and panic and suggests that a pregnancy is indeed seen as a 'big deal' with large potential that was incommensurate with simply popping a pill. Yet, in practice it really was that simple.

The significance of a potential pregnancy and proliferation of possible alternative reproductive trajectories led several pre-parturient women to adopt a 'belt and braces' approach to contraception.⁸⁶ 'Belt and braces' is a colloquial expression denoting situations where two measures of control are used to protect against something, as when both a belt and braces are used to hold up trousers. The women I spoke to who used this expression were referring to using the pill in conjunction with another form of contraception thereby ostensibly leaving nothing to chance. They were aware that the pill was effective at preventing pregnancy but supplemented its use with condoms or the morning-after pill. Isabella, for example, told me that she was 'so terrified of getting pregnant that I was using two forms of contraception'.

Teresa and Karen, both London-based professional single women in their early forties, who had been on the pill continuously for over twenty years, always used two forms of contraception. They primarily took contraception to prevent pregnancy rather than to prevent sexually transmitted infections. Teresa said: 'I really, really don't want to get pregnant and I use a condom or something for safety reasons but my own personal back-up is knowing that I'm on the pill'. Karen echoed this: 'To be honest with you, if I could have covered myself in a body condom, I probably would of [*sic*], to stop myself getting pregnant'. Karen wanted to shroud her entire body against the potential of pregnancy. The use of two effective contraceptives to prevent pregnancy – since I am not convinced that their use of condoms was specifically to reduce exposure to sexual transmitted infections – indicates how seriously they took the possibility of becoming pregnant. More often than not, they kept their pill use as a secret 'personal reassurance' until they trusted their sexual partner (see next chapter).

The extensive discussions about pregnancy anxiety that these women shared with me demonstrate how they were actively concerned about getting pregnant, even when

⁸⁶ They also referred to this practice as 'dual protection'. This contrasts with the usage of 'dual protection' amongst health professionals where this phrase refers to the use of condoms to simultaneously protect against pregnancy and the transmission of sexually transmitted infections.

taking the pill. The significance of pregnancy and unplanned reproductive trajectories drove many of the women I spoke to into a heightened state of anxiety and deliberate pre-emptive or remedial action was considered the responsible response.

*Unwanted Pregnancies and Abortions*⁸⁷

The feared consequences of pregnancy became evident when their anxieties materialised, when they became pregnant and decided to terminate the pregnancy. These often secret stories about abortion were poignantly recollected events within the contraceptive histories I collected. I met Louise, a bubbly 35-year-old business manager, who was reluctant to participate in the study yet eventually arranged a meeting because, like many respondents, she had a story to tell. Over a glass of wine in a local pub, she told me she not only resented having to see a practitioner to get the pill (see the last chapter), but she also recounted how she had found herself pregnant at the age of sixteen because she and her boyfriend had not used contraception because they were 'too shy'. She told me that her abortion was a 'crisis situation when you are running on whatever, but not plan-my-future scenario, which I imagine, is the sensible thing to do'. She recalls being naïve and 'not feeling very sensible because I am only sixteen and the process I have to follow through, this feels very grown up, feels very suited to someone who is much more in control of their own body, decisions, emotions, et cetera and that is not how I was at sixteen'. Louise saw pregnancy as (ideally) a planned event that was part of a 'plan-for-the-future' scenario and associated with being sensible and in control, or in other words, grown up. An unplanned 'crisis' pregnancy fell outside her planned future trajectory. Louise has kept the abortion a secret from her friends, family and doctors but it has coloured her subsequent contraceptive practice. Soon after her abortion she went on the pill, which she has now taken continuously for 18 years, and, as we saw, she actively edits her clinical history in order to ensure continuous access to it.

The reasons why Louise chose to terminate her pregnancy continue to inform her reasoning for not wanting children and taking the pill. She does not want a child now

⁸⁷ There is an ongoing debate about the terms of 'unplanned', 'unintended' and 'unwanted' pregnancies. The definition of these terms was developed and applied by demographers and policy-makers based on post-pregnancy measures. The terms do not, however, capture the fluidity of pregnancy decisions. In addition, several studies have shown that the emic use of these terms varies in policy and academic applications, a fact that has led to empirical distortions (see Barrett and Welling 2002; Fischer 1999; FPA 1999 Santelli et al. 2003; Luker 1999).

because 'the time, the commitment, the money and the effort that have to go into having a child, it is all very practical and I do understand that, it's not the way I want to lead my life. Honestly I am selfish and justifiably so. I earn my cash and I spend my cash and my time is my own. Now I spend my time with Alan [her boyfriend] and with my friends and family as I chose to. I don't have anybody I have to put before myself unless I chose to'. She thought she was too 'selfish' to put someone else, like a child, first because she wanted to choose how she spent her time and money. She sees having a child as a 'practical' matter that requires money and effort. She also refers to a change of attitude that should accompany childrearing: 'You would want that person to be first. I don't think unless you are prepared to do that in advance, in my mind, in advance of having a child then it's not really a sensible option really'. In her assessment, having a child requires being practical as well as a change in the mother-to-be's focus and lifestyle. For her, being selfish is not negative but simply enjoying a lifestyle she has earned. She is waiting for her attitude to alter as she ages but, so far, it has not.

Maria, a 38-year-old advisor at a national charity who migrated to London from Italy fifteen years ago, nervously told me about how she became unintentionally pregnant at twenty-seven, when she was part-way through a Masters degree and working. She had come off the pill to mark the end of a long-term relationship, but then had unprotected sex with her ex-boyfriend. Maria explained how she had terminated the pregnancy because she was in an unstable situation and did not feel ready for the responsibility of being a parent, even though she wanted to be a mother and have children:

I never really felt, there have been times when I look at children, I suppose there is something there and you think how sweet, it makes you feel weird inside. I know that my circumstances have always been sort of irregular. There has not been that much stability in my life so certainly it would be a very difficult thing to take on and it's a major responsibility to take care of someone else to that extent. Shame, I guess, because it is such an experience but then you cannot do things because you cannot just try them, just to see what they are like, it is a major commitment. I suppose I was never in a relationship and thought 'yes this is the right time and this is the right relationship to be in to start a family'. Well, I didn't think it would be wise to remain with this same person, it wouldn't work out and adding children onto that would be a disaster for me, for them, for everybody. That is reason I had the termination that time, it wasn't possible.

Maria expressed how she realised that having a child was 'such an experience' but also 'difficult to take on' and a major commitment. She emphasises the importance of

practical considerations and being sensible and responsible. Irregularity and instability were not conducive to the responsibility of caring for someone else. Though Maria wanted children, pregnancy and motherhood were not a viable option because it was not 'the right time', practically speaking. She then explained how she felt that coming off the pill had put her at the 'mercy of fate' and, like Louise, has been on the pill ever since. She told me that 'if I don't take it, once again I will be at the mercy of fate. I would be at the mercy of fate and I couldn't possibly put myself in that situation again though I have before unwisely'. By using the pill, Maria felt she could control the impractical 'fate' of pregnancy and be sensible and responsible. Though she framed her comments within an overall sense of a 'weird feeling inside', a feeling she could not control when she saw a child. Like the previous respondent, Maria thought that maternal longings would come before the existence of an actual child, implying a natural trajectory, in which she would feel overwhelmed by maternal love before moving from one stage of life and into the parenting stage.

Emily's and Heidi's unintended pregnancies and subsequent abortions occurred while they were using the pill. In spite of their pre-emptive measures they both became pregnant. Emily, a 35-year-old manager and single mother of one, found herself unintentionally pregnant at twenty-seven, part-way through an undergraduate degree that she had moved to London to undertake; she decided to continue the pregnancy. Twelve months later while she was on the pill and breast-feeding she became unintentionally pregnant again but this time opted to terminate:

I ended up terminating. There was absolutely no way with the way my life as it was. I was working my sabbatical with very little money coming in. It was only a year, I only had another a year of contract and it couldn't be renewed after that. I could not really face the idea of John [father of first and second pregnancy] in my life any more than he had to be. That was way more, the whole concept of me going through that all by myself and him being around and having to negotiate... I wasn't in any fit state, so I ended up terminating.

Emily terminated the pregnancy because she did not feel the conditions were appropriate for having another child: she had recently split from her partner, had a low-paying job, no employment security and a young child to support. Emily does want more children but feels that her current material and relational circumstances prevent her from being in a "fit state" to care properly for them.

Heidi, a 24-year-old administrator, became unintentionally pregnant with her new boyfriend while on the pill at the age of twenty-two when she was starting her undergraduate degree in London. Heidi thought having a child is 'ultimately what we are here for' but that this depends on the right conditions and timing: 'once my career is in line and I have got the house and the dog, maybe, I suppose, the next thing is having children'. Heidi's reflections on her abortion reveal an attempt to balance her desire for a child with her wanting to create the most appropriate circumstances for doing this: 'I've just got to keep thinking what is right at the time was right... So, you know, it was justified as such but I am just going to keep reflecting on that, you know, at the time there was no options'. Similar to other accounts of unintended pregnancies, Heidi only wants a child in the right conditions and is, therefore, vigilant with her contraception: 'I use the pill and most times I use condoms as well because it just scares me... What if I fall pregnant again? I don't think I could go through another abortion, but I am definitely not ready to have children. It scares me even more so now, especially as I was so careful in the first place'. Heidi was so concerned about timing that, during my fieldwork, she switched from the pill to the contraceptive injection, thereby completely reducing her control and responsibility for any error.

Abortion is more than an expression of pregnancy anxiety but the tangible realisation of an unanticipated reproductive trajectory. In these narratives, pill use is framed as a consequence of a fear of getting pregnant. Implicit in all these accounts of unintended pregnancies and abortions is the idea that pregnancy is desirable and inevitable but also life changing and therefore should occur under the 'right' conditions. Faye Ginsburg and Heather Paxson's ethnographies of motherhood illustrate how the decision to have an abortion can be seen as a responsible, 'mature' choice to prevent suffering for a potential child and hence relate to rational fertility choices. The concerns that led to pregnancy anxieties and the termination of unintended pregnancies point to the reasons why women in this study wanted to use the pill: rather than simply to prevent pregnancy, the decision to take the pill is the effect of *planning* their future pregnancies.

Planning Pregnancy

Early in their contraceptive narratives many women told me they took the pill so as not to get pregnant at the present time and to sensibly plan having children. These plans include the practical considerations of parenting and its timing within a larger

anticipated life-course. This may be particular to the women who attend the Pyke as other studies of pregnancy intentionality suggest a range of attitudes to planning pregnancy amongst different socio-economic groups.⁸⁸

Kristen, a single 34-year-old civil servant at the Home Office, told me, 'I kind of feel that you should have money to have lots of kids, in a certain way, just give them what they deserve. I do think that when you have a child, that child is the utmost, should be to both parents, or if mum does want the child, everything the child needs should be paramount and come first'. Kristen explained how getting the material conditions right was part of properly caring for a child and that having a child required putting them and their needs first. Isabella, who was starting a new job and had a long-term partner, shared these concerns. She told me that she did not 'feel financially ready, like you would need to be to be a suitable mother, but then mentally as well because you go to university and then you spend maybe twelve months in a proper job and then you start getting some sort of graduate traineeship and it is almost like you feel very young for a very long time when really you are not, you're not too young to have a kid, but your circumstances make it inappropriate. I am living close to a city centre, sharing a house with other people, still paying off student loans. So even if you feel ready physically and mentally, financially, you don't feel ready, but that is starting to balance out now'. Practical and financial concerns were a critical part of timing pregnancy as they were seen as necessary in order to mother 'suitably'.

Many of the women I spoke to saw themselves as in the process of establishing their careers and therefore unable to be a mother. Nancy, who recently qualified as a medical doctor, explained that she could not have a child now because 'at the moment I am still at university. Having children would mean I would have to stop university and that would affect my career and I just want to move up the career ladder a bit before I start having children and be a bit more stable in my life'. Having a child at the wrong time in her career would undermine her past efforts and future plans. Francis, a homeowner

⁸⁸ An FPA (1999) study found that women from different socio-economic groups had different attitudes to motherhood and to children. The first group was the 'natural mothers' in which pregnancy was an accepted part of life, not subject to choice and of unquestioned status. For 'natural mothers' there is a sense of the natural inevitability of pregnancy and the logical progression to motherhood and these occurred independent of career goals or long-term relationships. Natural mothers were contrasted with 'lifestyle mothers'. 'Lifestyle mothers' were characterised by their prioritising of other life events and plans, such as qualifications, employment progression, marriage and house-buying, over pregnancy. Pregnancy and motherhood were an integrated part of these plans when they happened at a set time while unintended pregnancies jeopardised these plans.

with a long-term partner, does not want to have a child now because she is trying to establish her career, which requires her to work unpredictable and long hours. She told me that if she had a child: 'I would have to change my career, the way I see, I need a good couple of years to get into something so I wasn't trying to fit around it. I would want to find a job that is, I suppose more nine to five, more flexible or part-time whatever'. She explained that she was trying to 'get higher up the scale' and 'it's not that a baby would be awful but it doesn't fit into my grand scheme of things right now'. The desire and demands of establishing a career, such as limited ability to negotiate contracts and unpredictable and intensive working hours, do not fit with the expected demands of raising a child.

A long-term, secure and committed relationship, whether involving marriage or cohabitation, was another determining variable in planning pregnancy. Kate had achieved her professional and financial aspirations but lacked a long-term partner and told me she did not have a child because she had not 'met the right person up till now'. For Kate, having the 'right' partner was part of being a good parent. This desire for a long-term relationship can also be seen as partly pragmatic as it was assumed that it would be difficult to achieve the necessary material conditions for good parenting alone. Yet for some women, the presence of a long-term partner changed their attitude to having a child even when they had not realised the 'right' conditions. Elizabeth told me: 'Everyone thinks they would like to have a baby, especially when you are in a long-term relationship, married or out of it, with a loving partner'.

For these women the 'right' professional, financial and relationship conditions form part of an expected life-course that include, but precede, having a child. Elizabeth's description of her ideal life plan best illustrates the ideal life-course shared by the women I spoke to:

When you are a kid you always have life plans and you think I am going to have a job, a house, get married by this age. I am twenty-six now, I like to think that I would be married by the time I am thirty, settled down. I am a bit practical; I would need to have a house, a secure job, before I was responsible enough. Bringing a child into the world is a huge responsibility so I would need to know that I am set up enough to cope with that and look after them ... everything was in place and the next thing right is to have a child.

Having a child is part of a clear sequence of events that establish the 'right' conditions for responsible parenting. A job, a house and marriage are the practical 'set up' necessary to properly care and cope with a child. This account parallels what Sarah Franklin defined as the expected life-course amongst IVF users: 'an assumed worldview, an assumed trajectory of the lifecycle, an assumed sequence of events' (Franklin 1997: 131). Similarly Linda Layne (2003: 66) ethnographic study of miscarriage found that in this life course, having a child and motherhood were part of women's 'cherished narratives of linear progress'. Both Franklin (1997) and Layne (2003) ethnographically demonstrate the connection between individual personal life course and cultural ideas of shared trajectories and linear progress and the desired location of pregnancy in them.

Sita explained to me how an unintended pregnancy is experienced as a disruption to the linear sequence of the expected life-course: 'As far I am concerned I feel too young for that in terms of what I have planned. Unintentionally I have the next three years planned out in terms of what type of schooling I want to do, in terms of career and I think I am very selfish in that respect... I was probably always brought up to think, get on with your career, do what you want first and then think about all that stuff'. She conveys a clear order of events that had to happen first, which she thought of as 'selfish' as they focused on her. Fiona, a 28-year-old circus performer, told me she is 'excited by the possibilities I can achieve, you know, and having a child would limit that even though I have a partner I am pretty much convinced we will have children'. She plans to be a mother but having an unplanned pregnancy would limit *her* possibilities because it would change her focus and plans, even though pregnancy is part of them.

Pregnancy was part of the anticipated sequence of a larger life plan for these women I spoke to but an unintended pregnancy would lead to a different reproductive trajectory. Getting pregnant at university would have been a 'disaster' for Mary because it was 'not the right time' and she thought that this would be unfair to the child. But, after having bought a house with her long-term partner and moved to the civil service, which has a better maternity leave package, she thought she was 'nearing the family planning time' and she told me, 'we are getting married at the end of this year. I don't really want it [a child], it might happen this time next year, not that the time is right. It is not planned for another three or four years but something might happen. He has a very, very good job at the moment and if that job becomes permanent, or he gets one at a similar level we would be silly not to start'. The assumed sequence of planned events (secure income

and careers) had been followed and she now felt it was time for the next step. With this progress, precise timing had become less important to her.

On the whole, these women wanted and assumed that they would have children, yet they felt that this should occur at the right time and in the 'right' relationship. Ideally, this would be once they had completed a specific sequenced plan of achievement in higher education, professional progression, secure employment and established a long-term relationship. There are practical issues associated with desired life-courses such as increased professional stability achieved through permanent contracts that ensure decent maternity leave packages, the possibility of flexible working and the stability of a long-term relationship or marriage. These steps were seen to provide the financial stability and emotional security necessary to being a committed and responsible mother. The women I spoke to therefore used the pill to precisely delay their assumed fertility until the time when conditions would be 'right'. Therefore, taking the pill allowed them to secure their desired reproductive trajectory.

Becoming a Mother

The women who were mothers (whom, as noted in Chapter Two, I recruited after realising the respondents engaged through the clinic were all pre-parturient) explained to me how the realisation of particular practical conditions was crucial in their decision to stop taking the pill in order to actively try and conceive. For the new mothers, Karen and Bridget, achieving their planned practical conditions was critical in their decisions to stop taking the pill and 'let nature take its course'. Karen, a 40-year-old part-time teacher and mother of two, described how she had always wanted children as we shared a pew at a raucous local playgroup held in a church building. She outlined the events leading up to her decision to stop taking the pill:

My partner and I had always wanted kids for a long time. It just seems silly, I have always said jokingly that twenty-eight to thirty-two was my bracket, I had always said that since I have known him. A lot of circumstances happened, we completed a lot of things that we wanted to do. I know it sounds silly but we ran out of excuses not to have a child. We had a house in Southampton we sold and made money, we always wanted to go travelling and we started to plan this big trip with six months off work. It was linked to jobs. It was also, I said to him theoretically if we are going to have kids one day, I always said I would have them by thirty-two, and so we technically we have to be back in the country by my thirty-second birthday. So we went away six months before my thirty-second

birthday. Within my birthday we came back to the UK and we were renting for six months and we started the process of buying a house, we bought a house in December and the following year in January I got a new job. Then it was like I have done the travelling, I have got the house, I have got the job, so there were no reasons to stop, so why not try?

Karen describes how her and her partner's desire for a child was tempered by the things they 'wanted' and needed to do first. Having a child was part of a planned and timed sequence that acted as 'excuses' not to have a child. As she and her partner achieved their life-plans there were no more reasons to further delay having a child. The idea of 'running out of excuses' suggests a submission to fate or biological imperative. There is a shift before and after childbirth – before having children, certain activities such as travelling, seemed like perfectly reasonable goals for them, but when having had the child, all those previous plans are dismissed as excuses not to have a child, implying that they now realise that having a child was the most important thing that they had simply been putting off. This suggests a shift in priorities, but also a recognition of the social status of parenthood – now they are parents they can no longer entertain the idea that anything could possibly be more important than their child.

Bridget, a 27-year-old paediatrician on six months maternity leave, explained to me whilst breast-feeding her 2-month-old daughter on her sofa why she had actively decided to have a child:

I suppose a mixture of things. For me, work is a major part of my life. I had managed to get a job in the speciality I wanted to be in, paediatrics. I was really enjoying it and I thought, I will stick with the speciality. I was in a job for a year and I was thinking that I could get a job that would cover me for two years because if you are in six-month rotations then it is difficult with a baby and hunting for jobs and changing jobs all the time. I think Sean [her partner] wanted to do it right now, sooner rather than later. I think he has been saying it for about a year, two years now. He is going to be thirty this year and he has finished all the exams that he needs to do. He has been in the same job for the last five years, he is more settled than I was. He just thought about the next stage.

Bridget revealed that she longed for a child but this had to be managed alongside her desire to have a specialised career as well as the desires of her partner and his timings. Only when she felt she had achieved the desired conditions, could she move to the 'next stage' and stop using contraception to actively get pregnant and initiate her planned reproductive future.

Just as pre-parturient women had chosen to abort and to plan their pregnancies through taking the pill plus other ‘back-up’ contraceptive measures, those women who had had children that I spoke to had planned their pregnancies in line with the assumption that pregnancy should occur as the culmination of a series of timed events to create the right conditions in which to raise a child. In these different reflections, the women I spoke to described pregnancy as a desirable, life-changing event that entailed a shift from a focus on themselves to others. Their thoughts about pregnancy were impossible to separate from ideas about motherhood and mothering. This life change required the ‘right’ conditions to be ‘set up’ in a particular sequence in order that they could be ‘suitable’ mothers. For them pregnancy is closely associated with timing the necessary conditions for a desired reproductive future and the pill is integrated into its realisation. The pill can be seen as instrumental in these women’s imagined reproductive trajectories; they imagine several possible avenues and the pill is used to determine which one to follow.

The Pill and Planning Motherhood

In these accounts, pregnancy, both intended and unintended, was a social, emotional, financial and physical event pivotal to the concerns and actions of the women in this study. For them, the question was not whether or not to get pregnant but rather *when* to undertake this ‘cherished’ event. Rachel captures this perfectly: ‘I suppose it is not the fear of having babies but the fear of having them at the wrong time’. Pregnancy was, for many, an incontrovertible and significant part of their life-course yet it was clear that they felt it should be the intended outcome of deliberate timing and planning. This assumption presupposes the capacity to control one’s reproductive future.

Many women said that they expected pregnancy to radically change their lives. Rachel told me: ‘I think it [having a child] represents a turning point, a life-changing thing’. Getting pregnant and having a child were presented in the contraceptive narratives as a unique, life-altering planned event that caused a profound shift in priorities. These shifts were broadly conceived as a move from selfishly caring for themselves to selflessly caring for a child. Betty, a 29-year-old NHS coordinator and pre-parturient pill user, said, for example, ‘I think it [a child] is probably the biggest responsibility you can have. And at the moment I am not ready. I am getting there but you know, they take over your life, your priorities change and you do not come first anymore. They come first, your children’. Tania said: ‘If you are thinking about having a child then your whole

responsibility is for that child and you should want to bring it up in the best way that you can'. For these women, pregnancy was seen as an incomparable turning point because a child may 'take over' their priorities. This claim that pregnancy was seen to radically change a woman's life and identity as new responsibilities 'take over' and change priorities resonates with Daniel Miller's (1997) study of mothers in north London. Miller argues that for those women pregnancy and motherhood signified a change in previously held expectations and values, negating previous life-projects which were reoriented towards the child, thus signalling a new form of adulthood. The women I spoke to anticipated a similarly radical change and used the pill to postpone it until they thought of themselves as ready to do it the 'best' way.⁸⁹

The idea of pregnancy as a 'turning point' for a woman corresponds with anthropological studies of pregnancy that have shown that it is more than just a physiological state, but is rather a socially, culturally and psychologically significant transformation (see Ginsburg and Rapp 1991; Davis-Floyd 1992; Ginsburg 1989; Jordan 1992; Miller 1997; McCormack 1994; van Gennepe 1960; Homans 1994; Rapp 1999; Martin 1988; Layne 2003; Speier 2004). Pregnancy and child-bearing are archetypal life-crisis events, as defined by van Gennepe (1960), which every culture specially marks and regulates with ritual processes that socially and culturally demarcate the transition between life-stages and identities. These ritual processes are typically characterised by a 'before', a period of training that is 'betwixt and between', and an 'after' which completely transforms the person. These rituals facilitate physical and identity changes that establish a new way of seeing and acting as well as new recognition from others (van Gennepe 1960). Pregnancy and birth are replete with social proscriptions that express the meanings and values of the social and cultural context in which they occur (see Davis-Floyd and Georges 1996; Davis-Floyd 1992; Layne 2003). Though rites of passage are seen to be less ritualised in clinical settings in Great Britain there are a host of dietary and behavioural prohibitions and prescriptions as well as purification and seclusion rites around pregnancy and birth (see McLaren 1984; Homans 1984; Jordan 1992; McCormack 1994). In her study of hospital birth practices in the US, Robbie Davis-Floyd (1992) maintains that despite the shift of birth from the home to the hospital there continues to be a proliferation of rituals that separate women from their former structural identities and facilitate their integration and the adoption of their new maternal identity.

⁸⁹ Interestingly, these women conflated the biological fact of pregnancy with consequent motherhood.

In their accounts, these women spoke about pregnancy as a life-crisis event. For them, getting pregnant, giving birth and becoming a mother represent a social and personal transformation and a new form of adulthood with a new centre of focus and priorities incongruent with their previously held priorities and personal qualities. For them, pregnancy and motherhood confer new statuses, new responsibilities and obligations and new expectations of appropriate conduct. Elizabeth explained how she thought having a child would affect her:

E: Yeah, it [a child] changes your life I mean you are responsible for creating this child. You are responsible for teaching this child, feeding it, nurturing it. It is huge, it is going to take up a lot of your life. Which is a great thing but you need to be prepared that you are going to have to stay in. You will not be able to go out like you used to do. It is a lifestyle change which I think can be good. But you just need to be ready for that.

V: So what does it take to be ready?

E: Quite a lot, your independence for a start. You can't just think, I am going to do this now, you have to take into account that they are there and that their needs should come first. I don't know, the fact that you are not always going to be available, that you are going to have to stay in. Things with relationships as well, it's not just your partner in the relationship. You have to set aside time for someone else, which could be tricky. There are so many things, a completely different type of life.

She conveyed how pregnancy represented a momentous transformation accompanied by a reorientation towards putting the child's needs first. Elizabeth saw this as a 'completely different type of life' from her current pre-parturient life as she would become less independent and more responsible, selfless and altruistic. Yet this new relational type of adulthood required a period of earlier selfishness and independence.

The women I spoke to regularly expressed how their current 'selfishness' prevented them, at that time, from being ready to be a good mother. Beth, a 25-year-old account manager for a large company, considered herself to be too selfish to have a child. She told me: 'I just feel like there is just so much to handle in my own life right now, not selfish, I wouldn't say selfish, but I want to figure out what I want to do with my life before I start telling someone else what to do, you know what I mean'. When Beth states that 'I wouldn't say selfish' she is saying she is not selfish though she is implying she thought she was. Inverting the statement 'I am too selfish to have a child' to 'It is selfless to have a child' reveals how selflessness is perceived as a defining quality of a motherhood. Rachel described her experience of maternal selflessness when she became

involved in the life of her ex-boyfriend and his son (from a previous relationship). She said: 'It [having a child] would absolutely turn my world upside down. And you realise that you actually find that it is hard to find room for yourself in that world, you are all about those two people. For me it was my boyfriend and him [the child], and being there for them'. Here, Rachel refers to the way her world has been reversed, so with a child present there is no room for her and she has to reorient herself towards a relational focus on the needs of others.

The mothers I spoke to, like the pre-parturient women, experienced pregnancy and birth as something life-altering that engendered a new identity characterised by selfless ways of seeing and acting. Tracy, a 34-year-old events organiser and mother of three, explained the difference between life with and without children: 'You can do a lot with children but you can do a lot more without them... I had to put things aside and start thinking differently... Your life changes again, especially the first couple of years, when she was two years old and running around and do whatever but you know you have to change your lifestyle'. Tracy explained how she had to think differently, put her needs aside and centre her life on the child. Karen noted a similar change: 'I suppose we were party people, we were out and about a lot of the time, dinner, pub, out on the weekend. We had a lot of friends we partied with. We try and still do it a bit. But realistically, I have to admit, especially as she gets a bit older and she needs more routine, I have to stop kidding myself that we can have quite the life we used to. Putting her [the child] stuff first'. Her attitude to life transformed by placing her child at the centre of her priorities. Alongside those personal transformations, many mothers experienced a change in their social worlds. As a consequence of becoming mothers, many women with children described how they restructured their social activities around child-focused activities. When I interviewed women with children at a baby and toddler group run by a local church, they praised it as a space where they could share the physical and social changes they were undergoing with similarly positioned women.⁹⁰

The selflessness associated with motherhood and mothering equate with the cultural image of a mother as someone selfless, nurturing and altruistic (see Ginsburg 1989; Ragoné 1994; Paxson 2004; Cannell 1990). Sharon Hays (1996: 9) described this as an

⁹⁰ These are spaces where women with small children bond and socialise to become part of the 'culture of shared pregnancy' and to cope with their new identity, roles and social world, characteristic of rites of passage (also see Davis-Floyd 1992; Miller 1997).

'ideology of intensive motherhood',⁹¹ premised on the idea that the biological mother is assigned complete responsibility for mothering, places the child before all other commitments at all times and represses her agency and autonomy in favour of the child (also see O'Reilly 2004; Paxson 2004; Nakano et al. 1994). Yet, as discussed earlier, there were preconditions seen as necessary to mothering 'intensively'. In the earlier accounts of planning for pregnancy, obtaining the financial stability of secure employment and sufficient income were both pragmatic considerations for raising a child. Though having a child is 'priceless' (Zelizer 1981), the process is still expensive and provides little economic return.⁹² The fifth annual 'Cost of a Child' survey, published in 2007, estimated that raising a child from birth to the age of twenty-one in the UK costs parents £186,000.⁹³ I repeatedly heard statements about the necessity of financial security, both in terms of level of income and secure employment with an adequate maternity package, from those I interviewed, which suggests that financial concerns are decisive in planning pregnancies and are, for these women, integral to being a good mother.

These statements correspond with Heather Paxson's (2004) study of mothers in urban Greece who incorporated money and the consumption of goods within the demonstration of maternal love in modern capitalist society. Paxson argues that consumerism has changed how maternal love is expressed as women are expected to buy the 'necessary' commodities to be a good mother and produce successful 'high-quality' children. For contemporary Western mothers the questions are, as Janelle Taylor points out, 'What must I (and what can I) do and have and buy in order to properly love, value, educate and nurture, provide for – in a word, mother – my child(ren)?' (2004:12). This situation recasts maternal love as the provision of the best material goods for one's children so that motherhood requires a pre-existing secure and stable income. The centrality of money and goods to mothering suggests that secure employment and income are prerequisites for having children and mothering because these ensure the necessary provision of material goods, a view that is confirmed by my

⁹¹ O'Reilly (2004) outlines the characteristics of motherhood in the following way: a child can only be properly cared for by their biological mother who must provide constantly, put the child's needs first, lavish excessive amounts of time, energy and money on child-rearing and be fully satisfied, completed and composed in motherhood. Hays (1996) outlines similar qualities that emphasise how the mother is the central and best care-giver who must spend copious amounts of time, energy and finances on raising a child, whose needs come first.

⁹² Zelizer (1981: 3) explains that children are priceless but 'economically worthless' - an expensive economic investment with no return.

⁹³ Taken from *Annual Cost of a Child Survey* (2007) http://www.lv.com/media_centre/press_releases/cost accessed on July 11 2008.

research. Work, money and financial considerations are a constitutive part of being a good mother and, as Taylor (2004) contends, motherhood is shaped and enabled by consumerism as mothers purchase goods to meet their children's basic needs and balance employment with childcare.

Paxson argues that these 'material expressions of maternal love' incorporate new consumer practices into 'traditional' social relations: 'Consumerism materialises and exteriorises the self-sacrifice of motherhood. And maternal love is as calculating as it is passionate and moral' (2004: 129). These financial characteristics of contemporary mothering challenge the ideological opposition between the public sphere of market and the private realm of the family in which 'motherhood offers a powerful model of human relationships that stands in opposition to the logic of the marketplace' (for similar discussions see Taylor 2004: 3; see also Cannell 1990; Ginsburg 1989; Ragoné 1994; Zelizer 1981). Rather, material expressions of 'maternal love' illustrate that affective relationships require financial resources. Engagement with money is, therefore, necessary in order to properly love and parent a child. The responses from the women I spoke to are characteristic of the material practices of maternal love typical in modern capitalist society but also imply that acts of pre-parturient 'selfishness' are a prerequisite for building the necessary financial bases for the future display of selfless 'material expressions' of 'intensive' selfless maternal love.

The desired conditions for pregnancy were not only financial but also affective. As described earlier, the women I spoke to did not want to have a child outside of a stable and loving relationship. Indeed, a stable relationship overrode all the other practical conditions whereas other social relationships with friends and family had a lesser influence on when to have a child. Studies of pregnancy intentionality have also shown the importance intimate relationships with their partners have in determining women's attitudes towards pregnancy. Wellings and Barrett's analysis (2002) and the FPA's (1999) study of pregnancy intentionality show that attitudes toward pregnancies, whether they were wanted or not, are often closely linked to the pregnant woman's partner's attitude towards a pregnancy. A pregnancy could shift from being unintended to being wanted if a partner's commitment is confirmed, or might change from unintended and wanted to unwanted if the reverse is the case. In the contraceptive narratives I elicited, many pregnancy anxieties arose in contexts where women were unsure of their relationships with their partners; many of the terminated pregnancies

occurred at the start or end of a relationship. This suggests another way in which women's attitudes to pregnancy are relationally defined, not only to the potential child but also to their sexual partner/the child's father.

In addition to these financial and relational conditions, the women I spoke to planned to be physically prepared for pregnancy; this formed part of being a good mother in terms of providing the 'best start' *in utero*. Many women described how they planned to prepare their bodies prior to pregnancy, purging themselves of artificial additives and toxins, such as alcohol and cigarettes, to improve the child's development. Through their plans to physically prepare themselves they begin to demonstrate maternal self-sacrifice by returning their bodies to their 'natural' state before trying to conceive. Physically preparing the body is, then, for many women, part of planning a pregnancy. Tina and Tania are both current pill users who plan to have children in the distant future and they detailed how they would prepare their bodies prior to pregnancy. Tania plans to 'purify' herself because she wants 'to make everything as perfect it as it could be so I could have healthy baby and have a healthy lifestyle as well'. Tina told me that she plans 'to stop smoking again. Do it proper, as always to get fit and healthy, start taking my Well-Woman tablets, which you don't need and obviously you don't need because people get pregnant without all that stuff. But try to spend six months preparing myself still with using contraception'. Tina planned to use the pill to 'ready' her body for a child as part of 'doing it properly' and to demonstrate her maternal love. The logic of taking the pill to postpone pregnancy in order to ready oneself and to make things ideal for becoming a good mother parallels the achievement of the 'right' financial and relational conditions.

The expectation of future pregnancy and motherhood were not questioned as their were part of the 'cherished' narrative of linear progress, however, there was a clearly articulated concern amongst these women with timing a pregnancy within the 'right' sequence of financial, physical and relational conditions. Selfless and altruistic mothering, though desired and expected, should coincide with the most appropriate practical circumstances to enable it. Therefore, the pill was not used to indefinitely prevent pregnancy but to postpone it until the appropriate time. This focus on conditions suggests that planning pregnancy was not so much about the desire, or not, for a child but rather a woman's perceived ability to appropriately care for a child, i.e. they did not question whether to become pregnant, but only controlled for it – they assume that all

women desire to have a child and that, whether or not they desire it, it will happen to them anyway. The women I spoke to used the pill to postpone and plan this radical transformation until they thought of themselves as ready to be responsible, selfless and altruistic mothers. In other words, the pill was part of the planning and timing of 'good' motherhood. The postponement of pregnancy and pre-parturient selfishness were both seen as necessary to attain the conditions to mother selflessly and responsibly. Thus the selfish act of postponing pregnancy is, in fact, a selfless act of maternal love. Such planning can be seen as an extension of earlier strategies for having families, including the postponement of age at marriage which was historically the main means of ensuring children were born into the right circumstances in English society.⁹⁴

The pill can, therefore, be seen as an integrated part of contemporary ideas of pregnancy and motherhood because it enables the postponement of pregnancy and hence a demonstration of future maternal love. A closer examination of contraceptive practices indicates that the pill is ideologically incorporated into the practices of mothering and motherhood. These practices can be seen as 'rational', as various practical factors are taken into consideration when timing and planning pregnancy, but they are also informed by the conventions of motherhood. This suggests that contraceptive practices are not autonomous and self interested, but rather, relationally defined in regards to a potential child, sexual partners and the wider social institution of motherhood.

The 'Nature' of Achieved Motherhood

Concerns about timing and planning were used alongside references to 'nature' in the conversations about pregnancy and motherhood I had with respondents. Nature was used to express the idea that pregnancy and motherhood are seen as an expected and almost inevitable part of the life-course for a woman (see also Layne 2003; Franklin 1997; Becker 2000; Thompson 2005). This assumed inevitability was communicated in the commonly-held notion amongst these women that they would get pregnant if they did not use contraception. 'Nature's course' was a commonly used euphemism to describe pregnancy as the destiny of the unmedicated female body. For instance, Kate

⁹⁴ The current trend towards the postponement of childbirth is part of a longer historical trajectory towards delaying parenthood. In early modern England couples delayed marriage as they could not inherit a household or accumulate enough resources to establish a home and consequently also delayed child-bearing (see Schofield and Wrigley 1989; MacFarlane 1986). In that era and the contemporary context couples postpone parenthood, not always willingly. Thus the hope of having children, while a 'natural

told me after having unprotected sex with a partner that she was just 'going to let nature take its course and see what happens'; in other words she was not going to intervene. Similarly, other women told me that when they wanted a child and consequently stopped taking the pill, they would be just 'letting nature do its thing' and 'relaxing and letting nature take its course'.

These women are expressing what Sarah Franklin (1997:134) termed an 'automatic natural assumption' of pregnancy and motherhood as elements of a shared sense of 'normal' and 'natural' anticipated progression for women's lives. In her study of couples using IVF to conceive, Franklin found that: 'The desire to have children, or to have more than one child, is thus a desire which expresses in part the need to feel one is progressing along a chosen, expected, or even biologically determined path' (1997: 133). A similar 'natural assumption' was communicated during my research. Heidi told me that having a child is 'ultimately what we are here for' and 'is part of what comes naturally'. She assumed pregnancy was both the 'natural' role and destiny of women and that, through pregnancy, a woman achieves her natural capacity and function.

The 'natural assumption' implicit in the idea of 'nature's course' was also expressed when women I spoke to talked about the desire for a child, which increased with age, up to a certain point. Though many respondents did not want children at the present time, they tended to imagine that this could 'change at any time'. Beth told me that having a child 'is one of those things where I can't imagine it at the moment but I think inevitably I will consider it, but right now I am not even thinking about it'. She feels that she does not even have to think about wanting children as it will inevitably happen. She expanded: 'I am assuming one day it will come up that I will want a child, but it has not. As a child, I assumed I would have children but that is only because people assume they are going to have children ... So I have a feeling that it will happen naturally, I am assuming that instinct will happen'. Beth expresses a 'natural assumption' of her expected desire for children and she uses nature to refer to what she thinks is normal. She describes an emotional impulse to have a child that will inevitably occur without thought as she thinks the desire to have a child is inevitable so she does not even have to think about it, though in fact she does.

destiny', is constrained by social and economic forces. Yet contemporary practices differ from the past because previous postponement required delaying sex, which was not the case for the women I spoke to.

This 'inevitable' desire for a child was factored into these women's appropriate planning of pregnancies. The women I spoke to all explained how the desire for a child was closely tied to age and a corresponding sense of ever-decreasing fertility over time. Kate, 34 years old, who has an established career but no long-term partner, stated that, 'It has just been in the last two to three years, it has been in the front of mind for me and it hadn't been up until that point, until I hit big 3-0'. She feels that she will not 'leave it too late, the clock is ticking, whatever, it is in the back of my mind, but I don't want it to become the be-all and end-all, you know. So I don't want to get too hung up about it... I suppose I would like to in the next couple of years, I suppose I don't want to leave it 'til I am forty. I know people do, but you're lessening your chances every year and I don't really want to be so old I can't pick them up, as that great expression goes'. She uses a common metaphor of a 'ticking clock' that suggests the idea of time passing and there is a dwindling countdown as her chances lessen. For Kate the desire for children has only occurred recently and she is worried about the consequences of continuing to postpone pregnancy.

Moreover, there was an ideal age associated with when to plan the 'natural destiny' of pregnancy. Tania, a 24-year-old personal assistant at a large multinational management consultancy firm, plans to have a child and knows roughly when she wants one: 'About thirty-two I reckon, it's going up slightly, because I always thought I would be married by thirty. I am going to be twenty-five next month but I haven't got a boyfriend. After thirty, but before thirty-five, would be the perfect time'. Mary, 27 years old, had similar timing: 'Late twenties, early thirties which is about right and it's at the end of the right bit, the right bit is two years ago. It does concern me but it doesn't concern me enough to worry because I know I am starting earlier enough'. Beatrice, 32 years old, told me: 'I think if I was really honest with myself there is the amber light of thirty-five and, you know, if it hasn't been properly discussed or time scales introduced by thirty-five I would be hysterical ... I don't want to be an old mum'. Thirty to thirty-five was generally considered the ideal age bracket to become pregnant as there was enough time to achieve the conditions and after this time it was thought of as increasingly difficult to conceive. Beyond this point there was increased 'concern', 'amber lights' and 'hysteria'. Several women who were over thirty-five thought it was 'too late' and that they 'had left it too long'. Age, then, was an explicit factor in their planning of pregnancy and motherhood.

When referring to nature and biology these women invoke an idea of the inevitability of pregnancy and motherhood. Pregnancy and motherhood are a convention, the 'automatic natural assumption', that is part of their ideas of an inevitable imagined future as elements of a shared sense of anticipated 'normal' progression for women. Yet this 'natural assumption' could occur at different points and lead to different trajectories. They, therefore, felt a need to intervene and manage their bodies in order to embody a specific reproductive linearity. The use of technical interventions to attain an imagined reproductive trajectory suggests that this planning is not 'natural' but rather part of a normative gendered script of 'natural femininity'.

This imagined trajectory is both gendered and naturalised through biology, a natural ideology. The women in this study repeatedly talked about how women's unique reproductive biology made them responsible for planning pregnancy and hence contraception. Mary took responsibility for contraception because if she 'was to get pregnant it is me who bears the brunt of the whole ... well, it would affect me in most major ways if I was to get pregnant. To them [men] it is like a game, okay so what, it does not affect them [men] as much as it affects a woman'. She justified her contraceptive responsibility, as pregnancy would affect her 'in major ways' because she was a woman, and so implicitly defined by her reproductive biology. Louise echoed this sentiment: 'I just think that whatever advances there have been in contraception, that ultimately the responsibility will always lie with the woman because she carries the burden of the conception'. References to female reproductive biology naturalise the responsibility for mothering as well as planning pregnancy within an imagined reproductive trajectory.

The ways that these women talked about using the pill in order to plan pregnancy indicate that pregnancy and motherhood are expected and desired events but also their concerns about ensuring the 'right' practical conditions in which it is possible to be a good mother. For them, 'nature's course' was not sufficient cause to warrant getting pregnant but rather motherhood required at least attempting to create the 'right' circumstances, those that could facilitate their efforts to embody the valued attributes of responsibility, selflessness and altruism. The women I spoke to noted how 'nature's course' did not map neatly onto their expected life-plans. For the women I spoke to, the desire to have a child had to be balanced against particular and necessary educational, professional and relationship plans. Earlier, Elizabeth explained the delicate balance of

having a child: 'I would need to have a house, a secure job, before I was responsible enough. ... I would need to know that I am set up enough to cope with that and look after them... Everything was in place and the next thing right is to have a child'.

Elizabeth took the pill to postpone pregnancy to coincide with the 'right' conditions. She did not use the pill to reject her natural destiny but to actively and appropriately situate this (in terms of time) within what she perceived as the necessary conditions for being a good mother. She used the pill in such a way in order to actively work towards realising her natural destiny as a good mother, which begins with the appropriate timing of pregnancies. In this way, the pill has become an integrated part of planning pregnancy and motherhood as it allowed for her to balance the contradictions of 'nature's course' and the compulsion to plan pregnancy and mothering.

Yet it is the technical capacity to control conception and effectively chose when to be pregnant and to mother enabled by the pill that changes pregnancy and motherhood from an 'inevitable' destiny into an achieved outcome of personal choice, which when realised represents an accomplishment. With control over reproduction come choices and the responsibility for making the best choice about when they are ready to conceive and to demonstrate maternal love. Linda Layne argues that the choice about when and how to be a mother is a 'purposeful morally laden activity' (2003: 147). Faye Ginsburg (1989) and Heather Paxson (2004) also argue that the capacity to responsibly plan pregnancy has recast the meaning of motherhood as an achievement.

The construction of motherhood as an achievement is the effect of separating the biological and social facts of reproduction. Faye Ginsburg (1998) argues that access to legal and safe abortions makes motherhood a deliberate choice and an achievement. Helene Ragoné (1994) illustrates how surrogates and adoptive mothers separate biological and social motherhood and emphasise social motherhood to side-step the problematic biogenetic relationship inherent in surrogacy. Similarly, Franklin (1997) shows how IVF and achieving pregnancy separate the social and biological facts of parenthood. Reproductive technologies, including the pill, disrupt the taken-for-granted natural trajectory of women's lives and having a child becomes, instead, 'an obstacle course' of accomplished decisions and procedures. As discussed in the Introduction, reproductive technologies have fragmented the naturalised cultural arrangement of sexual intercourse, reproduction and gender. Making explicit the social construction of taken-for-granted and inevitable 'natural facts', which are increasingly seen as

contingent and subject to choice, denaturalises motherhood. The pill, like other reproductive technologies, separates and displaces and denaturalises the 'natural facts' of reproduction and redefines motherhood as an accomplishment.

Yet these accounts of achieved motherhood suggest that the separation of social and biological facts is not so neat in practice but rather that ideas of nature remain important in understanding motherhood as an achievement. This is most apparent in the use of nature to limit the infinite possibility of planning. Tina told me that she was not 'ready emotionally or financially. Not that you ever are but I am getting there. I am almost there but not quite...Not quite where I am in the career, in the workplace but not only that. I am having a bit too much fun. I am getting broodier, especially hitting the big 3-0 next week. Within about year I will be like, "I need babies immediately" but not just yet'. The naturalised inevitability of pregnancy and motherhood were inseparable from the practical considerations discussed earlier. Tina describes how she does not feel quite ready emotionally and financially yet the 'biological clock' limits her postponement and her choice to achieve motherhood. Kate reflected on how her attitude to pregnancy had changed as she aged: 'When I was seventeen, eighteen, I absolutely can't get pregnant. At twenty-five you think well, you know, okay, maybe, I would have to think twice. Whereas now I think that's not a problem, it changes'. She then told me why she thought this happened: 'I think when you are younger, well it depends your life stage. I think obviously ten years or twenty, fifteen years ago it wouldn't of [*sic*] been only inconvenient it would've been just really ridiculous, I was studying, financially couldn't afford to do it, you know I was not at the right life stage. Whereas now I think if it happens it is not such a disaster'. She suggests that her change in attitude to pregnancy was due to changes in her circumstances that made pregnancy less inconvenient. As she aged, the 'right' conditions were achieved and she entered to the optimal age bracket, so the idea of an unintended pregnancy shifted from being disruptive to becoming a minor inconvenience.

For the women I spoke to the 'ticking clock' emerged out of the desire to have a child. As they aged they expected the inevitable desire for a child to kick in, tempering their anxieties about getting the conditions exactly right. The achievement of the ideal conditions was, therefore, combined with the imperative of the biological clock, which marked a change in attitude towards pregnancy. As we have seen, then, planning a pregnancy required achieving the perfect social conditions for becoming a parent, yet

these were balanced against the natural assumption of maternity and anxieties about ever-reducing fertility. Biology and nature are metaphors for the inevitability of women's anticipated life-course and they work to limit the endless pursuit of trying to achieve the ideal conditions and thus set the boundaries for appropriate choices and behaviour. This is particularly the case when the desire to plan pregnancy was about gaining control, yet achieving the conditions to plan a pregnancy was often impossible and unachievable.

Heidi, like the other women in this study, took the pill to control the timing of pregnancy, to respond to pregnancy anxieties and appropriately realise her natural destinies and imagined reproductive future as a mother and woman. Heidi explains how she tries to balance different demands when planning her imagined reproductive future:

Why? Don't know. I suppose ultimately, I say ultimately, it's what we are here for. But it sounds a bit clichéd. I suppose like the majority you want a little part of you. I mean just not yet though. I just can't think of anything worse right now for me. I know eventually I am bound to change. I suppose once my career is in line and I have got the house and the dog maybe I suppose the next thing is having children. I wouldn't say I am following the crowd but at the same time I guess it is what part of what comes naturally.

In certain ways, the natural course of pregnancy is denaturalised when taking the pill yet through implicit references to nature (such as 'nature's course', 'maternal instinct' and 'biological clock') regarding achieved motherhood in fact re-naturalises planned pregnancies. Ideas about 'nature', such as the conventions of the desired reproductive trajectory, women's responsibility and limits on the otherwise infinite possibilities of planning to mother, are part of the way women talk about their reproductive futures and pregnancy as an achievement. The desire for 'natural' and 'planned' pregnancy, distinctions made possible by the pill and which appear ideologically opposed, actually overlap in these contraceptive narratives. The pill is used in such a way as to fulfil the conditions in which the natural imperative of motherhood is best achieved by strategically calculating the infinite possibilities of planning within natural assumptions.

In this way, existing naturalised ideas about motherhood structure the pill's use. Through their accounts, these women can be seen to be drawing on existing cultural resources to make sense of their contradictory ideas of pregnancy and motherhood and femininity more generally. These women interpret their options and choices in terms of

'traditional', often contradictory, cultural understandings of pregnancy, maternal love and motherhood and use existing cultural models of nature and of choice to make sense of their options (see Ragoné 1994; Rapp 1999; Ginsburg 1989; Franklin 2006b). They emphasise those aspects of the pill that are congruent with conventional understandings of the 'natural assumption' of their desired reproductive future (also see Ragoné 1994; Franklin 2006b).

These accounts provide insights into the complex ways that reproductive technologies simultaneously denaturalise and re-naturalise the 'natural facts' of reproduction as well as 'natural femininity'. 'Achieved' motherhood denaturalises the natural facts of femininity, yet pregnancy and motherhood remain central to ideas of femininity. The re-naturalisation of deliberate pregnancies can be seen as an attempt to associate women with reproduction thereby upholding 'naturalised' gender differences, which are otherwise threatened by women's presence in public and professional spheres. Heather Paxson (2006) observes how in Greece: 'To view motherhood as an achievement is to impose new value judgements on how women go about becoming and being mothers. When motherhood is talked about as a personal achievement, it cannot be consistently taken-for-granted as an essential aspect of womanhood. And when motherhood is no longer taken as part of female adulthood, the majority of Athenian women feel compelled to (at least try to) achieve motherhood in order to fully realise their womanly nature' (2006: 9). The women in this study are similarly achieving motherhood in order to realise their 'femininity'. The pill has rewritten the meaning of motherhood and pregnancy, both of which continue to signify 'natural femininity' in a context where femininity is fragmented and gender difference is being eroded (see Ginsburg 1989; Paxson 2004).

Conclusion

Examining the claim 'I am too selfish to have children' suggests that there are many layers to ideas about pregnancy, and its prevention. Taking the pill is much more complicated than might appear at first sight and a closer analysis reveals that it is more appropriate to describe women's motivations to use the pill as related to getting pregnant at the right time, being a good mother and demonstrating maternal love, rather than simply not getting pregnant at all. Pregnancy and motherhood were often considered to be a part of women's natural destiny and their imagined reproductive

future, though several possibilities trajectories – or variations on a general trajectory – were possible. Their experiences of using the pill reflect their sense that pregnancy and motherhood are no longer inevitable, but are rather the proper outcome of active and deliberate timing of motherhood within a desired reproductive future.

This challenges the assumption that the pill separates sex and reproduction, therefore freeing women from their inevitable reproductive destinies. The pill is, rather, ideologically incorporated into deliberate practices to achieve motherhood in an ‘appropriate’ way and to sustain femininity while meeting the other competing expectations of being a woman. This is one of several roles that these women simultaneously inhabit and maintain alongside their other roles as professionals, lovers, daughters, sisters and friends.

Pregnancy and motherhood as both nature’s course and a planned achievement are not incommensurable or ideologically opposed. For these women, then, pregnancy is an orderly and strategically planned progression from one state to the next but one that is still defined by natural assumptions. Pregnancy and motherhood are a natural and inevitable part of femininity that cannot be left to fate and which should, therefore, be planned in order to ‘intensively’ mother and demonstrate maternal love. On the pill, pregnancy and motherhood are a matter of choice (as to when is the most appropriate time) and therefore represent a redefinition of motherhood that is constrained by natural assumption. Moreover, these accounts of postponing pregnancy with the pill indicate that this decision is far from autonomous and self-interested but is, rather, relational, incorporating the interests of a potential child and a partner as well as the social conventions of motherhood. This is not to say that it is not rational, however, as these women undertake a complex calculation of different incommensurate fields in their decisions to try and control their fertility.

In this chapter I have started to outline a set of cultural practices regarding the pill which the following chapters will expand upon and consider from different angles. The pill enables women to deliberately achieve aspects of femininity by disassembling and reassembling natural facts. In the current political economy their ideas of femininity have expanded and have resulted in mixed affective, personal and professional goals. Taking the pill is part of a strategy to manage competing goals by introducing a degree of control and choice into previously ‘inevitable’ natural processes to better balance

these contradictions. Yet in this process the 'natural facts' of femininity, the symbolic bases that defined their goals, are displaced and the women in this study are, therefore, newly deploying existing cultural resources and reworking the symbolic natural associations at the heart of their affective and personal goals. This chapter illustrates how the 'natural facts' of pregnancy and motherhood, characteristic of femininity, are re-organised to meet the contradictory ideas about femininity which encompass motherhood.

Chapter Five

Sex on the Pill

The pill is usually associated with pregnancy but the reason why these women were anxious about pregnancy in the first place derived from the fact that they were having sex.⁹⁵ Many of the women in this study only took the pill when they were, or wanted to be, sexually active. Although sex is closely associated with reproduction it is not necessarily the reason why people have sex and therefore contraception tends to be about sex.⁹⁶ In this chapter, I explore how the pill acts as a lens onto assumptions and expectations about sexual pleasure, intimacy and intimate relationships.

In public discourse, the pill is presented as separating sex from reproduction and therefore having implications for sexual morality as it is seen to encourage sexual promiscuity. This is evident in the media coverage of recent government plans to make the pill available over the counter or online. On June 23rd 2009, for example, the Daily Mail headline read: 'Fears for Girls as the pill is sold online'. The feature story describes how young girls will 'abuse' the services aimed at working mothers as it will act as an incentive to become sexually active. The association of the pill and promiscuity are, as this suggests, still salient today (Cannell 1990). In this chapter I explore how the women in this study associate sex with the pill by examining how they think the pill affects their sexual encounters and relationships. In their accounts, they describe how taking the pill does enhance sexual pleasure but, somewhat counter-intuitively, it is not related to promiscuity and casual sex but rather with companionate long-term relationships.

The contraceptive narratives focused on heterosexual penetration while other sexual practices were excluded or mentioned only in passing and, therefore, I focus on pill use in heterosexual relationships. Though I initially concentrated on sex while on the pill, other contraceptive methods, particularly condoms, frequently figured in their narratives. The pill and condoms are the most popular forms of contraception in Great Britain (see ONS 2006 and 2008 for statistical breakdown) and both feature heavily in the accounts of sexual practices and relationships I collected. The pill, particularly for intermittent

⁹⁵ Sex here refers to penetrative heterosexual intercourse whether it be in one-night stands, casual and novel relationships, longer-term relationships, cohabiting and non-cohabiting partnerships or marriage.

users, was part of a complex, ad hoc bricolage of discrete contraceptive methods and events scattered throughout their sexual lives. Sex on the pill cannot, therefore, be disentangled from sex with other contraceptive methods; in juxtaposing these methods, these women's ideas and expectations about sex, sexual relationships and intimacy emerge into the foreground.

This chapter starts by illustrating how the women I spoke to use the pill to increase sexual pleasure. I then outline how the decision to take the pill works in the context of their sexual relationships. These accounts are then related to ideas about companionate relationships in order to provide insights into how ideals of companionate intimate relationships are mobilised in practice. I then relate these discussions about the pill and sex to the assumption that sexual intercourse and reproduction have been 'separated' leading to a transformation of intimacy.

Contraceptive Choice and the Pursuit of Pleasure

Emily, a vivacious and frank 34-year-old single mother of one who moved to London ten years ago, described to me why she used the pill on one particular occasion in the past. She had an active sex life with her then-boyfriend but felt that condoms limited their sexual relationship:

Sex was very spontaneous, we were both students, you couldn't prepare for the night, you were likely to have sex at three in the afternoon in the hallway on the banisters as you were at nine o'clock at night in bed. I am quite happy I had quite an active sex life. I knew what it was like. I didn't want to have sex and say 'give me a minute darling I have to go and ...' No. I have to do that seven days of each month. I don't need to have to do it every time. I want to think about having sex.

Emily thought pleasurable sex should be active, spontaneous and uncontrolled as well as free in terms of timing and location. She wanted no interference and just wanted 'to think about having sex' without the disruption of the 'give me a minute darling' involved in using a condom. She was sexually active and wanted to enjoy it and therefore she started using the pill.⁹⁷

⁹⁶ See Boydell, Philpott and Knerr (2006) for a discussion on the exclusion of sexual pleasure from sexuality education and safe-sex campaigns.

⁹⁷ Pam Lowe (2005b) found that changes in sexual frequency affect contraception choice. The anticipation of increased sexual intercourse, for example, leads to a change in method, but changes in method trigger increased frequency of sexual intercourse.

Like Emily, Kate, who used condoms in new or casual sexual relationships, also felt that they distracting during and detracted from sex:

You have that moment of what happens if [the condom] splits, because that has happened to me, a long time ago, but it has happened to me. So maybe you don't relax as much or it's all over very quickly and quick get out because something might come out, I don't know. I am actually saying that I don't trust condoms at all. I suppose I trust them less because I have had the experience of it breaking on me, whereas touch wood, I haven't had the pill fail me. I haven't got pregnant on it ... When you're using condoms, I know this sounds awful, but you are almost relieved when it's over because you are like that's okay, you know we got there and it's fine whereas on the pill you're not thinking about that you just sort of enjoying it.

Kate was not relaxed with condoms and as a result she wanted sex over with quickly and could not focus on 'enjoyment'. The distraction was partly due to intrusion but also due to concerns about effectiveness. The women I spoke to did not trust condoms, this lack of trust being based on personal experience and/or hearsay. They worried about condoms breaking and slipping. The interruption and worry involved in using condoms distracted them and lessened their sexual satisfaction. When they were on the pill, on the other hand, they 'didn't have to think' and could just enjoy the sex.

The texture, smell, expense and sensation of condoms generally provoked a negative reaction. There were references to the materiality of condoms: 'small and flimsy,' 'not sexy really' and 'a bit rubbery, it's unpleasant'. Mary, who used condoms in any new or casual relationship, explained how condoms reduced sensation: 'I just don't like them ... the texture, the smell and the whole thing. We always get them, Tesco's carrier bags would give you more sensation than the ones you get'. Condoms also restricted sexual possibilities because of their occasional lack of immediate availability and because of the practicalities involved in their use. Elizabeth, a soft-spoken and timid 26-year-old patent lawyer, who had recently become sexually active told me: 'Yeah, condoms - I don't really like them because you have to stop the moment and pre-plan that you have one on you. It is restrictive, it does feel different. With the pill you don't have the trouble'. She associated condoms with the need to pre-plan, interruption and restriction, which were not qualities she associated with using the pill. For Francis: 'Condoms affect your whole mood, you have to stop and put a condom on'.

Overall, condoms negatively affected the overall sexual experience for the women I spoke to because they reduce sensation, restrict possibilities and interrupt sex. They also reduced intimacy, as Beth explained: 'It doesn't feel as nice, I don't care about the interruption as much, putting it on, but it's more it doesn't feel as nice, that is probably the problem I have ... [condoms] are another responsibility we tack onto having sex as well so it's like oh yeah I better remember to do this and hold it down when he comes out and da, da, da, all that little stuff and you can't really cuddle immediately after'. In sum, as Beth says, condoms were a 'blow to bedroom life'.

Reversing the negative qualities associated with condoms reveals what the women I spoke to thought sex ought to be like: heightened sensation, uninterrupted, unrestricted, worry-free and pleasurable. The recounting of Elizabeth's complex contraceptive career provided me with an impromptu comparison of the various methods she has tried and how she thought they affected her sexual experience. At the behest of her friend, I met Elizabeth who had had up until then a short and varied contraceptive career. She explained that she had recently become sexually active and how in a short period of time since, had tried several contraceptive methods, each of which affected her sexual experience:

You feel quite safe with the condom because you see the man putting it on and it's there, you can test. I suppose it is me taking the pill or the coil, I know I am protected and I don't have to worry about what he does, whereas with condoms, it's him taking control and doing it. When you get to know someone a bit better you get more adventurous and condoms don't help that at all, it is kind of, stop and adjust. With the pill you can be freer and a bit more spontaneous which is always good anyway. In terms of the first time we had sex after the coil I was really concerned that he would feel the strings or it would be different. No problems at all. There is no difference between the pill and the coil. It's cool, you know you're protected and you can go and do it whenever, wherever. It does feel better as well, it's a bit more intimate, and there is not some piece of latex between you and him. It is better as well, you do feel it more, a better orgasm. It's a bit messier for women, it's a bit grim, I suppose, condoms are a bit cleaner – you tie it up and throw it anyway afterwards.

Elizabeth thought sex should be worry-free, adventurous, spontaneous in terms of timing and location, intimate and pleasurable. The ideal contraception should facilitate these desired qualities of sex; condoms reduced them while the pill enhanced them. For her, selecting a contraceptive method was a delicate balance between pleasure and protection and the pill was thought to provide both.

The women in this study did not problematise sex on the pill in the same way they did with condoms. Rather, the qualities of sex on the pill were mentioned in opposition to those associated with condoms. For example, Beatrice told me: 'I think it's easy to be spontaneous on the pill, it's easier because you don't have to stop to put a condom on. So that is definitely is a bonus'. Several respondents noted the lack of worry and the ability to focus on sex when on the pill. Kate told me: 'You're not thinking about that you just sort of enjoying it'. This was echoed by Emily: 'I was really so much more relaxed, I didn't have to think about it'. The lack of preoccupations and required interventions made them feel more 'relaxed,' 'carefree', and 'confident' during sex. The pill was not physically present during sex and therefore did not dampen sensation, interrupt the flow or restrict where, when and how the sex was had. In other words, sex on the pill "felt nice".

I use the term 'sexual pleasure' to capture the qualities of the kind of sex the women I spoke to wanted to have. In these accounts of using condoms and the pill they clearly distinguish how each contraceptive method differently affects sexual pleasure, which was an important consideration in their selection of contraceptive method. At first sight, these accounts suggest the pill is associated with sexual pleasure because it separates sex from the worries of reproduction. Yet situating sexual pleasure and contraceptive choice within the trajectories of their sexual relationships reveals a more complicated picture.

Contraceptive Choice and Casual and Intimate Sexual Relationships

The women I spoke to were explicit that they used the pill to increase sexual pleasure and this was an important factor in their selection of contraceptive method, but they often used condoms as well. In the contraceptive narratives, it was difficult to disentangle discussions of sex on the pill and those about sex with condoms. Here I further examine the juxtaposition between the pill and condoms with a specific focus on when and why they choose one method over the other.

Many of the women I spoke explained to me that they tended to use condoms for new sexual encounters.⁹⁸ Rachel, a continuous long-term pill user, explained:

⁹⁸ Condoms were also used in longer-term sexual relationships. Several women continuously used condoms with the pill to doubly ensure against pregnancy (see Chapter Four). Condoms were employed when there were concerns about efficacy due to missing a pill, sickness or contraindications. They also

Remembering back, if you have met somebody and you go back with them, for me it is a no-brainer to use a condom with them anyway. And I was on the pill anyway. It is about that you don't know this person and that makes it so much more personal. You don't necessarily have this barrier. Condoms feel clean, whereas if you know the person and you love them, it is a very different feeling.

She always used condoms with new sexual partners even though she was already on the pill. The lack of knowledge about a partner prompted her condom use, which, in turn, made sex less 'personal' because condoms were seen to act as a physical and emotional barrier during sex with a partner. However, Rachel did not use condoms with a known and loved partner because this was 'a very different thing'; in this situation using a condom was a barrier and acted to depersonalise sex.

For Rachel continued use of condoms was uncharacteristic of longer-term relationships, as she explained: 'I really dislike using condoms, I just find them crude, they are too real, they are not very romantic ... I just don't like them, they don't fit in with what you are doing at the time. It just gets in the way, it makes it less passionate and more of an act'. Rachel describes how sex on the pill signified a specific kind of sexual relationship that was more personal, romantic, passionate and longer term.

Isabella, who also took the pill when she was in longer-term relationships, described a similar pattern. She told me:

I think it's almost, because I either I have used condoms with someone if I wasn't in a really long-term relationship with or at the beginning of a long-term relationship. And then the anxieties were going to be there anyway. Not really anxiety, but slight awkwardness. So I think the two things, it might of [*sic*] compounded it a little but it wasn't a be-all and end-all. I don't have a massive problem with condoms, some people do. It doesn't really spoil the relationship for me, it is not that dramatic but I think you can have a more intimate relationship if you don't have to worry about that because you just don't have that stiltedness and you don't have to have a conversation about it.

made for 'cleaner' sex (particularly during menstruation) or to avoid post-coital 'mess'. They also tended to prolong and enhance sex in some cases. Tracey said: 'The man always complains even though it can be a bit more enjoyable for me because they have to work a bit harder if you know what I mean because they can't get no feeling'. Sophie explained the benefits of continued condom-use: 'With regards to sensation, well the thing is that condoms are fine, for me, I don't mind them at all, because you're not the one with mess at the end, which is nice and the chap usually lasts a bit longer. I know that most don't like them, in a way they have to work harder'. Condoms can, thus, have positive qualities in 'trusting' relationships.

Isabella equates the sexual awkwardness related to using condoms with the awkwardness of a novel sexual relationship with a new and/or unknown partner. In more intimate relationships not using a condom made sex less 'stilted' partly because it required prior communication between partners. Isabella and Rachel both used condoms when they did not know their partners and then switched to the pill when they knew their partners and as a result the sex became more personal, passionate and intimate. This suggests that pill use is associated with having sex with a known partner in a longer-term relationship, whereas condoms are used with unknown partners in casual relationships.

Jessica described when and why she changed from using condoms to the pill with a particular sexual partner and the effect it had on the relationship for both of them:

This boyfriend I am with now, we used condoms for five months and I hated it and never really felt close to him in that period of time. But as soon as we stopped using them I suddenly felt closer to him. I don't know why that was but I felt like maybe because he did not want not to use condoms and because I have never had a bloke say that before. I thought why does he not want not to use it, but as soon as we stopped we actually got closer because of it. Well I got closer to him. I never thought I would feel like that about condoms, I didn't think it would make any effect psychologically but it did. It really surprised me that it actually affected it. Maybe just I really don't like them, I just don't, it's weird.

When she used condoms at the start of the relationship she did not feel 'close' to her boyfriend but when she changed to the pill they became 'closer'.

Further questioning revealed why and when they had changed from condoms to the pill in a particular sexual relationship. Beth, a continuous pill user, explained that using a condom is a 'trust thing'; she only used them in 'not quite a trusting relationship'. Donna told me: 'I have only not used condoms when I have been on the pill. When I have been on the pill I have been in a relationship when I was at a stage that I felt comfortable and trusted'. Switching to the pill is related to the assumption that trust has built up between sexual partners and the presence of trust indicated different types of sexual and romantic relationships.

This transition from condoms to the pill was not a hard and fast course of action. Some women skipped using condoms and built trust in other ways.⁹⁹ For instance, they and their partner might test for sexually transmitted infections prior to condom-free intercourse. Beatrice told me: 'The condoms came off when we both went for a full check-up, smears, HIV test'. One respondent undertook a slow and meticulous sexual history of a potential partner over an extended period prior to intercourse. She recounted to me: 'This is going to make me sound old-fashioned but I am pretty certain about the person before I start sleeping with them. I tend to know a lot about their history, so it is not something that ever comes up. I usually go out with someone for a couple of months, my last boyfriend it was three months before I even started sleeping with him'. These represent different ways of gaining trust prior to exclusively using the pill and suggest that condom use can be a way to build trust with a partner.

To be effective, condoms require communication and collaboration between partners and, therefore, increase one's knowledge of one's partner. In a sense, then, condoms may function as a test in order to demonstrate whether a 'closer' sexual relationship is possible or not. Several ethnographies illustrate the role of male-led contraceptive methods in the generation of long-term relationships (Hirsch 2003; Schneider and Schneider 1996; Sobo 1995; Paxson 2007). In Mexico, the male-led methods of rhythm and withdrawal require joint decision-making and signify that the male partner is 'taking care' of the female partner (Hirsch and Nathanson 2001).¹⁰⁰ Heather Paxson (2007) found that Athenian couples preferred condoms and withdrawal and rhythm techniques because these methods required the type of communication characteristic of enduring love and relationships.

Trust was a decisive factor in the decision to change method for the women I spoke to. It was generated through increased knowledge of the partner, a mutual 'opening out' gained through communication. A study of sexual and contraceptive practices amongst young people in London also found that increased communication and trust prompted

⁹⁹ In other instances, there were simply no condoms available, the passion was unstoppable or those involved simply enjoyed the 'risk'. Detailed accounts of the deviations suggest, however, that these were considered 'transgressions'.

¹⁰⁰ Hirsch and Nathanson (2001: 421) have identified the key conceptual differences between withdrawal and rhythm techniques. Withdrawal means that a woman never has to say no with the man sacrificing his pleasure in order to put his wife's pleasure first. With the rhythm method both partners suppress their sexual urges, focusing instead on ensuring mutual sexual pleasure.

the switching of methods:¹⁰¹ ‘The transition from condoms with a new or “risky” partner to the pill with steady partners can be used to signify the seriousness of a relationship, a way of showing someone that they are special ... Going on the pill expresses trust for both partners that the other presents no risk of infection’ (Holland et al. 1998: 50). For the respondents in my study communication, knowledge and trust were prerequisites for taking the pill and having more intimate sexual relationships, themselves characterised by longer-term contraception and more personal and pleasurable sex. Hence, condoms and other ‘testing and talking’ strategies can be seen as attempts to ascertain the knowledge necessary for trust in longer-term relationships. The switch from the condoms to the pill marks trust both in a sexual partner and a relationship.

Elizabeth, who earlier compared different contraceptive methods, has only ever had one partner and became sexually active later than others, so she did not have the same range of experience as other women. This implies that, since her feelings about contraception echo those of others, they relate to wider cultural ideas rather than simply the internal dynamics of her particular relationship. She explained what switching to the pill meant for her relationship:

This might just be me, but it is a big thing when going from someone who you have sex with a condom to going to sex without. It’s a bigger step, it’s like yeah I trust you, let’s move on and you have to put a protection in place because you are not using it ... it implies a level of trust when you move onto not using condoms. I think he had to trust me as well, I mean I said I took the pill but he can’t sit there and watch me take it everyday.¹⁰²

For Elizabeth switching contraceptive method demonstrated trust and marked a transformation in a sexual relationship. Switching to the pill was ‘a big thing’ because it implied mutual trust based on communication and knowledge between partners. Karen, a continuous pill user for twenty-two years, echoed this: ‘It [not using condoms] will take the relationship, for me, it takes the relationship to a whole different level’.

¹⁰¹ The switch in method as a symbol of the transformation or pursuit of an intimate relationship has, however, been noted to have negative consequences for safer sex practices (see Day 2007; Hirsch 2006; Holland et al. 1998; Sobo 1995).

¹⁰² Elizabeth further elaborated on this: ‘I mean we talked about it anyway, but it was quite a big thing, like, stop using condoms because I had to trust him first and know he was clean. I know that sounds horrible’. It is interesting to note that women did not explicitly mention the prevention of sexually transmitted diseases as a reason to use condoms though this was indirectly implied.

The transformation in a sexual relationship which accompanies and is partly brought about by the switch to the pill is also often signified by a change towards monogamy and more 'personal' sexual pleasure. The switch to the pill was a highly symbolic moment in a relationship and had embodied repercussions on sexual pleasure. The respondents considered the impersonal and awkward sex associated with condoms appropriate for novel relationships and the personal and pleasurable sex experienced on the pill proper for trusting, intimate and exclusive relationships. The choice of contraceptive method distinguishes two types of sexual relationships. The types of relationships were not mutually exclusive but rather possible transformations of one to the other. The switch to the pill occurred when a sexual relationship transformed from an impersonal encounter into a more personal, sustained and trusting relationship. The change of method was indicative of this transformation but was also seen to enhance sexual pleasure in the fledgling relationship. Moreover, the impersonal sexual encounters with condoms form part of the process necessary for transforming a relationship. Heather Paxson (2004: 122) found in urban Greece, that the fleeting physical sexual intimacy of impersonal sex could become the enduring sexual intimacy of a longer-term relationship, though often it did not.

In this respect, using only the pill indicated exclusivity. Louise explained how not using condoms 'is based on a decision that we are boyfriend and girlfriend, we are not going out with anybody else. We are not seeing anybody else'. The same sexual act, then, had different meanings depending on the contraceptive choice. Sophie Day's (2007) research amongst London sex workers similarly illustrates how different contraceptive methods distinguish different kinds of sexual relationships. Sex with paying partners involved impersonal barrier methods and less personal sex. For intimate (non-paying) partners, on the other hand, foregoing contraception identified the relationship as private, personal and trusting. Sex workers clothe 'their paying partners in latex, surrounding them with pessaries, spermicides, disinfectants and so forth, all in such a way as to make clients incapable of transmitting infections' (Day 2007: 151). In their accounts the women I spoke to similarly associate contraceptive choice with specific types of intimate sexual relationship.

The accounts of sex on the pill that I collected reveal common assumptions and expectations about how a sexual relationship should develop and the specific role of contraceptives in this development. Together, these indicate a shared ideal trajectory of

a sexual relationship in which contraceptive methods are associated with the different phases of the trajectory.¹⁰³ This idealised trajectory served as a reference with which to guide and judge sexual relationships. Accounts of how they, or their friends, had diverted from this trajectory reveal its constituent parts. The contraceptive narratives indicate that limited communication, knowledge and trust of a partner characterised the initial phase of a relationship during which time condoms were used and sex was consequently impersonal and awkward. With increased communication, mutual knowledge and trust a relationship became more intimate. For the women in this study, this transformation was marked by a switch from condoms to the pill and more pleasurable and personal sex. The final phase of the trajectory was characterised by full knowledge and trust, joint reproductive and contraceptive decision-making and ever-increasing sexual intimacy. Hence, an intimate relationship evolved by means of increasing communication, knowledge and trust and increasing mutual sexual pleasure.

Both the expected trajectory of a sexual relationship and the symbolic nature of contraceptives illustrate how wider social and cultural meanings and values inform ideas about sexual practices. Social theorists of sex argue that though sex is not a discrete private physical encounter, it is laden with situated social and cultural meanings and values. Research on the social and cultural factors that mediate sexuality and sexual conduct have increased as a consequence of the HIV/AIDS epidemic (see Parker 2001; Vance 1991). Anthropological research on sexuality demonstrates that sex is more than a physical act or individual biological drive; it is, rather, a shared and learnt social activity situated within wider ideas of gender, marriage, kinship, consumption, and production in specific social, political and economic contexts (see Herdt and Lindenbaum 1992; Parker 2001; Parker and Aggleton 1991; Vance 1991; Manderson 1999). This research highlights the importance of cultural systems and social meanings in shaping sexual expectations and practices (see Sobo 1995; Hirsch 2006) and illustrates that sexuality is diffusely regulated by ideologies and institutions (Foucault 1978; Weeks 1989). Sexual proscriptions and prescriptions govern the possibility of sexual interactions and the range of potential partners and practices. Parker (2001) reminds us:

¹⁰³ These contraceptive narratives, however, only account for the experiences of sexual intimacy at the fledgling stage of a relationship and are not representative of shifts in sexual intimacy over the life-course or amongst different social classes.

With whom one may have sex, in what ways, under what circumstances, and with what specific outcomes are never simply random questions. Such possibilities are defined through the implicit and explicit rules and regulations imposed by the sexual cultures of specific communities as well as the economic and political power relations that underpin the sexual cultures (2001: 69).

Simon and Gagnon maintain that: 'Even though most actual sexual activity in contemporary societies goes on in private settings, often devoid of apparent social costuming, the sexual encounter remains a profoundly social act in its enactment and even more so in its antecedents and consequences' (2003: 492). They argue that sexual encounters follow learnt socially and culturally informed sexual scripts that provide shared understandings of what a sexual situation is, what sexual activities are and the values attached to them (also see Firth and Kitzinger 2001; Jackson 1996).¹⁰⁴ As such, in sexual encounters people are rehearsing scripts based on shared symbolic interpretations of sexual action.¹⁰⁵ In the accounts of the women in this study the pill is part of their sexual scripts and closely implicated in the symbolic action of sex.

The choice of method was not only guided by the pursuit of pleasure; it was also influenced by the kind of sexual relationship they were involved in and/or desired. To summarise, women in this study used condoms and the pill both separately and jointly in their sexual relationships. Condoms alone, or in combination with the pill, tended to be used in novel or casual sexual encounters where there was little knowledge of and trust between the partners. Regular interaction and communication between partners increased mutual knowledge and trust and triggered a switch to the pill. Hence, transformation in relationships is marked by changes in contraceptive practice. Examining when and why these women switched to the pill reveals that the pill is associated with trusting longer-term relationships. Trust, generated through increased communication and mutual knowledge, was a decisive factor in switching to and using the pill with a particular partner. Contrary to public discourse, these accounts suggest that the pill is associated with longer-term sexual relationships rather than novel or casual sexual relationships.

¹⁰⁴ Simon and Gagnon (2003) describe the sexual script of heterosexual intercourse as follows: kissing, then tongue kissing, then touching breasts and then genitals, this followed by some form of genital contact.

¹⁰⁵ The sexual script approach is the dominant explanatory model of sexual behaviour but it has been critiqued by Firth and Kitzinger (2001) because it overemphasises individual cognition and neglects the social context. They offer an alternative account of the scripted quality of sexual interaction.

Achieving Companionate Relationships

In the previous sections I have outlined how sexual pleasure and the formation of longer-term sexual relationships make taking the pill a desirable course of action. Now I situate these practices in relation to wider theories about intimate sexual relationships. Intimate relationships tend to be analytically framed as ‘pure relationships’ or ‘companionate marriage’, referring to long-term relationships where partners are sexually involved with each other as well as being encompassed in each other’s daily affairs.

Anthony Giddens (1992) argues that contemporary intimate relationships are part of a longer historical trajectory in which ideals of intimacy centred on sex, reproduction, marriage and the family have been replaced by intimacy based on the affective ties between a couple. He maintains that previously intimate relationships and sex were restricted to marriage, a gendered unit of production that organised physical and social reproduction. Recent economic and demographic changes have transformed the heterosexual relationship from a productive unit to an affective sphere where primacy is placed on the partners’ emotional ties.¹⁰⁶ Affective ties between the couple are thought to emerge from emotional compatibility and mutual sexual satisfaction rather than a sense of obligation associated with marriage and reproduction.¹⁰⁷ Mutual emotional and sexual satisfaction are the outcome of active and contingent negotiations between partners as they open out to the other. Hence, according to Giddens, communication and emotional and sexual intimacy are at the centre of ‘close and continuing’ ‘pure relationships’ (Giddens 1992).¹⁰⁸

Hirsch and Woodrow have built on and termed this transformation of intimacy as the conjugal ideal of a ‘companionate marriage’ in which ‘emotional closeness is understood to be both one of the measures of success in marriage and a central practice

¹⁰⁶ Also see Shumway (2003) and Skolnik (1991) for historical accounts of the conditions that gave rise to companionate marriage in the late nineteenth-century such as the decline in fertility and infant mortality and the promotion of the nuclear family that encouraged enduring affective ties between spouses and between parents and children.

¹⁰⁷ The transformation of intimacy that valorises emotional compatibility and sexual satisfaction is apparent in the works of the early family-planning advocate, Marie Stopes. Stopes published several marriage manuals that stressed the importance of mutual sexual satisfaction and suggested that contraception strengthened the conjugal relationship.

¹⁰⁸ Ideals of companionate marital relationships have gone global: see Hirsch et al. (2007) for a summary of cross-cultural ethnographic accounts of the transformation of intimacy.

through which the relationship is constituted and reinforced' (2006: 4).¹⁰⁹ They suggest that 'companionate marriage' is sustained through 'prioritising the ongoing affective primacy of the conjugal unit' (Hirsch and Woodrow 2006). Like Giddens, the affective intimacy of enduring companionate relationships requires ongoing emotional and sexual satisfaction and if this fails, it provides socially acceptable grounds for separation and divorce. Unlike traditional marriage, 'companionate marriage' is not a permanent tie of obligation but a process of ongoing and ever-increasing affection and sexual and emotional satisfaction. Therefore, emotional and sexual intimacy are both fundamental in building and evaluating a relationship and are the goal and the means to intimacy that guide relational strategies. They, however, also point out the continued expectation that the couple will become a reproductive unit as partners become spouses and parents. I use the term 'companionate relationship' here to refer to these companionate ideals but also recognise that they are not limited to marriage but include cohabiting and non-cohabiting couples. The over-generalisation of theories of companionate relationships is discussed later.

The purported companionate turn of intimacy has implications for understanding the function and meaning of sexual intercourse. The separation of sex and reproduction with modern contraceptives has fragmented the association of sex, marriage and reproduction as sex is freed from its procreative potential. According to such theories, in companionate relationships sex is no longer limited to being a reproductive function, but is part of the 'active and contingent negotiation' (1992: 50) and bonding between partners. Giddens argues that prior to 'pure relationships' sexual intercourse was symbolically restricted to conjugal relationships 'in the service of reproduction' (1992: 181). Sex as a matter of reproduction symbolically tied together the cultural arrangement of sexuality, kinship and gender with different types of intimacy. Moreover traditional institutions and moral codes ensured an exclusive and permanent 'structural congruence' between marriage and sex (Giddens 1992).

According to Giddens (1992) sexual intercourse no longer only signifies conjugal and familial love. Sexual intercourse has, rather, been redefined as a part of the active and contingent process of generating and sustaining a relationship in which mutual sexual pleasure is integral to, and an indicator of, a satisfactory relationship and therefore, a

¹⁰⁹ Hirsch and Woodrow (2006) identify several identifying features of companionate marriage and its related ideas and practices.

goal and a means for generating and sustaining intimacy. Jennifer Hirsch (2007) also argues that mutually pleasurable sex is considered the foundation of modern relationships as it strengthens enduring bonds. She states that 'Couples court to develop intimacy through shared secrets and kisses, and after marriage the development of intimacy is a central task of relationship building. Discursively (though not always actually), pleasure is the key force holding relationships together' (Hirsch 2007: 95).¹¹⁰ Reciprocal and increasing sexual pleasure creates the possibility of a successful 'close and continuing' relationship.

In the theory of companionate relationships, sexual intercourse plays a dual role. It is a means by which to create and sustain this type of relationship but also a gamble on a possible 'close and continuing' relationship. As a gamble on love, Giddens argues that contemporary 'sexual encounters are seen as detours on the way to an eventual love relationship. Sex is, as it were, a sparking device, with romance as the quest for destiny. The search for romantic love here, however, no longer means deferring sexual activity until the desired relationship comes along. Having sex with a new partner may be the start of a fateful encounter, which is sought after, but more than likely is not' (1992: 51). Along similar lines, Heather Paxson (2007) found that urban Greek women see sex as a gamble on a possible companionate relationship. Greek women distinguish between *erotas*, a crazy, fleeting physical erotic love, and *aghape*, an enduring intimate love that creates children, and both figure in women's ideas about intimate relationships. In terms of Greek cultural logic *erotas* can potentially be transformed into *aghape*. Paxson outlines how impersonal casual sex can be part of courtship and the creation of an enduring companionate relationship. These examples show how heterosexual intercourse is no longer structurally and symbolically congruent with and exclusive to marriage; the association of sex, marriage and reproduction is fragmented.

Evidence suggests that economic, demographic and social transformations have altered and multiplied the intimate possibilities of these respondents at the Pyke. This is most clearly demonstrated in their ideas about what are socially acceptable sexual practices and relationships, a point which has been substantiated in studies of changing sexual practices. Kaye Wellings' (1994, 2001) studies of sexual attitudes and lifestyles record significant changes in sexual activity in the United Kingdom over the last fifty years,

¹¹⁰ For more ethnographic examples see Hirsch 2003; Collier 1997; Paxson 2004 and Schneider and Schneider 1995.

particularly with regard to women. Wellings documents a reduction in the age of the sexual 'debut', the average age of which for men and women in the 1950s was approximately twenty compared to sixteen in the mid-1990s. The majority of women in the 1950s were married or engaged to their sexual partner prior to their sexual debut while this applied to less than one percent of men and women in the 1990s. The FPA (2008) further reports changes since the 1990s, namely an increase in the number of heterosexual partners of individuals and more concurrent partnerships.¹¹¹ The majority of women now have more than one sexual partner over their lifetime and the number of women who have just one partner halved between 1990 and 2000. The average number of lifetime partners increased from 3.7 to 6.5 between 1990 and 2000. In the same period, the proportion of women who had had ten or more partners increased from 9.7 percent to 19.4 percent. There has also been an increase in the number of women with concurrent partners, from 5.4 percent in 1990 to 11.4 percent in 2000. This last figure rises to 15 percent for women aged 15 to 24. These studies indicate that sexual practices are significantly changing and point to a growing trend where sexual intercourse is no longer associated with a single partner within marriage in the context of starting a family.

In the contraceptive narratives I collected, ideals of companionate relationships can be seen to inform the sexual and contraceptive practices of the women interviewed and provide the context for their pill use. Hirsch and Nathanson (2001) have shown how the ideals of companionate relationships are intertwined with contraceptive practices, as they demonstrate the way people classify and strategically use contraceptives in terms of their effects on companionate relationships. In addition, Elisa Sobó (1995) and Jennifer Hirsch (2003) have provided ethnographic examples of how the strategic use of contraception creates a sense of intimacy. Similarly the women in this research indicate that their sexual and contraceptive practices are situated within broader companionate ideals.

The descriptions of contraceptive practices given by the women in this study illustrate how contraception figures in the processes of companionate relationships. The symbolic association of condoms and the pill with different types of relationships and the transformation between them is illustrative of the 'active and contingent negotiation' between partners. Using condoms to increase knowledge and communication between

¹¹¹ Heterosexual partners here being defined as partners in oral, anal or vaginal sex.

partners necessary for trust can be seen as part of 'opening out to each other' (Giddens 1992:61). Moreover, the women I spoke to share a common ideal trajectory about how sexual relationships should progress, in which a casual physical encounter may be transformed into an enduring companionate relationship. This transformation was both signified and facilitated by changing from condoms to the pill. Condom use could be seen as an integrated part of 'gamble on love'. By switching to the pill the women I spoke to can facilitate more pleasurable, spontaneous, intimate, and generally satisfying sex. They portray how they can facilitate and, therefore, sustain a companionate relationship. Through these practices, sexual intercourse and pleasure acts to hold together a companionate relationship; as a relationship becomes more intimate, sex can be made more pleasurable. In this way, ideals of companionate relationships guide contraceptive strategies as contraceptives are used in such a way to build and evaluate relationships.

These accounts demonstrate that the choice of contraceptives is integral to generating and sustaining companionate relationships. Contraceptive are used in such as way as to increase communication and trust, distinguish relationships and potentially enhance the sexual pleasure necessary to sustain a relationship. Sex on the pill not only signifies an increased intimacy in a relationship but was also a means to achieve it. These descriptions of contraceptive practices suggest that the relationship between sex, intimacy and companionate relationship is not fixed but open to choice and deliberation. Furthermore, the association between sex and intimacy is not taken-for-granted; rather sex is a means to generate intimacy. Through their contraceptive practices, the women in this study could use the pill strategically to achieve more pleasurable sex in evolving relationships and to actively facilitate intimacy. Intimacy, like motherhood, can be seen as an achievement of purposeful choice.

Naturalising Achieved Sexual Intimacy

These accounts of sex on the pill conform with the ideals of intimacy in companionate relationships but they also portray a more complex situation in practice. They suggest a more complicated engagement as the respondents continue to relate sex and intimacy to reproduction. Here I examine the different ways reproduction, that is ideas of generative sex (sex that may potentially result in reproduction), emerge in conversations

about sex on the pill and its implications for Giddens's theory of the transformation of intimacy.

Historical records suggest that the purported transformation of intimacy is over-generalised and does not account for differences between social classes across different historical periods. Historical sources (both religious and medical) suggest that love, friendship and sexuality were encouraged in marriage in the 1600s and 1700s (Porter and Hall 1995; McLaren 1984, 1990) depending on the marriage system of different social classes.¹¹² There are complex debates amongst historians about the rise of the ideal of companionate marriage and these intimate that it is a gross over-simplification to suggest that love, affection and sexual enjoyment were unknown in the past (see MacFarlane 1986; Lacquer 1995; McLaren 1984; Porter and Hall 1995; Fisher 2006).¹¹³ Popular historical medical texts and sex manuals such as Nicholas Venette's (1720) *Conjugal Love Reveal'd* and (1955) Aristotle's *Masterpiece*, and Henry Bracken's (1737) *The Midwife's Companion* outline how mutual sexual pleasure was necessary for successful conception (Lacquer 1987, McLaren 1984, Porter and Hall 1995). This indicates that companionate ideals have previously been used in the 'service' of sex, marriage and reproduction. Moreover, common 'traditional' methods of fertility control – abstinence, withdrawal, barrier methods and coital positions – required mutual collaboration between sexual partners, which are more characteristic of companionate relationships (Himes 1936, McLaren 1984, Fisher 2006).

Such historical evidence suggest that the theory of companionate relationships is an ideology that juxtaposes ideas of intimacy based on affective relations with an ideology of reproductive intimacy that associates conjugality, sexuality and reproduction within a naturalised cultural arrangement. In an ideology of reproductive intimacy, sexual

¹¹² In the landed classes marriage was determined by family strategy and high fertility was promoted to ensure an heir. The first son had an arranged married and lived within an extended family and many younger children married late or not at all. Amongst the labouring class there was a different marriage system in which couples married later to a partner of their choice once they had adequate resources to sustain an independent household. The different marriage strategies and different age at marriage would inevitably affect the relationship between spouses. Hartman (2004:49) argues that late marriage gave rise to more companionate relationships because both partners were social adults. Late-marrying women had more productive years without children and autonomy and responsibility. Two socially mature adults marrying were expected to contribute to start-up costs of the household with their independent resources.

¹¹³ This account of demographic history has been contested as the nuclear family is a long-standing norm, late marriage, post partum abstinence and extended breast-feeding ensured controlled fertility and couples that married later were social adults with individual resources.

intercourse has a specific symbolic function as elaborated by David Schneider for American kinship:

Sexual intercourse as an act of procreation creates the blood relationship between parent and child and makes genitor and genetrix out of husband and wife. But it is an act which is exclusive to and distinctive of the husband–wife relationship: sexual intercourse is legitimate and proper only between husband and wife and each has the exclusive right to the sexual activity of the other (1968: 38).

According to Schneider, the powerful ‘natural’ symbol of conjugal sexual intercourse merges the ties of blood and love at the heart of kinship. Familial blood and love are the natural outcome of sexual intercourse and symbolise a unique ‘enduring diffuse solidarity’. Exclusive sexual intercourse between husband and wife is, therefore, a sign of conjugal and familial love:¹¹⁴ ‘Sexual intercourse is love and stands as a sign of love, and love stands for sexual intercourse and is a sign of it’ (1968: 52). An ideology of reproductive intimacy is contrasted with an affective ideology of sexual intimacy as outlined in the theory of companionate relationships. Therefore the separation of sex and reproduction is necessary for the smooth transition from one form of intimacy to the other. Yet, the way that some of the women I spoke to talk about sex and the pill suggests that taking the pill did not separate sex neatly from reproduction.

As described earlier, the more pleasurable sex on the pill was described as worry-free, uninterrupted, spontaneous, and an experience of heightened sensation. These are qualities associated with what Margaret Jackson (1984) defined as a biological model of sex, as an impulsive, spontaneous and uncontrollable urge (also see Lowe 2005; Herdt 1994; Pollack 1985).¹¹⁵ She states that: ‘Sex is conceptualised as a natural urge or drive, dependent on internal, biological factors, such as hormones, but capable of being triggered off by external stimuli’ (1984: 45). Sexual desire, therefore, is an involuntary, inevitable, irrepressible and spontaneous biological urge produced by a reproductive drive (see Pollack 1985; Lowe 2005). Jackson concludes that the biological model of sex privileges the reproductive function of heterosexual intercourse (see also Lowe

¹¹⁴ Schneider’s work was the first to stress the importance of emotional bonds in kinship systems; previously almost exclusive emphasis had been put on the structural and functional aspects of kinship.

¹¹⁵ In a biological model of sex, sex appears prior to culture as something without social and historical origins. Yet the biological model of sex has specific cultural and historical roots. Scientific research on sex (such as Ellis 1937, Kinsey 1948; Masters and Johnson 1966) that emphasised the biological function of sex governed by the ‘laws of nature’ removed sex from moral constraints and made it a legitimate area of scientific investigation. But in so doing, social and moral constraints became naturalised (Aggleton and Parker 1999).

2005; Herdt 1994; Pollack 1985). I argue that the women I spoke to preferred sex on the pill because it was impulsive, spontaneous and uncontrollable and accorded with the biological model of sex as I have demonstrated through the examples of Emily, Kate and Elizabeth at the start of this chapter. In doing so, sex on the pill retains the qualities of generative biological sex and, therefore, aspects of an ideology of reproductive intimacy.

Pam Lowe's (2005) study of contraception found that different contraceptive methods have differing degrees of pre-meditation and intervention at different times, which impact on the experience of sexual pleasure. She divides contraceptive methods into two categories, coital and non-coital. Coital-related methods, such as condoms, are applied at the time of intercourse and require sexual partners to incorporate them into the flow of sexual action. Non-coital methods such as the pill, on the other hand, are taken at a time unrelated to intercourse and do not disrupt the sexual encounter.¹¹⁶ She found, as with the women in this study, that condoms can be seen as a disruption to 'proper' sexual practice. Meanwhile the pill, where control and intervention occur prior to sex and do not intrude upon or require immediate control during the sexual encounter, allowed for, what Lowe terms as, 'natural and proper sexual practices' (2005: 90). The pill facilitates pleasurable sex by allowing spontaneity and freedom in terms of when, where and how one has sex commensurate with a biological model of sex.¹¹⁷

The women I spoke to also found condoms interrupted intercourse, required planning to ensure availability and communication and collaboration for their application. Their material quality made them an ever-present participant in the sexual encounter. In general condoms were antithetical to pleasurable sex whereas the pill enabled pleasurable sex because it made sex appear and feel more 'natural'. Moreover, for many respondents sex on the pill was better than sex without any contraception because it removed their anxieties about pregnancy. Therefore, switching to the pill allowed for more pleasurable 'safe' sex, coded as biological and 'natural'. Ironically the more pleasurable 'natural' sex was achieved through deliberate contraceptive practice.

¹¹⁶ Marks suggests that the pill was the first method that did not involve disrupting sex: 'Taken by mouth at a time independent of intercourse, the innovative feature of the pill was that it was sexually unobtrusive. The pill was unlike most other current forms of contraception which coincided with, and indeed often interrupted, sexual intercourse' (2001:193).

The conflation of pleasurable and biological sex enabled by the pill introduces the logic of reproductive sexual intimacy into companionate relationships. Accordingly, the symbolic association of sex with procreation remains a meaningful part of intimate relationships for the women in this study. The women I spoke to were, therefore, actively taking the pill to make sexual intercourse appear and feel 'natural' (precisely because it does not disrupt the association of sex and reproduction) within what appear also to be companionate relationships. They were using the pill to actively pursue the sensation and characteristics of biological sex thereby symbolically connecting sex, reproduction and conjugality in the generation and sustaining of their more companionate intimate relationships and, thus, interweaving affective and reproductive sexual intimacy.

For some respondents, moreover, the procreative potential of sex was a source of pleasure. Tania told me about one casual sexual encounter without a condom:

Neither of us had condoms and we were so horny that we just had sex and he didn't come in me, but I was on the pill. I think, but it was emotion, it was too much basically I said, 'fuck it' and it sort of adds to the pleasure. It's really fucked up but it adds to it that he might be getting me pregnant ... I never really want it but in the height of passion it's like, you know, fuck me so hard that you might get me pregnant but I don't actually want you to get me pregnant.

For her, the uncontrollable urge for sex and risk of pregnancy are part of the demonstration of passion and desire important to sexual pleasure. By using the pill Tania simulated the "natural" qualities of a biological model of sex yet at the same time removed the risk of pregnancy.¹¹⁸

Sex on the pill is also associated with reproduction through naturalised gendered contraceptive responsibilities. Heather Paxson (2002) argues that modern contraceptives have shifted reproductive and contraceptive regulation by social institutions to those directly involved in sexual relations. Luker (1975) points out that the burden of personalised contraceptive responsibility falls, for the main part, on women as the

¹¹⁷ The pill has created a new contraceptive and sexual precedent; sex has become safe, anxiety-free and without interference, enabling spontaneity and freedom in terms of timing, location and position as well as increasing intimacy (see Marks 2001).

¹¹⁸ McLaren (1984) argues that in the sixteenth and seventh century it was commonly assumed that women found pleasure in sexual intercourse and that it was necessary if the union was to be fruitful. This was based on a Galenic theory of equal responsibility and pleasure is sexual activity. Also see Lacuquer (1987) and Stonehouse (1999).

majority of modern contraceptives are designed for female physiology. This brings out the underlying irony of the contraceptive practices of companionate relationships. In the sexual trajectories described already the switch from condoms to the pill is based on and aims to generate a companionate relationship. Yet it is precisely this switch that makes women exclusively responsible for contraception and mutual sexual pleasure. For instance, Beth recounted how after we had first met, she had realised the degree of responsibility she was taking for contraception and how she had, as a result, demanded gratitude from her partner for her efforts to achieve mutually pleasurable sex:

I said, 'You didn't thank me for going in my lunch hour to get that pill'. He was like, 'Oh I'm sorry baby, thank you' and I was like 'I am the one that has to do that'. Which is totally true and everyone knows that, and I was kind of joking around but it is true. So I remind him of that, I am the one who has to remember to take the pills and I am not the only one having sex.

Jessica, a close friend of Beth, commented on this incident:

She said that she went home to her boyfriend and said: 'I went and got some more pills today' and he said 'Yeah, alright'. And she said, 'You should be thanking me' ... and I never thought about that before, I never thought that they should be thanking you. I always thought it's my responsibility not theirs and really they don't have to do anything.

The incident caused Jessica to reflect on the fact that she had assumed the mutual sexual pleasure generated by taking the pill was automatically the woman's responsibility. These recollections illustrate the implicit gendered responsibility involved in the contraceptive practices of companionate relationships in that although men wear condoms in practical terms these require both parties to incorporate them into sex unlike with the pill where women exclusively administer it at a time disassociated from intercourse with little involvement from their partner. The typical change in methods seen in evolving companionate relationship involves a move from joint cooperation to women's overall contraceptive responsibility. Ironically, a switch in method representing increased mutual emotional and sexual intimacy means, in practical terms, women's exclusive burden and responsibility. For the women in this study, there was no pattern as to which partner led the method-switch, yet once this had been made all the women took full contraceptive responsibility by taking the pill.¹¹⁹

¹¹⁹ The contraceptive switch varied between women as to whether they or their sexual partner led. It also depended on the current partner and the particularities of the relationship and changed over the life-course as some women become more vigilant and others more lax. Over half the women who participated in this

Though the administration of the pill is premised on female physiology, the rationale for women's responsibility was, in fact, their naturalised role in reproduction. Teresa explained: 'I've taken responsibility because it's my ultimate responsibility; it's my body, so I take that responsibility. It is not that I wouldn't trust the other person actually, it just feels right for me to take responsibility for something that I really care about it, so that's why'. Tania said something similar: 'I must admit it is like trusting anybody with anything that is unique to you, isn't? Would you trust a guy to feed you every day? Would [you] trust a guy to do anything? I don't know if I would, like something that important. No I definitely wouldn't but I know myself completely, through and through, so I can trust myself to do it, but I don't think I could trust anyone else to do it'. The trust necessary for transforming a relationship was not a trust to facilitate it. Mary put it more succinctly: 'I certainly wouldn't trust them with something so important'. Tania, Teresa and Maria, all long-term continuous pill users, wanted to control contraception because it was their body, their responsibility and because they distrusted their male partners to take full contraceptive responsibility, though it also symbolised trust.

The women I spoke to did not trust men to be responsible for contraception because they felt that the consequences of pregnancy would not affect men in the same way. The women I spoke to thought of their contraceptive responsibility as unfair. Elizabeth told me: 'I don't know, I just think blokes get away with it, the whole thing quite easily'. Jenny expressed similar thoughts: 'It's complete unfair, you are doing something to your body to save them, I mean they don't have any responsibility, he doesn't have to think about it, I mean its cheaper, its free, you don't have to worry about it. ... [They] are getting all the pleasure and none of the pain, this is completely unfair'. For them naturalised sexual differences in reproduction made women responsible for contraception. Tina told me: 'I certainly wouldn't leave it up to the man, even something as simple as a condom or the male pill, forget it. I am not saying my current partner is irresponsible but it'd be me carrying the baby for nine months, not him. He might forget as it is not so urgent for him them. It's not the same pressure, it doesn't physically affect them'. Fiona echoed this: 'I never trusted men because they are not the ones living nine months and eventually having a baby and it is much easier to walk away ... Men see it a different way. They don't have the fear to have an abortion or

study claimed that they decided when to change while a third alleged that their partners decided and a few suggested that they jointly decided.

anything like that because they will never experience it. So should it be equal? Probably but it can never be by its nature. Women are stupid not to get involved’.

This distrust of men’s ability to take contraceptive responsibility was also expressed in comments about the male pill. One respondent told me: ‘You never trust the guy to take it [the male pill] you need to have that, it comes back to control that you would not trust anybody else to be responsible for something that would affect you more than anybody else eventually’. Another respondent echoed this: ‘I think if there was a male pill that would be good, I think they are doing trials, but I just wouldn’t trust them. Not that I wouldn’t trust him to not, but the consequences of him forgetting are so big for me that I would rather take control of it. I mean if there was some way that I could physically give him the pill, or inject him. If I could control it’. The biological implications of pregnancy translated into women’s naturalised responsibility for contraceptive and sexual practices in companionate relationships.

In the ideal trajectory of an intimate relationship a casual physical encounter could transform into an enduring companionate relationship. This transformation was both signified and facilitated by changing from using condoms to the pill. These contraceptive practices are congruent with the qualities of companionate relationships in which communication and sexual pleasure creates and sustains intimacy. The theoretical understanding of companionate relationships argues that the transformation of intimacy relates to the separation of sex, reproduction and marriage. My analysis suggests that aspects of this association continue to be part of intimacy, sexual pleasure and companionate relationships. Though symbolic and structural congruences between sex and reproduction can be potentially displaced in companionate relationships, this congruence was revalidated in their contraceptive practices through different references to reproductive intimacy. On the pill the association of sex and reproduction is revised in new ways to encompass companionate ideals and processes. In these heterosexual relationships, sex is a defining and distinguishing feature of companionate relationships because of its gendered association with reproductive intimacy. These emotive and messy contraceptive and sexual practices draw on both ideas of companionate and reproductive intimacy and imply that there is no complete transformation of intimacy.

Conclusion

In these accounts, more pleasurable 'natural' sex is the achieved outcome of deliberate contraceptive practice. Paradoxically, spontaneous, uninterrupted and 'natural' sex requires women to control, manage and plan for sexual intercourse and intimacy. The deliberate intervention required to achieve pleasurable sex, which the women I spoke to code as natural, and intimate relationships parallels women's efforts to achieve their natural destiny of motherhood as described in the previous chapter. Ideas about intervening in 'nature' to achieve 'natural' ends run throughout different social fields as the purported disruption of the taken-for-granted symbolic and structural congruence between sex and reproduction are connected in new ways through contraceptive practices. Like motherhood and maternal love, the connection between reproduction and sex requires deliberate planning and the strategic deployment of nature that draw upon and merges two ideologies of sexual intimacy concurrently.

Contrary to the assumptions of both public discourse and the theory of companionate relationships, sex on the pill does not separate sex, reproduction and intimacy but rather reconstitutes it in new ways. The accounts of contraceptive practices and sexual intimacy collected in this study suggest that this purported neat transformation of intimacy is actually more complicated in practice. These women draw on both reproductive and companionate cultural ideals, expressed through their contraceptive practices. Sex on the pill incorporates the increasing emotional and sexual intimacy of companionate relationships as well as retaining the association between sex and reproduction.

Similar to the analysis of achieved motherhood, a closer reading of sex on the pill reveals that women have mixed goals, drawn from different ideals which are shaped by the context in which the decision to take the pill occurs. The pill is used in such a way to manage mixed goals by introducing a degree of control and choice into previously taken-for-granted processes and a better balance between competing expectations. Yet this process, like pregnancy, displaces the symbolic referents that define their goals and they employ particular renaturalisation strategies to alleviate this disruption. In regards to sexual relationships, these strategies emphasise those aspects of the pill that integrate the sexual values of companionate relationships with conventional assumptions about

reproductive intimacy. Within these contradictions, the pill is used to manage the conflicting expectations in their sexual lives.

The previous chapter focused on how certain conventions of femininity, namely pregnancy and motherhood, are reworked and redefined in contraceptive practices. In this chapter, I have explored how the various possible meanings of sex and intimacy described by the respondents reveal the alterable nature of the 'natural' facts of sex and reproduction. These two chapters illustrate the different ways the respondents used the pill to manage the conflicts of natural femininity. The accounts of pregnancy and sex share a similar logic that a degree of control and choice, enabled by the pill, is introduced into previously taken-for-granted 'natural facts' yet the two continue to coexist. The next chapter illustrates how a similar logic also applies to menstruation.

Chapter Six

The Pill and Menstruation

Menstruation is part of the female reproductive cycle that starts when girls become sexually mature at puberty and continues until menopause when the monthly menstrual bleeding stops.¹²⁰ The amount of blood lost and the length of the bleeding varies as does the degree of discomfort.¹²¹ Fewer pregnancies, childbirths and shorter periods of breastfeeding in Western Europe have made menstruation and menstrual discomfort a regular feature of many women's lives.¹²² For the women I spoke to, this private physiological process occurred within the public settings of daily life.

The women who participated in this research were aware, either explicitly or experientially, that the pill affected their menstrual cycle and gave them the capacity to predict their periods as well as to alter and suppress their menstruation at will. Beatrice, an occasional pill user, described how by using the pill she could manage her menstruation:

So that is one of the nice things about being on the pill actually, I can control the beast of my periods, I don't have cramps, I can say, 'I don't want it today,' I can carry on the pack. Say I am going on holiday and I really don't want to have a period. So that is actually a very big reason for being on the pill because I can control what has been in the past been a complete random chaos really.

She compares the convenience of controlling her periods on the pill to coping with the random chaos of the unmedicated 'beast'. These effects of the pill on menstruation are, for some, the primary reason for taking the pill; for others this is simply an added benefit alongside contraception.

In this chapter, I discuss how menstruation was considered undesirable, disruptive and inconvenient by many of the women I spoke to. I then examine how they felt about their

¹²⁰ During this time, menstrual bleeding occurs approximately every twenty-eight days unless a woman becomes pregnant or is breastfeeding. The menstrual bleed, from the uterus via the vagina, is composed of the endometrial tissue and blood produced as the endometrium detaches from the uterus.

¹²¹ There are several common problems associated with periods, including pain (dysmenorrhoea), heavy bleeding (menorrhagia), and skipped or missing periods (amenorrhoea). Menstruation is, therefore, a regular defining feature of adult female life.

¹²² See Van de Walle and Reine (2001) and Snowden and Christian (1983) for accounts of cross-cultural variation in the patterns and perceptions of menstruation. Much of this research into cross-cultural

periods and how they use the pill to optimise the practicalities of their periods, a unique feature of the pill that distinguishes it from other contraceptive methods. Yet the majority of the women I spoke to chose to continue to menstruate despite the fact that they could use the pill to suppress menstruation. Here I will relate these practices to the earlier analysis of sex and pregnancy where future-oriented parental and intimate aspirations shape pill use and examine how the pill was integrated into these women's daily working bodies.

Menstruation as Disruption

I met Karen, a tall, slim, attractive 42-year-old wearing a figure-hugging dress, in a fashionable café off Carnaby Street. After we had sat down at a secluded table, she explained why she had contacted me. She had recently met with her friend, Kate, whom I had met through the Pyke, who told her about our conversation and she had realised the great difference in their experiences. Though similar in many respects – both high-earning senior professional women in London's thriving media industry in their late thirties to early forties, living alone and pre-parturient – the two friends had had different experiences on the pill. Each time Kate had taken the pill she had experienced side-effects that eventually caused her to stop. Karen, on the other hand, found it wholly positive and life-enhancing and had consequently taken it continuously for twenty-two years. The difference between these two long-standing friends was only revealed to them through this research, which again points to the fact that even close female friends may not routinely share their contraceptive experiences with each other.

Secreted away in a corner, Karen told me her story. She had started to menstruate at the tender age of nine; she was the first in her class at school to do so. As well as having arrived early, her periods were extremely heavy. She told me what they were like: 'If I knew that I couldn't get to a loo within two hours of having just been to the loo, I would have to double up, two tampons or tampons and a sanitary towel. It was horrific'. They were also erratic: 'My periods were pretty random before, they could come at any time; I would have two in one month, not very often but occasionally'. In her descriptions she was describing her experience of menstruating as unpredictable, 'horrific' and having

patterns of vaginal bleeding has been undertaken as part of studies to assess the acceptability of contraceptive methods.

negative effects on how she lived her life, and so needing substantial efforts on her part to control it.

She recalled how her periods impacted on her daily life:

All the girls when they had their periods, they all wore their tight trousers, light colours, everything, all the time. For example, now if I had been meeting you now, at this point, I wouldn't be wearing this dress for a start. I probably would have worn something dark. I would have wanted to know specifically how long we would be so I could know if I could get toilet breaks and all that kind of stuff.

She describes how, in order to cope with her horrific periods, she controlled other variables, such as what clothes she wore, where she went and for how long and a host of other considerations. In these comments, she expresses how her random heavy periods required extensive logistical management, prevented her from doing many ordinary things that her peers did, and so brought with them an accompanying sense of abnormality.

She vividly expresses how she copes with the sense of abnormality brought about by heavy periods:

I was convinced that my heavy periods meant that there was something wrong with me. I read somewhere that the average woman during her period loses a tablespoon of blood, which made me feel even more abnormal. I just thought there is no way, that is a litre, there is no way, whoever said that is lying. I think that now but at the time it made me think I was completely abnormal.

Her periods made her feel 'something was wrong' and not like the 'average woman' whom she thought did not share these problems. From the age of nine until she was nineteen Karen's periods limited her choices, made her feel different and she had to adjust her life in order to cope.

In the eighties, at the age of nineteen Karen had a routine medical examination as part of a new job and discovered that she was severely anaemic. One cause was her heavy menses and her haematologist accordingly recommended that she take the pill. She describes the radical change in her periods and her life more generally:

I felt like a normal human being. Instead of having all these barriers that were stopping me from doing things, now I was like everyone else, not superhuman, but now I am like everyone else and now I can live my life like everybody else.

The pill had a marked impact on her periods and changed the way she lived her life. Taking the pill made her 'normal', an 'average woman', because she no longer had to cope with her disruptive periods. They were no longer a 'barrier' and she could be like 'everyone else'. In addition to regulating her heavy menstruation, the pill improved her skin and, when she became sexually active at the age of twenty-eight, it also proved an effective form of contraception. Karen was continuously on the pill until the age of forty-one, over half of her life until then. Over the last twenty-two years she has come off the pill twice, only to discover that her horrific periods and concurrent sense of abnormality returned.

Tania recounted a similar story. A continuous pill user for nine years, she recalled how her periods before the pill had been extremely painful: 'I used [to] describe it as Freddy Krueger's hand coming into my stomach and squeezing on my womb. Basically that is what it was like. It was really, really painful'. In comparing her pain with the actions of a classic horror film character, she describes her period as an external, supernatural force that took her over. When she went on the pill for contraceptive purposes, she found that it did not have to be like that: 'Having one amount of hormone the whole time might make me normal so I can be like Jessica, who has a regular period ... When you say period, you think pain, you think uncomfortable, all these kinds of words, and it doesn't necessarily have to be like that, I just never thought about it before because of all the associations that come with it'. Her supernatural period had made her feel abnormal and different from her friends, but by taking the pill she had 'regular' periods and could be normal. On the pill, she no longer associated her periods with discomfort and being abnormal.

Isabella, a 28-year-old communications manager at a national charity who attends the Pyke also started to take the pill in order to regulate her 'really disruptive' periods. She remembered how at the age of fifteen she went to a party and had to go home early, embarrassed and upset because her clothes ended up stained with blood. She explained that:

From the age of thirteen to eighteen I had seriously irregular periods and it just became something that made me feel like I couldn't always go out because I didn't know, it could sometimes be really painful and it could sometimes be really heavy. It wasn't that I couldn't. I just felt very self-conscious and I didn't want to end up in a situation that I was staying at a friend's house and had really bad pains.

She describes a sense of menstrual shame alongside the pain that prevented her from doing normal things. All she could do to cope was to curtail her social life. She then told me how taking the pill had changed this: 'You don't feel like you have to stop doing something and I very rarely get period pain now. So I suppose that is a kind of independence and being in control, I am a bit of a control freak'. She felt in control when she took the pill because she no longer needed to change her life to suit her periods. She also felt more confident and independent: 'So I used to worry about it a lot so when I went on the pill, it regulated it and the pain stopped so I feel much more confident'.

Late on a week night at her workplace at the Home Office, civil servant Kristen recounted how she had started to take the pill at the age of sixteen so that she did not have a period while on holiday and had then used it continuously for the next sixteen years. She recently came off the pill and detailed the resulting change in her menstruation:

A pain in the arse, isn't it? A real hassle. It is probably that slight worry that, have I just started? Better go to the loo to check, I am probably doing a lot more of that now than I am ever used to and most of the time it is nothing to worry about. I am carrying it [sanitary protection] in my bag wherever I am going out. If I am going on holiday, do I have enough with me if it comes on even if I am not due to come on?

The 'hassle' and worry of her period off the pill again affected what she could do since she has to go to the bathroom more, carry around sanitary protection and worry about her period unexpectedly coming on.

Jessica, Tania, Isabella and Kristen are a few of the women who mentioned painful periods as a serious problem in their lives. Approximately 50 women out of 67 women, roughly 73 percent, I interviewed mentioned some kind of menstrual discomfort as a constant concern and consequently took the pill to address it. These illustrative accounts indicate how these women see their periods as problems and hassles that cause

discomfort, disrupt everyday life and require adjustments to normal activities. The uncontrollable force of menstruation was seen as limiting them, causing them to have to take time off from work, disrupting work in order to go the loo more frequently, affecting clothing choices and social activities and making it impossible to sit through a three-hour lecture. In order to cope they adapted their activities around their unpredictable periods. For these women with troublesome periods, menstruation was a source of shame, worry and it made them feel less confident and in control of themselves and their lives and therefore different from average women. In contrast, when they started to take the pill they found 'life was easier', periods were not 'an issue', they didn't worry, they could do 'stuff', they had no 'barriers' and they could be normal. Taking the pill made them feel confident and independent; it put them in control.

'Controlling the Beast'

The oral contraceptive pill, both in its combined and progesterone-only versions, is a known and medically-recommended method for regulating menstruation.¹²³ A typical physiological effect of taking the pill consistently is a standard 28-day menstrual cycle with a predictable, shorter, lighter and less painful 'withdrawal bleed'. Active pills are taken for twenty-one days followed by a pill-free week and a predictable frequency, flow and length of lighter, less painful withdrawal bleed.¹²⁴ Pill-assisted regularity and predictability allows for an unprecedented degree of accuracy in predicting the onset of their periods for the women who take the pill.¹²⁵ Moreover, by taking active pills they can adjust the onset and length of their periods, or even completely suppress them, at will. The opportunity to adjust and suppress menstruation makes the pill truly unique and irreplaceable amongst contraceptives, as all other easily accessible methods of 'modern' and 'traditional' contraception lack this feature.

¹²³ The active pills introduce sufficient levels of oestrogen and progesterone in the bloodstream to prevent uterine bleeding and the reduced intake of hormones in the pill-free period causes the shedding of the uterine lining, a 'hormone withdrawal bleed' (Guillebaud 2004).

¹²⁴ This applies only to the combined oral contraceptive pill. Progesterone-only pills induce little or no bleeding.

¹²⁵ When the pill was initially approved by the US Food and Drug Administration in the United States (FDA) in 1957 it was as a treatment for menstrual disorders; only later was it approved as a contraceptive. The pill is often prescribed to treat menstrual disorders, particularly the irregular, painful and heavy periods experienced by adolescent women. The Patient Information Leaflets indicate the benefits of taking the pill in relation to menstruation, particularly in terms of producing a regular, lighter, shorter and less painful period.

The two previous chapters outlined how many women in this study took the pill when they were sexually active because they wanted to have pleasurable sex and plan motherhood. Most did not intentionally start to use the pill to regulate their periods however once they experienced its effects on menstruation this became an additional benefit. They frequently commented how they had regular and predictable periods on the pill, and continued to use it when they were no longer sexually active or had pregnancy anxiety because of this effect.

I met Sita, a 22-year-old law student, through the Pyke. She recently started taking the pill after becoming sexually active with her long-term boyfriend to address her pregnancy anxieties but was delighted by the effect on her periods. She told me: 'It is really convenient in terms of being able to control your cycle. Once I saw it working for my friends I thought it might work for me, it might be worthwhile checking it out. It was convenient and also, obviously, for the contraception as well'. She defines convenience as knowing when she would menstruate and being able to prepare, for example, she said, 'I was really irregular before and so preparation wasn't always spot on. So it's very convenient in that sense'. On the pill, she knew when her period would start and what was previously irregular and disruptive became predictable and hence manageable.

Nancy, a 25-year medical student, started to take the pill after using the morning-after pill. Like Sita, she was pleasantly surprised by the effects on her period: 'Before I did not realise that my periods were quite heavy, it was just something I coped with because I have always had heavy periods but I never really realised it. I have noticed my periods have been a lot lighter. I also know when they coming up, when my periods are about to come on'. When she started on the pill she questioned what she had previously taken-for-granted and realised she could change it. Like many others, she liked the ability to accurately forecast her periods:

When you have your seven day break, I always know that after I have finished the last of the pack, my period usually comes on about three days after. It's good when you have sanitary towels and tampons handy. I remember once before when I went on my period unexpectedly while on holiday and it wasn't a very pleasant experience.

The ability to know exactly when she will start her period allowed Nancy to be prepared with sanitary towels and thus avoid unpleasant or embarrassing experiences. These

experiences of taking the pill illustrate how these women moved from coping with to managing menstruation once they knew when they would start their periods. Because of this beneficial effect on their menstruation, Sita and Nancy plan to stay on the pill even if their relationships end.

For the last six years Jessica, a 22-year-old temporary worker in Central London, has been taking the pill. Like many others, she had started to take the pill as a contraceptive but stayed on it because of the effect on her periods. She noted how she could precisely predict her periods on the pill:

I start taking it on a Saturday always, if I started messing with that, that would screw it up. Finish it on Friday and start taking it on the Saturday. I start to bleed on the Sunday night, Monday until sort of Friday or Saturday, sometimes Sunday, but I take the pill again on the Saturday.

Jessica values this precision because, she says, 'I like that I always come on on the same day. I would hate not to know when I was going to come on because I like to be prepared. That's a definite benefit, that's one of the reasons, when I've broken up with a boyfriend, even if I was single for two years, I would stay on it because I like that I know when I am going to come on, yeah'. Again, menstrual regularity and predictability generated by taking the pill are considered beneficial by nearly all the women who use it regardless of their experiences of menstrual discomfort.

The majority of the women in this study valued the fact that the regulated menstrual cycle produced by taking the pill means they can precisely anticipate their periods. Francis liked the pill because she 'like[d] having that routine, it's easy. You kind of know, oh look, it's the last one in the packet, I can tell what is going to happen next'. Kristen has 'always relied on the pill and the periods have always come at the right time'. Donna 'could kind of almost, not to the hour, but predict it, like on Tuesday afternoon I am going to come on and which is quite handy as you are never caught short'. On the pill they could forecast, schedule and 'work around' regulated periods which then became less hassle and worry. Kate explained the benefits as 'being more confident with what you can do and having a bit more control'. The precise predictability described by these women allowed for an unprecedented degree of anticipation, preparation and a sense of confidence.

When coping with their menstruation they were concerned about not being prepared, while when managing their periods through pill use they emphasised their ability to prepare. This raises the question of why they are so concerned with menstrual preparation. Menstrual predictability and preparation were considered necessary by these women for managing menstruation in their daily lives. Here I will explore how their desire for predictability and consequent preparedness reveal cultural values associated with menstruating bodies and related codes of conduct. These women did not share any set proscriptions on the social interactions and physical activities they could undertake while menstruating, nor were they excluded from studying, working, exercising, socialising, having sex, cooking and so on. However, they were constantly concerned about how to manage their menstruation in these different circumstances. Though they did not identify proscriptions, their concerns about preparation suggest they were affected by cultural norms and codes of conduct related to menstruating bodies. Kissling (2006) argues that these ideas are apparent in advertisements for feminine hygiene products that provide a normative ideal of menstruating bodies and menstrual conduct.¹²⁶

My own analysis of these advertisements shows that the ideal menstruating body conveyed to viewers appears not to menstruate at all. They focus on how these products conceal any externally visible signs of menstruation in order to make it appear as if the body is not menstruating. Television and print media advertisements, sanitary product packaging in general and the websites of four feminine hygiene products companies (namely Tampax™, Kotex™, Always™ and Lil-lets™) provide ample evidence of this. These various media all highlight the products' qualities of being neat and discreet. This phrase, 'neat and discreet', refers to both the efficacy of the product and the product itself. The first level of discretion refers to the products being tailored to female bodies, as in such phrases as 'body-fitting', 'natural shape' and 'fit your body perfectly'. This second-skin quality serves a dual function, firstly in preventing the product being used from being visually discerned and secondly, as Always proclaims, 'the better the fit, the better the protection'. This is 'protection' from the risk of exposure – from others knowing that the body is menstruating. The message is the need for protection and concealment, which corresponds with the implicit sense of menstrual shame expressed

¹²⁶ Menstruation is not necessarily included in the sexual education curriculum as there are no mandatory modules in which it is included, just loose guidelines. Sexual education only became compulsory in British schools in 1992. Previous to that it was discretionary and often covered in biology classes.

by these respondents.¹²⁷ The threat of possible exposure and consequent embarrassment has the curious secondary level of discretion that results in the products themselves being camouflaged through colourful packaging and being 'easy to dispose of'. In a 2007 Kotex™ television advertisement, the viewer watches a red dot move across a black and white backdrop of women's faces. The visual is accompanied by a female voiceover which says:

We women love to share, but not with the whole world.
Case in point, periods.
That's why Kotex only makes quiet pad wrappers.
Remarkably rustle-free.
Could be the best news you'll never hear.
Kotex fits. Period.

Women do not want to 'advertise' the fact that they are menstruating. 'Rustle-free' products can achieve this by concealing the obvious signs of menstruation but by also concealing the fact of their own use, which would otherwise give them away. It is interesting to note that that the pill facilitates increased knowledge and intimacy in the case of sex, yet is secretive and even alienating in relation to menstruation which suggests that menstruation remains more taboo than sex.

These advertisements display three recurrent ideas: firstly, that menstruation should not disrupt normal activities; secondly, that menstruation should be concealed and discreet; and thirdly, that menstruation can be managed and is not something that has to be passively endured. According to the advertising, with the right products menstruating bodies can be managed and women can have 'confidence and control' – even on those 'up-and-down days' (Kotex). Menstruation is, then, private, something to be concealed and managed, something that should disappear into the background and not affect normal performance. This translates into implicit rules of conduct in which women are responsible for managing menstruation in a 'neat and discreet' fashion using the available products.

The accounts presented earlier illustrate the difficulty in upholding ideal menstrual conduct as these women worried about being caught unprepared, without sanitary wear

Consequently the women in this study would typically have received formal education about menstruation only as part of the biology curriculum in their secondary schools.

¹²⁷ For work examining the causes of menstrual shame and concealment see Rezvani 2005; Roberts et al. 2002.

and painkillers, by a period. Their worries were about being exposed as menstruating women by stained clothes, obvious discomfort or changed behaviour such as frequent bathroom breaks or days off, as well as the disruption to their normal routines.¹²⁸ These consequences of unregulated menstruation make their desire for accurate menstrual predictability and need for preparation (made possible by the pill) understandable.

As a technique of menstrual management, the pill meets and surpasses the requirements of the implicit code of menstrual conduct by allowing women to be able to predict exactly when menstruation will start, accurate to within hours. This high degree of predictability, with the added benefit of a lighter and less painful period, enabled women to be prepared and therefore to conduct themselves appropriately. On the pill, women could conceal any sign of their menstruation in a neat and discreet fashion as external signs of menstruation, such as heavy bleeding that required changing planned activities, pain that forced them to take leave from work or mood swings that made one difficult to deal with, were removed. The pill was used in such a way as to ensure appropriate menstrual conduct, by masking any sign of menstruation so that it appeared as if they were not menstruating. The pill, like sanitary products, made appropriate menstrual conduct and the ideal menstruating body easily achievable by ensuring regularity and predictability, a pressing concern for these women who are active in the public sphere.

Optimal Periods and Working Bodies

The pill does far more than generate a predictable period, by adding active pills to the set regimen, the length of the menstrual cycle can be extended and the onset of periods delayed. A popular practice is to run two blister packs of active pills back-to-back, thus omitting the pill-free interval and avoiding the withdrawal bleed altogether.¹²⁹ This is often referred to as ‘bicycling’ (two packs, back-to-back) or ‘tricycling’ (three packs, back-to-back).¹³⁰ Sometimes additional pills from another pack can be added to extend the bleed-free interval as desired. I will use ‘cycling’ to refer to this general practice

¹²⁸ What remains unclear from the adverts and the accounts is why, exactly, menstruation must be concealed.

¹²⁹ The pill is often used ‘off license’, i.e. in ways not prescribed or approved by the relevant medical practitioner and not in adherence with the set uses and directions specified in the national medicine licensing outlined by the British National Formulary and found in the patient information leaflets.

¹³⁰ ‘Cycling’ is sometimes suggested by medical professionals for the treatment of certain medical conditions; otherwise consumers adopt the practice for planning purposes in order to shorten the pill-free interval or to cease menses altogether.

from now on. The ability to time the onset of menses is historically unprecedented prior to the pill. In the past it was possible to induce a delayed menstruation with emmenagogues, substances that provoke and stimulate menstrual flow, but not to directly determine its onset.

Approximately a third of the women I spoke to use the pill to conveniently time the onset of their periods. Teresa explained how she used the pill to time her periods to fall mid-week: 'I do organise the dates I start and finish so the period always starts in the middle of the week, not on the weekend. I have done that for years, it's always started on Monday or Tuesday. I take my last pill on a Friday'. She said she did this: 'Because, weekends, you never know what's going to happen on weekends. When I was in a relationship I only ever used to see him at the weekend so there is no point having my period in one of four of those weekends I see him, I'll start during the week'. She wanted her weekends free of menstrual interruption and for the last ten years she had started her active pills on a Saturday to ensure that her period ran from Tuesday to Friday. Teresa said: 'It always seemed more sensible to me to have a period during the week than on the weekend. Since you have control over it'. With the pill she could control and sensibly plan her periods to improve her personal life. In contrast, Kristen timed her periods to fall on the weekends so that they did not disrupt her at work. She told me:

I roughly knew that Friday nights, it was quite good because it was late Friday night and so I would get most of the pain over the weekend. So by the time it came to the Monday, not very good for your weekend, but in terms of not having really bad period pain when you're working, it fits in quite nicely.

Kristen similarly controlled her periods to suit her activities, but she wanted to enhance her professional performance. Teresa and Kristen both used the pill to ensure that the hassle of periods fell at a time most convenient for them.

Elizabeth also praised her new capacity to determine when she menstruated: 'With the pill if you want to adjust your period you keep taking it or whatever, you know when your period is going to be, it's going to be every month. I mean the pill is good for that [timing onset], if you go away you can extend your pill-free break and move it backward and forward'. Not only were her periods predictable but she could schedule them for the most suitable time. She explained why this capacity was important for her:

‘Quite good really, my calendar gets quite fully quickly and having to adjust it around your period. I wouldn’t do that either because I couldn’t cope with that as well as meet all these people and do all these things, but the fact that you can extend your period to when you need it to be is good’. She had little time in her calendar for a disruptive period, and therefore had to plan her period for the most suitable time. Betty made a similar observation: ‘I like being able to schedule my life accordingly. Like you are going on holiday, I will sometimes take two packs with no break, especially if I am going away. I like the fact that I can control that ... it seems to control everything I need it to control ... I just prefer it, it is one less thing you need to think about’. On the pill, periods were no longer inevitable and unpredictable but rather an event to be scheduled around their activities and priorities.

Some occasionally adjusted their menstruation around pre-planned activities. For example, Beth ran her active pills together when she saw her long-distance boyfriend: ‘Obviously I don’t want it when I am with him’, as well as for holidays, work or just when she felt like it. She told me: ‘I feel more liberated to it, I should probably do it more often’. She described this capacity to determine the onset as a form of liberation. Donna simply cycled when she ‘didn’t want the hassle of dealing with a period when I didn’t have to’. In a few cases, some women choose to completely suppress their periods for an extended period.¹³¹ Kristen decided to ‘cycle’ in order to menstruate just four times a year. She said: ‘I thought, this is wonderful, all my, not all, problems will be gone. This will make life so much easier ... no periods whatsoever, no having to worry about having your day off, because you take your three packs for every three months, you don’t have to worry about it’. She told me: ‘I wouldn’t put up with all the bleeding. I wouldn’t put up with pain’. Having fewer periods is ‘less hassle and easy’ as she did not have to adapt to them.¹³² Mary told me that she had not menstruated since 2003 and that she loved not having periods:

Periods? It was like volunteering for a period, that’s not good. Pills are free, sanitary towels and tampons cost money, simple budgeting. It was, I had forgotten sometimes to come back off the break, you know, it was just more

¹³¹ In 2003, the FDA approved a new oral contraceptive pill for the market in the United States that markets itself as an ‘extended-regimen of birth control’: ‘But SEASONIQUE offers something that your typical monthly pill can’t - more time between periods. Designed by a woman doctor, FDA-approved SEASONIQUE™ is a unique extended-regimen birth control pill. With SEASONIQUE™, you take 1 pill every day for 3 months instead of 3 weeks ... You should get your period the last week of the pack - that’s once every 3 months, for 4 periods a year.’

¹³² Due to the side-effects of ‘cycling’ Kristen subsequently came off the pill and her disruptive periods returned.

convenient. You don't want, it's something we have to live with as women, but if we can avoid it, do it.

In adjusting the onset or suppressing periods, these women could select and determine the inconvenience of menstruation and their periods thereby become a question of choice. Instead of scheduling their activities around their regulated periods they could schedule their periods around their priorities.¹³³

Whether using the pill to regulate menstruation, occasionally suppress it or very occasionally completely suppress it, there are commonalities in these efforts to ensure that menstruation was appropriately and conveniently planned and timed within these individuals' social and personal lives which overrode any possible concerns about the negative medical consequences. By taking the pill, uncontrollable and unpredictable periods could be managed and adjusted to suit personal, social and professional requirements and thereby to achieve culturally desirable discreet, short, painless, regular and unnoticeable menses to be undergone at convenient times and places. Similar to the practices of motherhood and sexual intimacy, on the pill menstruation could be *optimised*. The women I spoke to chose to optimise their periods to suit their priorities and lifestyle and to have hassle-free lives, free from the inconvenience and vigilance required for appropriate menstrual conduct. I refer to these practices as 'optimising' because they are using technologies as interventions to secure the best possible future and optimal state, not to treat illness or medical conditions (Rose 2007:6).

These accounts of menstruation on and off the pill show how the women in this study managed their menstruation and menstrual conduct in relation to the demands of their lives. This parallels Emily Martin's (1987) cultural analysis of menstruation in the US in which much of the discussion around menstruation centres on how to cope with a private function in public settings. Martin argues that many women see modern public spaces, such as schools and work places, as incompatible with menstruating bodies as they constrain women's movements and options. Similarly, a 2006 survey on menstrual suppression in the United States found that women view their periods as an

¹³³ Menstrual management is not new and has historical precedents in Western Europe (see Von de Walde and Rienne 2001; McLaren 1984). Many women, at present and in the past, have acted to effect menstrual regularity in order to regulate fertility, to stimulate delayed menstruation and/or address menstrual disorders. Yet what is considered regulated fertility or an orderly menstruation, what defines what activities and interactions women can and cannot undertake and what is the corresponding menstrual etiquette are socially and historically determined because every woman's cycle varies in length, quantity, consistency and relative discomfort.

inconvenient nuisance, as they felt it interfered with daily life and placed them at a disadvantage in society in relation to men (Greenberg and Berkold 2006). Martin argues that in relation to menstruation, there are parallels drawn between political economy and the image of the female body which have brute consequences for how bodies are perceived and treated. She describes how popular, medical and self understandings of the body are shaped and constrained by industrial tropes and productive metaphors of the prevailing political economy, such as menstruation as a 'wasting' of reproductive production.

Similarly, I suggest that the pursuit of regulated menstruation reflects more than an exulted assessment of choice— it was a necessity of public life. Taking the pill was seen as a material prerequisite in order to work and to be feminine. For instance, Francis, a theatre production professional, explained how her periods impacted on her working life. When she has her period 'all the pain comes on and being uncomfortable and I always need the toilet more. It's always a bizarre thing, I always need the toilet more I suppose it's like your body is cleaning your system out properly. It's a good thing. But a real pain if you're in a tech week, it's really difficult. I am sure every job has it'. She explains how it was difficult to deal with her menstruating body in relation to the requirements of her job. She detailed the practical aspects of this tension between menstruation and work: 'In my job ... I can't get to the loo that often'. Isabella echoed this conflict in more detail: 'You are often in very restricted environments, my job used to be really strict about what hours you had to be in and when you are in uni, you were in lectures for three hours at time. So just that inflexibility makes you want to be more in control'. For these women, the demands of working life were at odds with those of their menstruating bodies, and they used the pill to adjust their periods accordingly.

Teresa, who had used the pill continuously for sixteen years and earlier described how she timed her periods to improve her personal life as she moved in and out of sexual relationships, described the benefits of predictable periods in her working life. She told me that when she takes the pill she is barely aware of her period and does not 'worry about it at all'. Also she can precisely predict when she will menstruate: 'completely, sometimes to the hour. Two forty-five on the fourth Tuesday for a while'. She told me: 'It just starts on the same day, like I say there's a tiny bit of pain but nothing, awareness even rather than pain. So I don't think about it so it's one less thing to worry about in life, so if I can manage by taking the pill then that is fine by me'. On the pill her periods

became one less worry that she ‘can work around’ and control their impact. This was important to her because as a freelance journalist she ‘can’t be doing with having to worry about my periods being heavy and not knowing when it’s going to start and all that stuff’. In this way, she ensures that her private bodily experience does not conflict with her public role. For many of the women in this study, managing menstruation involved dealing with periods within their professional lives and their deliberations and planning involved considering available sick leave, permissible bathroom breaks and the inconvenience of attending to a menstruating body.

As discussed in the Introduction, the women presented in this research represent a specific social demographic that emerged due to recent changes in the British political economy. The Equal Opportunities Commission (2006) has noted an increase in women’s education and professional participation – 70 per cent of women of working age (16-59) are now working compared to 60 per cent in 1975. It is important to note that recent studies have found that gender continues to structure employment patterns and practices (Perrons 2007). In the UK, 57 per cent of women use alternative work arrangements such as part-time, flexitime, annualised hours, term-time working and job-sharing, compared to 9 per cent of male employees. In 2005, the full-time gender pay gap was 17.1 per cent; it was 38.4 per cent for part-time. These discrepancies persist despite women’s increased and equivalent education to men and anti-discrimination laws. Though women’s access to education and employment are safeguarded, the workplace still remains resistant to female bodies. For example, paid maternity leave in Britain is eighteen weeks and childcare provision in the United Kingdom remains the most limited in Europe (Perrons 2005). The working week and working space are not structured to accommodate the female bodies that require toilet breaks, leave for PMT and menopause or flexibility to get contraceptives during working hours. The majority of the women I interviewed hold higher education qualifications and were established or aspiring professionals and some had positions of influence and had moved to London for educational and/or professional advancement. The women who did not have established (or aspired towards) professional positions were coping with difficult circumstances such as recent migration to the United Kingdom or being single working mothers. In all cases, the threat of uncontrollable menstruating bodies was perceived to be professionally damaging and costly. Particularly in a context in which these women could not necessarily depend on the material support of their kin network, but expected to be financially independent.

Feminist theorists have argued that the public space of work privileges a particular form of embodiment – the disciplined body. This type of body is ‘highly controlled or regimented, lacking in desire, isolated in its own performance and disassociated from itself’ (Witz et al. 1996: 175). There is no space for disruptive and unruly bodies that unpredictably menstruate, procreate and lactate. Therefore, at work female bodies are ‘ruled out of order’ (Bordo 1993) in a way that male bodies are not. Joan Acker (1990) argues that organisational structures, rules and procedures that appear gender neutral obscure the embodied, and, therefore, gendered, nature and experience of work. Acker maintains that ‘gender is difficult to see when only the masculine is present ... Since men in organisations take their behaviour and perspectives to represent the human, organisational structures and processes are theorised as gender neutral’ (1990: 142). The ‘abstract job’ (Acker 1990) and the accompanying abstract worker, the building blocks of organisational structures, procedures and practices, appear gender-neutral and yet are premised on a normative idea of controlled, masculine embodiment. Building on Acker, Witz et al suggest that:

These masculine characteristics are normalised and presented as gender-neutral desirable characteristics of ‘organisation’ (thus shaping organisational design and practice) and of organisational employees (thus shaping organisational expectations of those workers). This gender-embodied sub-text underlying organisation means that men are more likely to (and/or more likely to be perceived to) match the (embodied) requirements of bureaucratic organisation far more closely than women do. (Witz et al. 1996: 175)

Jessica Roberts (2008) extends these arguments by proposing that the implicit ideal of the masculine worker makes the workplace an agent of discrimination, as the average work environment accommodates the average worker, who is male.¹³⁴

In her study of temporary employment provided by a multinational temporary-help company in Japan Gottfried argues that ‘Bureaucratic organisations validate and permit forms of male embodiment and invalidate or render impermissible forms of female embodiment’ (2003: 259). Bordo’s states in her study of obsessive body practices of contemporary culture (such as cosmetic surgery, obsessive dieting and physical training) in the construction of the female body: ‘Today, it is required of female desire loose in

¹³⁴ For example, some machinery is designed for the male body and the female body (since it is generally smaller) is therefore not capable of safely and efficiently operating this machinery and performing the related jobs (Roberts 2008). Yet other types of factory work are specifically aimed as female workers, with ‘small hands’ and ‘an eye for detail’.

the male world to be normalised according to professional (and male) standards of that world' (Bordo 1997: 208).¹³⁵ Therefore the workplace privileges controlled bodies and women must therefore control and transform their bodies, actively altering themselves to suit their structural working conditions. I argue that the menstrual management practices described here confirm the assessment of feminist analysts that women work within tacitly masculine structured workplaces and use the pill to relinquish all that makes them feminine, including unregulated menstruation, in order to better fit within this structure.

The women that I spoke to often mentioned the threat presented by and impact of their periods on their public and professional life – displaying their emotions in meetings, having unpredictable periods at work, at school or at parties. Rachel, who suffered extreme mood swings when she was not on the pill, recalled: 'Really having PMT, I think that is the biggest thing that people suffer with. I don't really suffer with that. Just emotional breakdowns, nothing major, well I suppose it gets quite major when people start doing it at work, reacting and swearing in a meeting. That can really affect your life'. Rachel saw her periods as a threat to the professional role she was expected to perform: 'I travel a lot with my job and my very busy period is between February and May, and I went on it [a new pill] in March. I knew I would be travelling a lot and I have to be on form; I can't afford to run a conference that is worth several hundred thousand when I have been sick all morning'. Rachel's found her menstruating body was incompatible with the bodily requirements of her work and she used the pill to change her body accordingly.

Emilia Sanabria's (2009) study of hormonal menstrual suppression in Salvador de Bahia, Brazil, argues that middle class women use menstrual suppressive hormonal contraceptives (such as the pill) as 'modern lifestyle' drugs that enable them to balance their professional and personal lives.¹³⁶ For Brazilian middle class women hormonal contraceptives were a form of self-control which they used in order to optimise the self and affect their social relationships. The women I spoke to similarly use the pill to optimise their periods according to normative ideals of the working body. They situate

¹³⁵ Witz et al. (1996) and Gottfried (2006) have noted that women work to achieve and maintain a particular kind of embodiment through self-presentation at work, for example in acceptable dress, body size and comportment, all of which are part of the tacit gender hierarchies that govern interactions in the workplace and highlight the material practices of gender embedded in organisational structures and practices.

¹³⁶ This was part of a distinct stratified discourse of womanhood that varied between low income and middle class women.

the management of their menstruating bodies within the material conditions of working life and they use the pill to discreetly manage and adapt their menstruating bodies. The optimising of menstruation with the pill highlights its pharmaceutical quality. In the next chapter I take a closer look at other ways women use the pill to optimise their bodies and how this affects their ideas about the body and the self.

Though the very real conditions of working life made taking the pill necessary, the women I spoke to did not model their body image around economic or productive metaphors suggested by Martin's earlier work on menstruation (1988). Rather they focused on how they related to their bodies such as generating necessary preparations, predictability, convenience and timing that corresponds with Martin's later work on flexible bodies. Martin (1992; 1994) argues that there has been a shift in the depiction and understanding of bodies towards a systems model that values flexibility, adaptability, fitness and multi-tasking paralleling the entrepreneurial values of the late capitalist economic system of flexible accumulation. The focus on individuals as a flexible set of resources, assets and capabilities places responsibility for personal well-being and performance on the individual which lends itself to self-management and self-improvement practices to maximise their potential. In the descriptions of menstruation described above, the women I spoke to clearly depict how they use the pill as a form of self-improvement to suit working conditions that require a distinctive body type.

The advent of increased female political, educational and professional participation resulting from over a century of struggle for women's emancipation has meant that women have made inroads into traditionally male spheres of work. The research participants in this study are well-educated, aspiring professional women who are engaged in the public space of work which only recently became accessible to women. Yet these spheres continue to be structured around a body coded as male, and changes to this have been slow. I suggest that for these women achieving menstrual control was necessary to participate in the public sphere of work, which is structured by ideas of gendered bodies (Fausto-Sterling 2000; Young 1990; Bordo 1993). In managing and adjusting their periods, these women who fully participate in 'traditionally' masculine arenas, can enhance their unruly female bodies toward a normative form of public embodiment.

Ambivalent Periods and Natural Femininity

The women that I spoke to complained about the pain, disruption and inconvenience of their periods and elaborated on the effort required to cope with, manage or adjust them. They praised the pill as they could regulate and optimise their periods within their personal and professional lives. These findings correspond with a survey undertaken by the Association of Reproductive Health Professionals that found that the majority of women, if given an option, would prefer less frequent periods, as periods were seen to place them at a disadvantage (seventy eight percent would choose less frequent menstruations and forty percent would prefer never to have a period) (Greenberg and Berktold 2006).¹³⁷ Regardless of their statements about the inconveniences of menstruation, the majority of women I spoke to (over ninety per cent), when asked, said that they would not use the pill to completely suppress their menstruation and would only adjust it.

Despite the hassle and shame associated with menstruation and the effort of managing it, for most of these women it simply did not 'feel right' not to menstruate. Teresa, the freelance journalist who liked her precisely regulated periods on the pill for personal reasons, rarely adjusted or suppressed them. She told me: 'I don't like doing that very much actually. Although I feel completely comfortable taking it and having a break, the odd time I have taken it straight through and I feel, I don't know if it's psychological or not, different. It doesn't feel quite right somehow. I feel alright, you know. I feel as if it's a sort of PMT type feeling or something not quite right to take a break from it [menstruation]'. She expresses a sense of unease about not menstruating. Many women felt that repeatedly missing or suppressing menstruation did not 'feel quite right' or 'proper' and 'a bit odd'. Jessica, who occasionally suppressed her periods when she saw her boyfriend, explained why she still chose to have her (regulated) withdrawal bleeds: 'It's good to have regular periods because then obviously it must build up a bit if you overlap. So it's just better to have normal periods. I mean when I overlap they are not heavier, they are the same but it's better for me'. For her, having regulated periods was better, healthy and normal.

¹³⁷ These findings are based on a web survey of 1,021 women aged 18-40 who had not had hysterectomies and were not trying to get pregnant.

A sense of disorientation also accompanied missing a period. Tania, a long-term pill user who also liked her regulated periods told me that she never ran the active pills together because: 'To miss a month would be like missing a day out of the month and starting the month a day earlier'. Fiona shared this sense of disorientation: 'I don't know, you hate it at the time but I guess when it was not happening I did not like it. You are measuring your life, another month, part of your life, isn't it? Not having that is a bit odd'. In a way, her periods were a way by which she marked the passing of time. Tania and Fiona were quoted earlier saying they like the predictability of their achieved periods and often optimised them yet they also felt menstruation was necessary for well-being and orientation. Again, the female body was linked to ideas of time and associated naturalised trajectories.

Above all regular menstruation was seen as an indication that they were not pregnant. Jessica told me: 'It's because I want to know I got my period, I want to know that I am not pregnant basically'. Heidi, who had had an abortion, explained that: 'In my head having a bleed means I am not pregnant, which I know sounds daft but I can't get it out of my head because I obviously did not want the child at the time. It petrifies me getting pregnant again and I can't quite get it out of my head. So I find with the pill, having a bleed, I know it's even a fake bleed, still having that informs me that everything is going as it should'.¹³⁸ Her periods reassured her that she was not pregnant, she did not need another termination and 'everything was okay', even though she thought it was 'fake'.

Menstruation was also associated with potential fertility.¹³⁹ Nancy told me about her 'personal worry':

[B]eing female, it feels quite unnatural stopping you periods and ovulation and sometimes I do have this, at the back of my mind, will this affect my ability to have children in the future? It is stopping ovulation, when I actually go off the pill to have children it might cause some kind of damage or some kind of harm to my cycle, but I don't think there is any kind of evidence, I am not sure, I think it is.

Adjusting her cycle was 'unnatural' and hence she thought it could affect her future ability to have children. Kate also thought adjusting her menstruation would damage her

¹³⁸ A FPA (1999) study found that pregnancy anxieties were associated with the onset of menstruation.

¹³⁹ Several studies have found that the absence of menses can be an indication of an inability to conceive, pregnancy or ill health (see Van de Walle and Renee 2001; Potter 2001; Snowden and Christian 1983).

fertility: 'Suddenly you start thinking, what am I doing to my body, what am I doing here, actually am I causing long-term damage and also fertility-wise am I going to do something to damage my fertility in the long run?' Menstruation was both an assurance that pregnancy had not occurred but also a sign of potential fertility.¹⁴⁰

The majority of women in this study adhered to the pill's set regimen with a regulated cycle and regular withdrawal bleeds and only occasionally suppressed their periods. They chose the discomfort, potential embarrassment and effort (particularly that required to maintain appropriate menstrual conduct) that this involved because they considered periods to be a sign of health and fertility as well as an orienting feature of life.¹⁴¹ The association of well-being, orientation and fertility with regular menstruation differs from the menstrual shame related with ideal menstruating bodies and suggest the existence of multiple and ambivalent menstrual meanings for these women. Anthropologists studying menstruation have argued that such ambivalence is present further afield than the United Kingdom and not unique to the women in this study (see Buckley and Gottlieb 1988 edited volume).

Menstruation receives extraordinary symbolic and social elaboration (see Buckley and Gottlieb 1988; Van de Walle and Renee 2001) and traditional ethnographic accounts of menstruation have focused on the taboos and social prohibitions surrounding menstruating women's activities and interactions. Buckley and Gottlieb (1988) posit that these accounts generally adopt a 'menstruation-as-pollution theory', drawing on Mary Douglas's (1966) theory of pollution, which defines a pollutant as something anomalous and 'out of place' that disrupts the symbolic and social order. Such pollutants tend to be accompanied by prohibitions that attempt to limit their capacity for disruption. According to this theory, menstrual blood and menstruating women are polluting, potentially dangerous and therefore subject to prohibitions. Buckley and Gottlieb (1988) problematised the 'menstruation-as-pollution' theory by outlining cross-

¹⁴⁰ I would further suggest that situating menstruation within the life-course is also instructive here. Menstruation is often a sign that conception has not occurred, this being something that can be read either positively or negatively depending on pregnancy intentionality, the stage of the life-course and the nature of the relationship with the sexual partner (Luker 1975; Barrett and Wellings 2000; Santelli et al 2003; FPA 1999). Many respondents in this research described the irony of how they spent half their lives willing their period to come to signal that they were not pregnant and the other half willing their period not to come, thereby signalling pregnancy.

¹⁴¹ When the pill was first designed menstruation was completely suppressed. During the clinical trials menstrual suppression was often the reason why women discontinued use (Marks 2001). As a result the withdrawal bleed was built into the pill's therapeutic regime and has become the recommended practice issued along with the medical licensing of the pill (Marks 2001; Clarke 2000).

cultural and intra-cultural variation in menstrual meanings and practices, which they argue no single theory can capture. They maintain that the 'menstruation-as-pollution' theory does not take into account women's own perspectives and experiences and hence only provides a partial picture.

Qualitative studies of menstruation that incorporate women's perspectives show instead that women's interpretations of their menstruation are not wholly negative and, in fact, tend to have positive associations with health and fertility (see Fingerson 2006 and Martin 1987 for the US; Skultans 1988 for the UK; Buckley 1988). Emily Martin's (1987, 1990) examination of complex menstrual meanings in the United States illustrates how medical models of menstruation frame menstruation as something pathological – a 'failure' of the female body to achieve its reproductive purpose leading to waste and decay – yet these sit alongside a more phenomenological view in which menstruation is representative of a life change. Martin surmises that : 'Menstruation could just as well be regarded as the making of life substance that marks us as women, or heralds our non-pregnant state, rather than as the casting off of the debris of endometrial decay or as the haemorrhage of necrotic blood vessels' (1990: 80). These studies suggest that menstruation can be simultaneously polluting, dangerous and shameful, a sign of good health, a precondition for fertility and a symbol of natural femininity.

In their accounts, the women in this study had similarly complex and ambivalent ideas associated with menstruating bodies, which are demonstrated by their ideas about how to use the pill to manage menstruation. The physical and social effects of unregulated and regulated menstruation persistently appeared in their thoughts, concerns and actions and were a structuring feature of their lives, representing both a hassle and a valorised aspect of embodied life. It is this ambivalence, rather than concrete medical knowledge, that made women, who were aware they could completely suppress their menstruation, choose rather to simply regulate or adjust their periods. Like pregnancy and intimacy, menstruation is no longer taken-for-granted but a question of choice and an optimised achievement. Similarly, for these women, the question was not of whether to menstruate or not, but of properly planning, timing and preparing for menstruation.

Though menstruation was achieved on the pill, it was still considered 'natural'. Tania, who had been on the pill continuously for nine years, told me that achieved

menstruation was 'a natural thing to do'; she never adjusted her period because 'I never think it's worth it, I am screwing up my body, not screwing it, I am putting something artificial in my body so I have this set period. Having a period at the end is something I feel quite strongly about. Again it's a paradox, I don't think it's a natural thing to do so I have never done it'. For her it was not unnatural to take artificial hormones to have set periods but it was unnatural to not to have periods at all. Nancy had similar feelings: 'It feels quite unnatural stopping your periods', she said, and for this reason she 'achieved' them by having a withdrawal bleed. Sita explained to me why she liked the pill: 'Definitely being able to track that is really handy. It sounds silly, but I feel that it is almost wrong to be kind of, it felt wrong at first to be kind to be conveniencing your body, to be treating your body as a gadget. It is something natural. I am not one for medicines in general so it seems very synthetic in that way, brave new world, you know, but at the same time it is just hugely convenient'. Implicit in this comment is a contrast between nature and convenience. She would not, however, regularly adjust or suppress her periods because, as she told me, 'It's very important to let my body do that at least, the natural cycle of things, maintain some sense of it, I suppose'. She reiterates that her assisted periods were not considered unnatural compared to not having periods at all. For Sita, and for many others, then, it was 'natural' to have optimised periods.

Their optimised menstruation provide a concrete example of what Marilyn Strathern (1992a) termed 'enterprising up', in that periods are designed to explicitly meet and conform with cultural expectations – both positive and negative - about what a natural periods should be. Strathern argues that this process collapses the difference between what is taken-for-granted and what is the result of intervention in which certain traits are desirable and profoundly cultural, not natural. Moreover, the women in this study referred to optimised menstruation as the standard; for them it was impossible to think of periods without thinking about the achieved cycle. In this way, their achieved periods became 'second nature' in that the 'natural' and 'cultivated' had come to mimic each other and thus become indistinguishable, so that 'culture acts and feels like nature' (Franklin et al. 2000: 25). The pill creates a regular and predictable 28-day cycle that becomes the normative cycle, de-naturalising the unassisted menstrual cycle and re-naturalising the assisted cycle. Menstruation had become something both produced and natural for them. Using the pill as part of menstrual management attempts to balance ambivalent ideas about menstruation, while also 'naturalising' their achieved periods.

They also expressed that it was not only natural to menstruate, but part of being feminine. Mary told me that periods are ‘something we have to live with as women’. Elizabeth, who occasionally adjusted her period to her schedule, said: ‘I would put it back for a month, but I wouldn’t do that more than once. It doesn’t feel right. It’s a bugger and I hate it but I mean they mentioned some things like you can have it and never have period again and yes that would be great but when you think about being a woman having period and grown up, sexually mature is the word I suppose’. Isabella mentioned similar feelings: ‘I still think it would be unnatural [not to menstruate], I associate that with either a problem or being old or being a kid. So I don’t know, it’s stupid and I know it’s inconvenient to have them but if I didn’t have them I would be worried ... I think I associate it [menses] with fertility and if it wasn’t there I think I wasn’t fertile’. For these women achieved menstruation was a sign of being a sexually mature woman and of femininity. Menstruation, like fertility, remains an expected and desired aspect of being a woman.

On the pill, menstruation was, then, no longer an inevitable and taken-for-granted aspect of the female body but rather a choice and an achievement. To view menstruation as a naturalised achievement is to impose new value judgements about what it is to be a woman as menstruation is no longer an inevitable part of femininity. The deliberate planning, timing and preparing for menstruation, made possible by the pill, exposes the artifice of ‘natural femininity’. Yet when presented with the opportunity to choose a more convenient lifestyle without the disruption and embarrassment of menstruation they opted to menstruate.

As I argued in relation to achieved motherhood, women opt to menstruate because they are compelled to achieve menstruation in order to realise their femininity. Menstruation as an achievement displaces the taken-for-granted tangible ‘natural facts’ of femininity and yet the women I spoke to continued to perceive achieved menstruation as a ‘natural’ sign of fertility and femininity even though it in many senses indicates the opposite. I argue that the women in this study chose the no longer inevitable physical and social discomforts of menstruation in order to materialise their femininity. This echoes Potter’s finding that: ‘The desire for menses and its verification of fertility and femininity exceeds the desire for comfort, convenience, or even full protection against pregnancy, regardless of how safe and easy to administer – and discreet? – the method is’ (2001: 150).

Conclusion

For many of the women in this study, coping with menstruation involved dealing with the hassle of unpredictable periods while still satisfying the demands of their personal and professional lives. By using the pill these women could manage ambivalent menstrual meanings by scheduling or planning neat and discreet periods for the most convenient and appropriate times to ensure appropriate menstrual conduct. On the pill, women moved from coping with menstruation and their bodies to increasingly managing and scheduling their periods. The majority of the women in this study used the pill to regulate and manage their menstruation even though they could have opted not to bleed and thus avoid the associated hassles. Despite their different individual strategies for managing their menstruation the majority agreed that it was 'right', 'normal' and 'healthy' to menstruate. Menstruation, seen as a hassle and inconvenience and a sign of wellbeing and fertility, remains an important part of embodied femininity for them. The pill is used in such a way as to marry external expectations with a sense of personal fulfilment.

Through a process of re-naturalisation, achieved menstruation incorporates the meanings of fertility and femininity. As a choice, assisted periods are talked about in such a way to (somewhat counter-intuitively) realise their 'feminine nature'. We can see, then, how the pill and efforts to manage menstruation have become integrated into embodied 'natural femininity'. This provides some insights into the complexity of 'choice' that includes achieving optimal periods as well as upholding femininity.

This chapter, like the two previous ones, stresses how the 'natural facts' of femininity are no longer inevitable but rather a question of choice, effort, planning and achievement. Yet the displaced 'natural facts' of femininity are re-assembled using existing cultural referents in order to reproduce norms of natural femininity. The accounts of achieved menstruation analysed here provide the clearest example of the process of re-naturalising of 'natural facts', when assisted biology replaces the unassisted as that which is seen as 'natural'. In this way, taking the pill was part of these women's efforts to re-create and maintain 'natural femininity' as part of their many demands.

This chapter also emphasises how the ‘natural facts’ of menstruation, unlike those of pregnancy and sex, are considered undesirable. Convenient menstruation required deliberation and effort on the part of the women affected as well as the capacity to control the female body and their performance in the wider economy. The pill was the means used to gain a degree of control over their unpredictable female bodies and the anxieties and hassles associated with disruptive and uncontrollable periods. Implicit in using the pill to manage ambivalence and contradictory demands is the capacity for optimising physiological and bodily processes. The idea that the pill enables the women I spoke to increasingly manage and schedule their taken-for-granted bodily processes presupposes the capacity to control their bodies with pharmaceutical technology, which will be examined in the next chapter.

Chapter Seven

Controlling Female Bodies

The pill is one of many medicines to become widely available since the advent of the mass production of affordable pharmaceuticals in the 1960s. In a relatively short period of time pharmaceuticals have become widespread, accessible and commonplace products stockpiled in almost any household and corner-shop. A range of pills, tablets and quick-releasing capsules are currently used in daily life to treat illness and as time-saving devices (Vuckovic 1999). Van der Geest and Reynolds Whyte (1989) argue that the popularity of medicines relates to their particular 'charm'. This 'charm' is not reducible to biochemically efficacy but rather their metonymic associations with biomedical expertise and advanced technology, as well as the democratisation of biomedicine as, with 'over-the-counter' medicines, anyone can use them without the involvement of medical professionals, kin or other social institutions. In this way, medicines are vehicles of individualisation, facilitating particular social and symbolic processes of late capitalism.

In the previous chapters I discussed the complicated ways in which the pill enabled individualised control, choice and autonomy in relation to motherhood, sexual intimacy and menstruation, and how these processes were seen to define femininity and to form the basis of its reconstitution. Female bodies and biology were at the centre of these accounts and are therefore at the heart of this ethnographic analysis of the pill. Here the pill and the female body provide a means to critically reflect on the social and symbolic processes associated with the widespread availability and use of pharmaceuticals.

In this chapter I first detail the bodily and biological control enabled by the pill that has been implicit throughout. I show how the female body is experienced as a source of interruption that is transformed by taking the pill. I then examine how the control and choice engendered by the pill are seen to enhance and optimise the body and how this parallels the self-management and self-discipline practices associated with pharmaceutical technologies in advanced liberal democracies. I then describe the respondents' ambivalence about control and choice and suggest a more complicated picture of their embodied engagement with self-management and self-discipline practices associated with pharmaceuticals.

Body Talk: Accounts of Bodily Interruption

I met Mary in a private consultation room at the Pyke and she spoke about how taking the pill changed her body and 'saved her life'. She had been on the pill continuously for eleven years¹⁴² but could vividly recall the menstrual pain that plagued her before she started to take it at the age of sixteen:

I went on it because I had absolutely horrific period pains, debilitating and it was awful and I wasn't sexually active at the time ... It was cramps; I was regular as clockwork. How can I best describe it, I was out one night and then came on in the evening. I was out with a group of blokes, then suddenly came on and I said 'I am going to go home' and they said 'It is half nine, what are you being such a lightweight for?' I said, 'Believe me this is no good'. I was doubled over, 'Oh it can't be that bad', 'Oi, you! up against the wall', I made this guy stand up against the wall and with all my effort I pushed into his lower abdomen with my fist and started rolling around and I just said, 'That is how it feels'. So that is how to describe it, these fists fighting with me up against a wall into my spine. It was like a permanent, it was like everything down there had turned to liquid. It was horrible. I was curled up against radiators, foetal position. I never took a day off school, I have never taken a day off work, I have struggled through the whole time. Absolute chronic agony and, in the intervening periods, when I have had gone back to have natural periods, it happened again.

Her periods were 'debilitating', a disability unique to women that stopped her doing normal things yet she felt compelled to continue doing them. In addition to the pain, she experienced severe pre-menstrual depression, which described as: 'sobbing, crying, just staring into a black pit, three days every month feeling like I was never going to come out of those three days'. For Mary, her periods were a disability that interrupted her normal physical and emotional life and meant she had to change her activities in order to cope.

Several women in this study took the pill to manage changes in their emotional states associated with their periods. Bridgit, a 39-year-old business consultant and mother of two, occasionally took the pill to stabilise her mood. She explained what her moods were like when she was not on the pill:

I think it improved my mood. I mean there was a period during then that I used to get quite bad pre-menstrual syndrome, PMT, PMS or whatever it's called. I could kill. In fact I do now. We always have a row. The day before I'm due we

¹⁴² She briefly experimented with the contraceptive injection but suffered side-effects and returned to the pill.

have a big row and it's always his fault. Afterwards I say, 'Look it's my hormones for God's sake'. And that's one of the things that I think it helped me with.

According to Bridgit her hormones make her aggressive, even murderous. It was not her but rather her hormones that take over and make her act like another person. This occupying force could be controlled by taking the pill, a synthetic hormone. Another example is Tania, who took the pill for nine years: 'I might be depressed for the whole or two weeks leading up to or three weeks because you can let your body take over and work against your logic so I am glad that I have got that, I can almost step back, most of the time anyway, step back and say it is because of this that I am feeling like this'. She describes how her body took over and worked 'against her logic', so that it seemed like it was her body, not her, that determined her feelings and actions.

Similarly, Rachel, a 30-year-old events manager, took the pill for thirteen years to stabilise her mood swings. She explained what happened when she was not on the pill: 'When I am not on the pill, I react immediately, there is no boundary, there is no wall, it just affects everything – my work, everything. I was literally freaking out over the smallest things, I can't cope. I am shaking. It is like being incredibly wound up'. Rachel uses a containment metaphor of boundaries and walls to describe her changing moods around her unregulated periods that prevent her coping with the 'smallest things'.¹⁴³ Tania, Mary, Bridgit and Rachel all experienced menstruation as their bodies take over and interrupting normal life. Implicit in their descriptions is the idea that normal life and activities require a predictable and constant physical and emotional state.

When they were not on the pill they had 'to be careful', 'worry' and to 'struggle through' the uncontrollable interruptions of their bodies onto their thoughts and actions. These women, like those observed by Susan Bordo in her study of obsessive body practices of contemporary Western culture, live their 'lives as a perpetual battle with their bodies' (1993: 137). These interruptions, both emotional and physical, were seen by the women in this study as biological in origin and related specifically to the cyclical bodily processes of female reproductive physiology including menstrual bleeding, mid-cycle pain, the dull ache of ovulation, breast tenderness, changes in complexion and

¹⁴³ These bodily disruptions were seen as minor compared to the disruption posed by an unplanned pregnancy. In Chapter Four, Heidi, Louise and Fiona described how unintended pregnancies threatened their current and future activities and had to be rectified with abortions.

volatile emotional states. These interruptions continually and independently surfaced provoking explicit bodily awareness that focused women's attention onto their bodies and detracted from their everyday concerns, activities and projects (see Gimlin 2006; Leder 1990). In these accounts, the body and biology were not passive but rather a force beyond direct control that disrupted everyday actions. These descriptions of a female body that becomes the focus of attention suggests a specifically female bodily awareness that repeatedly and cyclically comes into consciousness through the embodied experience of leaking bodies, mid-cycle discomfort and labile moods. This interior experience resonates with the writings of feminist phenomenologists, who maintain that gendered external bodily difference distinguishes between men and women's embodied experience and differently constrain how each inhabit the world (see Young 1990; Weiss 1999; de Beauvoir 1953; Sullivan 2000; Bigwood 1991).

Simone de Beauvoir (1956: 734) argued that women are enclosed by their reproductive functions, which characterise their embodied experience and have to be transcended in order to attain freedom and possess the autonomy of men. Carol Bigwood also maintains that there is an embodied female subject: 'The female body has its own indeterminate natural structures that non-causally motivate womanly ways of being in the world-earth-home' (1991: 110). Iris Young (1990) identifies the profound differences in female and male comportment that affect modality, meaning and movement. Modes and structures of the world shape and constrain women's bodily comportment and existence by inhibiting their use of space and movements and confining how they inhabit the world and assert themselves. These gendered styles of bodily comportment structure and circumscribe women's corporeal existence and embodiment and influence how this subject reaches out, with and through this body (Young 1990: 143). According to feminist phenomenologists, the conditions of embodiment are gendered and there are, therefore, different possibilities and constraints on practices and "being in the world" for men and for women. Here I suggest that the interior body is part of the condition of gendered embodiment.

In the accounts above there is a strong sense of the female body taking over, interrupting normal life and making these women act like another person. These are poignant examples of how these women's unassisted bodies and physiologies cause them discomfort, direct their actions, curtail their activities and limit their possibilities.

Their bodies and cyclical reproductive physiology determined what they did, what choices they made and how they engaged with the world. These few examples are particularly dramatic but all of the contraceptive narratives were peppered with instances of bodily interruptions. An extreme view was that the female body was a 'disability' but a more commonly held view was the female body as uncontrollable, unpredictable and somewhat pathological. I argue that the female body was a concern for these women because it affected and governed how they reached out into and inhabited the world and showed the tensions between their embodied experience and the different demands of 'normal' life. This experience of gendered "being in the world" produced a desire for a normal body, i.e. one that is controlled, constant and contained.

Pill Talk I: Accounts of Bodily Control

In the contraceptive narratives, accounts of bodily interruptions were juxtaposed with the embodied experience of taking the pill. These descriptions, therefore, are of mediated physical experiences constituted in hindsight in comparison to the experience of taking the pill. The pill introduces high levels of synthetic oestrogen and progesterone into the bloodstream that affect the endocrine system and the menstrual cycle, tangibly changing the body and biological processes. The women I spoke to vividly described how taking the pill changed their bodies and emotions and consequently, how they related to their bodies and how they inhabited the world.

Mary who had severely 'debilitating' periods told me how she 'loved' the pill because she no longer experienced uncontrollable pain and depression. However, this transformation had a price:

Even if you did tell me, 'if you hadn't gone on the pill you would be the size twelve and you would weigh the eleven stone, that is the right weight for you'. I would be like 'okay', I would have had horrific period pain, I might not have survived one bout of PMT. It was that bad. I might not have lived through it because I was contemplating it [suicide] on some occasions.

Mary describes how the pill directly relieved the disruption of her menstrual pain and depression and changed her body. This relief was worth the cost of weight gain, another bodily change she attributed to the pill, as she saw it as crucial to her survival. These accounts demonstrate respondents' priorities and values, and how they weigh these

against each other. Here Mary prioritises her mental health over the negative physiological, psychological and social effects of weight gain, while other women have different priorities, such as being able to function normally at work. The priorities that are important to them vary but structure their individual lives and how they were using the pill.

Karen, who experienced painful heavy periods that determined what she could and could not do, explained how taking the pill made her feel normal, or 'like one of the girls'. On the pill, she no longer felt she had to limit her activities:

I was just like, like one of the girls in the tampon ads running down the beach in her white trousers, that was me, whatever it is doing, I don't care ... bikinis, everything, it was fantastic, changing in gym, not having to worry about wrapping yourself in the white towel they always give you, you know ... Yes because I never, I never would wear close-fitting clothes, light-coloured clothes were just a no-no and also, socially I was having to be careful about what I did, where I would be going and this kind of stuff and I just didn't have to worry about it at all. In fact I was worried when I first went on the pill about putting weight on and in fact I lost it, maybe I went on a diet to be sure, but I did lose it anyway which made me feel even more better, it was just, it was like, it was similar but better to getting contact lenses after having worn horrible glasses for years.

Her description of taking the pill is a narrative of liberation from her earlier bodily constraints. Karen felt she could do normal things, like use a gym towel and wear light coloured clothes. Therefore she did not care what the pill was doing to her because she felt 'even more better.'

Rachel, who suffered extreme uncontrollable mood swings before taking the pill, told me how the pill had made her 'feel more comfortable' with herself:

I like the assurance of being able to control it. Knowing what is going to be happening. I get on really well with Femodene, I am an even-tempered person, it keeps me even-tempered. And I can definitely tell the difference when I am not on it ... I feel very secure when I am on that particular pill, it feels like it is part of who I am. Which is really weird but I suppose as it has been so long. I suppose because I see the character change when I am not on it, when I am on something else, I suppose it is quite scary because it makes you realise what it is really doing to you. But I don't mind the kind of person it makes me ... Yeah but the reason I want to get back on it is not for contraception anymore because I don't want to get into a relationship for a while but just because it is part of me ... I don't know how much I take it to like myself ... I feel comfortable with

myself when I am on it, I feel comfortable in how I react to things when I am on it.

Like Karen, Rachel describes a sense of liberation that accompanied the bodily control generated by the pill. She expresses how the pill produced a character change that made her comfortable, secure and more like herself. By using the pill she could match 'herself' with her body – the pill is part of being her. Like Karen and Mary, she was not concerned about the potential negative consequences of taking a medicine long-term as its effects were priceless.

For the women I spoke to the pill generated a bodily state that no longer interrupted their normal routine, making them normal and more like themselves. In Emily Martin's (2007) study of people with bipolar syndrome, she found that normality was defined by the positive attributes of constancy and coherence in which the assumed character of normal life was not interrupted by an uncontrollable force that makes them act like another person. She argues that these attributes relate to a specific idea of personhood based on an autonomous individual who exercises control over his or her body and its capacities through choosing his or her thoughts and actions. Normality is therefore a capacity for self-management. Instead of personhood being challenged by fluctuations in emotional states, as was the case for people with bipolar disorder, for the women in this study personhood was disturbed by emotional and physical fluctuations deriving from the female reproductive cycle. Like the people diagnosed with bipolar disorder taking psychiatric drugs, the women I spoke to use the pill to attain embodied consistency and coherence, to therefore be "normal". With the pill they could enact their autonomy by choosing their thoughts and actions by controlling their bodies and capacities.

The women I spoke to describe how taking the pill gave them control. Taking the pill was represented as something that involves 'being a control freak', or being 'sensible', 'practical' and 'responsible'. Isabella liked the pill because of the 'kind of independence and being in control' it offered, adding that 'I am a bit of a control freak'. Karen also strongly felt this need for control: 'Total control; total, total control'. Similarly, Kate commented: 'The control, it is very easy ... I am just a control freak ... being more confident with what you can do and having a bit more control'. Tina explained to me why she took the pill in an incredibly direct way by saying simply, 'I want to be in control'. This control they describe was twofold, firstly, restraining 'out of control'

bodies and, secondly, the capacity to direct those bodies and capacities.¹⁴⁴ Chia Wen stated: 'I prefer to control my own self, my own body ... I have control of my life and my own body'. In taking the pill these women manage and direct their bodies, therefore, how they inhabit the world and their lives.

Control was associated with a sense of self-mastery and autonomy. Beatrice felt 'grown-up' when she started on the pill at the age of nineteen: 'I am quite grown-up and I am taking control'. Isabella, who started the pill at eighteen, stated: 'I would say it was more of a positive feeling because it was about taking control and growing up and all the rest of it'. For her, control was positive and associated with making decisions and choices like a 'grown up'. Mary recalled: 'I decided it was time to start taking some control over my body and when one grows up one feels more autonomous. It took a long time for me to feel that ... yes, to take some control over it, to overcome this taboo feeling around the whole thing [menstruation, fertility, sexual relations] ... One does feel empowered to a certain extent, to a large extent that you have made this decision'. She related the control over her body to having the capacity to make decisions that induced a sense of independence, autonomy and empowerment.¹⁴⁵ These experiences of taking the pill are centred on a positive regard for controlling and choosing the body's form and processes and can be seen to form part of the self-management practices of autonomous persons.

These accounts of control and choice parallel the findings of recent analyses of the pharmaceutical practices of the current biotechnological age. Nikolas Rose (2007) argues that in the biotechnological age of advanced liberal democracies, pharmaceuticals are no longer limited to treating illness and pathology but rather engender the capacity to control, manage, reengineer and fabricate the biological qualities and capacities of human beings on demand. Taken-for-granted biology is no longer inevitable but is subject to interventions to optimise and enhance the self in line with societal norms and demands. In a case study of psychiatric conditions, Rose illustrates how new psychiatric drugs do not treat pathology but rather aim 'to adjust the individual and restore and maintain his or her capacity to enter the circuits of everyday life' (2007: 210).

¹⁴⁴ This control was limited to themselves and did not extend to controlling others. Rachel said: 'I quite like control, not of people, but I like to be in control of myself. I don't like to see people out of control ... doing something out of character and you feel out of control yourself'.

As outlined earlier, the women I spoke to felt that they were determined by their bodies and that with the pill they could manipulate their own bodies, thoughts and actions through the 'calculated intervention' of administering synthetic hormones to themselves. Their bodies were no longer seen as something inevitable but a contingent condition open to choice and re-engineered to a desired state. Rachel described this in the following way: 'It is very funny you know that it is essentially putting something inside you that is working for you'. The pill was a tool with which to intervene in the body and as a result has become a state they could control to their own ends. Like earlier discussions of motherhood, intimacy, and menstruation, the body itself was formed through choice and stood as personal achievement.

This idea of the body as an achievement is best illustrated by the pursuit of the perfect pill to induce specific effects. The women I spoke to frequently 'chopped and changed' pill until they found one that produced the optimal body to suit a desired identity. Jessica changed pill to increase her breast size: 'I've been on another [pill] because my friend and my sister both said that when they went on it their boobs got bigger, like a lot bigger. Part of the reason why I went on the pill in the first place was because of that. Also a couple of my friends had been on it and their boobs clearly grew and I thought that would clearly happen to me. I don't care about that anymore but at the time I wanted them to grow but they never did'. Isabella's breasts did grow on the pill and she explained it was 'everything I wanted ... I always felt flat-chested and it did increase my cup size'. Mary said: 'Well I have got quite large breasts but they have been, they were absolutely tiny and then I went on the pill and they went "Wow". They are now a G-cup'. Previously taken-for-granted aspects of the body, such as breast-size or menstruation, became open to choice and subject to desired transformation within a range of identities such as sex object or worker. This brought about a markedly different relationship to the body, based on the difference they perceived between how their bodies were according to whether they were on or off the pill.

Nikolas Rose argues that the optimization of biology with pharmaceutical technologies have intensified ideas about the 'care of self' (Foucault 1978). Rose (2007: 51) maintains that humans have become more biological exactly when biology has become

¹⁴⁵ It marked women's transition to adulthood as they shifted from being young and carefree to being sensible grown-ups (see also Lock 1997).

open to choice, by this he means that people are being defined by the language of biology. New pharmaceutical practices depend on a kind of biological determinism in which personalities, capacities, passions and identities are understood increasingly in biological terms. Biomedicine increasingly envisages life at the molecular level where determinants of physical and emotional states can be isolated and manipulated through 'calculated intervention'. With advances in biomedical knowledge and biotechnologies, tissues, proteins and hormones that are understood as the organic determinants of physical and emotional states are disassociated from specific organs and seen as open to intervention and enhancement. Hence biology no longer limits human ambitions but rather has become the contingent outcome of choice as we reshape our moods and bodies by consuming a pill in order to become the kind of person we are or want to be. Only by being more biological, in this view, can we optimise ourselves.

This shift in biology has been accompanied by an emphasis on individual responsibility for realising potential capacity, a form of self-discipline, through pharmaceutical enhancement. Rose argues that as the biological person has become open to choice and experimentation he or she also experiences a sense of prudence and a responsibility to monitor, modulate and improve himself or herself in line with the changing requirements of everyday life.¹⁴⁶ This generates a compulsion towards self-maximisation and self-optimisation. The women in this study expressed a sense of responsibility that accompanies their experience of taking the pill. Louise told me: 'I take responsibility for my own consequences'. Kristen also expressed this by saying that taking the pill was 'kind of, me being fairly sensible and me looking to the future and I have always been looking at the consequences of actions'. This ability to consider actions and outcomes made them responsible and accountable for how their body affected how they existed and performed in their world. As the body and bodily processes like pregnancy, sex and menstruation came to be under their own control they also became responsible for their choices and interventions. Their choices, such as when to get pregnant, when to become intimate and when to menstruate, require critical judgements in what bodily transformation to produce. In this way, their consumption of pharmaceuticals is part of an attempt to exercise self-discipline and care for themselves.

¹⁴⁶ Hawkes defines a responsible person as someone who 'foresees certain consequences of their actions and takes steps to avoid undesirable outcomes' (1995: 265).

Emily Martin (2007: 194) suggests in relation to bipolar disorder that individuals are seen as being responsible for their successes or failures in attaining psychological constancy as they can do things to develop their capacities in specific ways through self-management and drug enhancement. She argues that this new self-managed pharmaceutical person is modelled on a performance-based labour management style in the wider political economy and is based on a long, culturally specific tradition of self-improvement (2007:42).

As suggested in the previous chapter, current ways of understanding the body are closely linked a shift to individual responsibility for health, self improvement and dealing with suffering in a performance based culture.¹⁴⁷ Rose and Martin argue that, as a result of the shift toward individualised responsibility, individuals choose and are responsible for health behaviours and bodily practices and their overall social performance. The social factors and conditions for health and performance are removed and a premium is placed on self-enhancement with biomedical technologies, such as psychiatric drugs and the pill. The bodily practices described by women taking the pill not only reflect on the desired 'normal' body – normal for late capitalism – but also the industrial metaphors of flexibility and responsiveness.

I would also suggest that control and responsibility are, moreover, features of the pill itself and medicines more generally. The effective administering and efficacy of the pill requires users to comply with a set regimen. The pill is a 'user-dependent' method, in that the user is responsible for its effectiveness. Beatrice told me: 'With the pill you have more control and self-discipline, you can wake up one morning and say you don't want to take it anymore but with an implant you have to go and have it removed and just less control. Condoms, you can get caught in the heat of the moment and forget to put one or it can slip and I don't want to get pregnant ... And withdrawal is up to the man isn't it, and again it's about control'. She saw the technique of the pill as offering her more control and autonomy than other methods that involved other people and decreased personalised control and responsibility. Chia Wen succinctly captured the parallels between the sense of control on the pill and the pill's technique: 'That [the pill] makes me feel like I am responsible for my life and I make sure that I try my best to

¹⁴⁷ This line of thinking originates from the work of Michel Foucault (1978) on the relations of modern forms of power that operate through interlinked medical knowledge and bodily discipline. Authorities developed knowledge, information and created categories for improvement and regulatory control that were also internalised by individuals through self mastery and monitoring.

make sure I follow the regimen. I try my best to be a perfect user of the pill, so if that fails that is not something that I can control because the statistical probability is so tiny. So I think I am pretty much sure that I am doing the things I should be doing'. The principal qualities of this pharmaceutical technology resonate with the highly valued sense of control and responsibility it enables and relate to the 'charm' of this particular medicine.¹⁴⁸

On the pill, the respondents' embodied experience shifted from a sense of bodily interruption and lack of control to a new sense of bodily control and autonomy. By taking the pill they transcended their bodily constraints and came to feel a sense of control, choice, self-mastery and responsibility over the bodily processes that they had previously been unable to affect.¹⁴⁹ Taking the pill was framed as liberation from the unassisted body as well as a way to optimise or enhance the body toward a desired identity. This suggests a change in their relationship with their bodies as they became no longer inevitable and unruly, but rather something they could control, manage and fabricate. The body became, in a sense, a project, a personal endeavour and an achievement for which they were responsible. Taking the pill can be seen as enabling a kind of personhood that is autonomous, along with control and choice. In transforming their relationships with their bodies they better managed their lives, becoming agents who acted upon and through their bodies. The pill also engendered a sense of self-discipline as they became responsible for the types of bodies they fabricated and their capacity to 'enter the circuits of everyday life' (Rose 2007: 210). Yet their circumstances and how they inhabit the world, as feminist phenomenologists propose, remain intimately tied to their bodies.

¹⁴⁸ This 'charm' of user-dependent methods is neglected in the development of new contraceptive technologies. 'User-dependent' methods are contrasted against 'provider-dependent' methods in practitioners' debate around contraceptive compliance and continuation. User-dependent methods are not included in the development of new contraceptive technologies such as contraceptive implants and injections. This has been noted in the public health literature as one of the key issues in contraceptive efficacy. Because the pill is dependent on user-compliance and continuation this leaves efficacy in the hands of the user. Recent contraceptive technologies have tended more towards the development and promotion of 'provider-dependent' methods, such as implants and injections, where the administering is literally in the hands of the practitioner rather than the 'patient'.

¹⁴⁹ The desire to control 'unruly', unassisted natural bodies with the pill can be seen as part of a longer history of female bodily practices that pursue an ideal controlled state. Managing the female body comes prior to and must be taken apart from the taking of the pill; it involved and involves such things such as corsets, clitoridectomies and anorexia (see Bordo 1993; Weiss 1999; Showalter 1985). The experiences of taking the pill represent a continuation of gendered bodily practice of the ideal controlled body, where these attempts at control are often invisible to others.

Pill Talk II: Accounts of Loss of Bodily Control

By taking the pill, the women in this study could control the interruption of their bodies at will and deliberately induce specific effects and desired bodily states. Yet at the same time, many women endured ongoing side-effects that were experienced as *less* control rather than *more* control. Bridgit, a former pill user, who thought herself murderous, described this particular paradox of the pill: 'It [the pill] certainly sounded to me like it was the magic answer. This will solve all of your problems. But then obviously it doesn't and there are all sorts of other associated problems'. She expresses a deep ambivalence about the effects of the pill in that it solves some problems but creates others. This ambivalence provides a critical reflection on the current interpretation of self-management and self-discipline practices of pharmaceuticals.

Several women that I spoke to explained how they took the pill to address particular bodily interruptions yet in doing so it produced new forms of interruption. Kristen continuously used the pill for sixteen years and decided to tricycle to reduce her premenstrual pain and headaches.¹⁵⁰ She tricycled with three different pills and with each one suffered prolonged heavy bleeding, so heavy that she had to change 'superplus' tampons every hour and, even then, still bled through. She told me: 'I had a normal period for eight or nine days and then it got really heavy. It was when I got to the doctor's, when it got to that really heavy stage. I had no sleep that night because it came on at three o'clock at work, and I thought it was one of those things and luckily I had stuff with me. But I was going through it rather fast; I didn't go to work the next day and went straight to the doctor's'. Again, her body took over, interrupting her normal routines and demanding her attention, but this time originating from the 'assistance' of the pill. Her medicated body barred her from the 'circuits of everyday life' and as a result her attempts at self-management were thwarted.

Elizabeth, who was taking the pill to prevent pregnancy and to manage her menstruation, explained the unexpected and uncontrolled effects of the pill:

It was everywhere. I just started getting itchy one day. I changed toiletries, washing powder, didn't do anything. They thought I was just stressed and it might be that way. So I had some steroids tablets and steroid cream but it didn't get rid of it. And then I had some liver function tests which said that my liver

was not working properly. So I think they were thinking that it was a build up of toxins in the body that was causing me to have the rash and allergic reactions. So I went off alcohol for a while and it was over Christmas which was a bit of a bummer, and then I kind of watched my diet a bit better. Then I had a blood test, then I had an ultrasound and it couldn't find anything and then it cleared up.

She later found that the pill had affected her liver function and had caused a physical reaction that interrupted and reoriented her normal activities. Though she could control pregnancy and her periods with the pill, it also caused new sources of bodily interruption. Her attempts at self-management and self-discipline with the pill were, therefore, only partially achieved.

Beatrice took the pill to manage her periods but became increasingly emotional on the pill. She described how she felt: 'Incredibly sensitive, up and down, go through half a day being amazingly happy and brilliant and then suddenly you're feeling like the most anxious, stressed out and nervous person and it's just not, it didn't feel normal, it didn't feel like me anymore, I didn't feel in control of my feelings'. These extreme emotional fluctuations were beyond her control, interrupted her normal routine and she did not feel normal or 'like herself'. Though she could control her periods there were pill-induced sources of uncontrollable interruption that threatened her autonomy. As a result she changed pill and there was 'no comparison at all, no comparison, feeling, like, not normal to perfectly normal and being able to deal with things'.¹⁵¹

The vignettes presented are extreme examples but the majority of respondents did, in fact, experience and endure some effects while on the pill. These side-effects ranged from unstable moods and unpredictable bleeding to suppressed libido and physical pain (such as breast tenderness and headaches). Often the side-effects exaggerated the aspects of unassisted female embodiment that they were trying to control. In seeking to prevent these effects, many women tried different pills. In trying different pills, they were pursuing one that would address their side-effects and produce their desired bodily state of stable moods and weight, predictable, painless, short and light menstruations, controlled fertility, good libido and no pain (menstrual, breast, headaches and/or migraine). In other words, they sought to effect a controlled, constant and coherent bodily state.

Some women told me that they changed pills by ‘trial and error’ in order to identify the pill best-suited to their particular make-up because, as Francis put it, the pill ‘affects everyone differently, you are never guaranteed’. Karen explained that with the pill there was no need to have a bad experience: ‘To me there isn’t any need for your experience to be bad. If there is one that doesn’t suit you then there is always another one and another one and another one. And each one has its own little thing that it does, so there shouldn’t be any reason for that. It may take some time to chop and change and find one that suits you’. Finding the right pill, the one that induced the desired embodied change, was a common preoccupation. Teresa told me: ‘When I changed I remember half thinking “I wonder if this one will suit me as well”’. Mary echoed this: ‘I would rather find a pill that suits me and continue; it’s just trial and error’.

This ‘chopping and changing’ to find a suitable pill parallels what Martin (2007: 164) terms the ‘hyper-management of symptoms’, identifying a drug that produces a baseline or better than normal state. In her study of manic depression in the United States, Martin illustrates how the management of symptoms depends on the ‘specificity’ of a drug, one drug producing a desired effect over another. She illustrates how people treat drugs like ‘precision instruments’ that can excise suffering through the right combination to become better than normal. Individuals select these ‘precision instruments’ to optimise their capacities and flexibly adapt their minds and bodies to their changing environments, including side-effects. Tina’s pill change is an example of this management of symptoms through specificity as she aimed to prevent weight gain: ‘I hated it because it made me fat, I know that it is not clinically proven but for whatever I put on weight and did not enjoy being on it. So I stayed on that for probably three months ... When I started on Microgynon, absolutely fine, didn’t put any weight gain, didn’t have painful periods, it was very weird. It was fine, it did the job; I didn’t get pregnant’. By changing her pill she could change her symptoms, becoming normal or even better by finding the right ‘instrument’. Choosing a particular drug is another way, as Martin (2007: 171) points out, to attain the hallmarks of personhood.

However, changing pill was only one response to side-effects. Another response was not to change pill and simply endure them. Nichter (1994) and Etkins (1992) argue that side-effects are seen as problematic when they interfere with culturally important bodily

¹⁵¹ The preceding vignettes only capture the experiences of occasional pill users who were able to contrast the effects with other pills, other methods or with the experience of the unassisted body. Long-term continuous pill users found comparisons more difficult and often took longer to identify side-effects.

processes and the performance of social roles and duties. This definition allows us to better understand why women remained on the pill despite the fact that they experience side-effects and bodily interruptions. The endurance of side-effects depended on the degree to which a side-effect affected socially and culturally significant bodily processes, normal routines and social duties. Minor disruptions that only slightly affected bodily processes and the performance of social roles and duties were endured. For example headaches and decreased libido were seen as minor disruptions and only affected the women themselves without external impact. Women facing this situation tended to stay on the pill that provoked the least interruption rather than foregoing it altogether. With unbearable side-effects, such as bleeding and mood swings, that severely affected bodily processes and impacted on their performance of social roles, however, they changed or came off the pill.

Some women rationalised side-effects by disassociating the source of interruption from the pill. Emma did not associate certain effects with the pill and it was only when she changed pill, on her practitioner's recommendation, that she noticed a change: 'I suppose the scary thing is I went onto a new one and I didn't weep every Friday night or once a month and I didn't have that. I think I am a quite positive person but maybe if I did somehow feel more positive and better there is that worry that maybe the last six years have been, I've been on the wrong thing actually, but I didn't realise'. After changing pill, Emma realised for the first time that she could be better. Not recognising a correlation between the pill and side-effects was common amongst continuous users because they were habituated to the pill and its effects had therefore become intangible. Leder (1990) argues that successfully incorporated technologies become fixed habits and disappear into the corporeal background making it difficult to directly correlate certain effects with particular pharmaceutical products.

The different responses may relate to the perceived severity and impact of side-effects but the choice to endure them and to misrecognise their source suggests a more complex picture. These accounts of side-effects and individual women's different responses to them indicate that the women I spoke to experienced varying degrees of bodily control, from full to partial control to a decreased sense of control with the pill. This variability of control problematises the idea that, as with other pharmaceuticals, the pill enables these women to control their body, capacities and to choose their thoughts and actions, and this has implications for their ability to care for the self.

For both occasional and continuous users, the new forms of interruption experienced on the pill (the feelings of being 'up and down', 'not normal', 'stressed', 'searing headaches', 'vaguely ill' and 'zonked') drew their attention towards their bodies, threatened normal activities and social roles and forcibly reoriented their tasks and activities. Even with the sophisticated and systematic assistance of the pill, the body became an uncontrollable force that takes over and their desired controlled and constant bodily state was undermined. These women expressed ambivalence about control and about the pill. For instance, the control engendered by taking the pill was accompanied by a concurrent sense of a lack of control; the pill was both the problem and the solution. Their responses to side-effects, whether changing contraceptive method or enduring the effects, indicates the different degrees of bodily control and optimisation that they actually experienced in taking the pill. In practice, the pharmaceutical technique of the pill did not enable the complete choice and control necessary for full self-management and self-discipline; this raises the question of how we can account for these ambivalent pharmaceutical experiences.

Ambivalent and Contradictory Accounts of the Pill

The respondents' differing experiences and management of their side-effects reveal a profound ambivalence about the pill's capacity to enable control over some aspects of the body as if there was less control over others. Emily Martin argues that medicines are seen and experienced as ambivalent, which she defines as the same object surrounded by 'two sets of social meanings – one positive and one negative. The positive meaning sits uneasily with – and is shadowed by – the negative meaning' (2007: 274). These women's accounts, like those of users of psychiatric drugs in Martin's study, are permeated with ambivalence, which she describes in the following way: 'simultaneous and contradictory feelings of attraction and repulsion. The drugs help me, they hurt me, they ease one kind of pain and intensify another, and they take away one painful symptom but add a new one' (2007: 285). The ambivalence expressed about the effects of the pill is just one of several ambivalent statements about control and choice in the contraceptive narratives I elicited. I will explore how the explicit ambivalence about choice and control complicates the analyses of pharmaceutical practices and ideas about self-management and self-discipline of writers such as Emily Martin and Nikolas Rose.

Ambivalence about control was not only limited to dealing with side-effects in the present but also events in the future. Earlier, the women in this study described how pregnancy and motherhood are the 'natural course' for the female body and I showed that much pregnancy anxiety arose from disjunctures between the 'natural course' of the female body and the expected and desired life-course. I argued that the pill enables women to manage this disjuncture by timing pregnancy within the appropriate conditions to become a responsible and selfless mother and hence to realise their natural destiny. However, there was a flipside to pregnancy anxiety: having met the optimal conditions, there were anxieties about not getting pregnant on demand or not getting pregnant at all, a kind of *infertility* anxiety.¹⁵² This two-sided fertility anxiety was most clearly expressed in the irony highlighted by several of the women in this study that they spent half their life trying to prevent pregnancy and the other half then trying to conceive. Kathy commented: 'When I was a teenager and in my early twenties it was about not getting pregnant, but now it is about getting pregnant'.

The women I spoke to were anxious about getting pregnant when they did not want to, but could control this with the pill, however, anxieties about not getting pregnant could not be addressed with this or any pill. Many women were concerned they could not control getting pregnant on demand. Kate told me: 'So it's always that great contradiction isn't [it]? You try so long not to that when you want to maybe it does not happen immediately'. Tina concurred with this: 'It could take two days, it could take two years, you know, it's that uncertainty of it all, that's quite scary'.¹⁵³ Having achieved the desired conditions while on the pill, many women described a returning lack of control when they wanted to conceive. Bridgit, a 39-year-old business consultant, came off the pill when she decided it was appropriate to have a child but first experienced problems conceiving and then, having conceived, miscarried at forty weeks. She poignantly commented on the uncertainties of reproduction:

Well, it's a funny old thing. It's like when someone says to me now, I'm pregnant or they say I'm having a baby, I think hopefully you will be having a baby but you don't know. You don't know. There's nothing certain. It's just a whole kind of; I just find life so random and so unstructured now whereas before I thought it was all, you know, this happens, this happens, this happens.

¹⁵² See Sophie Day (2007) for accounts of fertility-testing and fertility anxiety amongst London sex workers.

¹⁵³ In response to the potential reproductive uncertainty and lack of control related to getting pregnant many women considered using other reproductive technologies, such as IVF, in order to regain control.

Reproductive control before and after the pill remained random, unstructured and unpredictable and therefore beyond her management. Reflecting on her experience, she commented on the limits of pharmaceutical control: 'Well, it [the pill] gives you some control, yeah, but with a flipside there's much less control isn't there? If there was a pill to stop you being pregnant and a pill to make you pregnant then things would be more even wouldn't they?' In the longer term, the pill does not produce control, choice and self-management over the body or over fertility, but rather, control and choice are momentary and recede when they came off the pill. Despite technological innovations and detailed calculations, conception at the desired time was rare and the uncertainty associated with the female body continued. This longer term perspective disrupts notions of control and planning of taken-for-granted biological processes.

There was also ambivalence about the responsibility implied by this reproductive control and choice. Some women wished for the control made possible by the pill to fail so that their destiny could be arrived at naturally. Tina said to me: 'Wouldn't it be lovely if the pill messed up and you had no choice, and you've got no choice you just get on with it, don't you?' Kate used the morning-after pill after unprotected sex but explained how she almost did not: 'For a moment I was going to let nature take its course and see what happens and that is very unlike me... I thought maybe I should have thrown caution to the wind'. In some sense unintentional pregnancies remain the ideal because they represent the resilience of a natural feminine destiny often overshadowed both by contraceptive technology and the responsibility of choice and planning.

Ambivalence about immediate side-effects and future fertility over the lifecourse were matched by ambivalence about choice, which is crucial feature of achieving optimised motherhood, intimacy and menstruation. Though the pill was considered to enable choice about motherhood, intimacy and menstruation, many women said they felt they had no choice but to take the pill. Beatrice said: 'So, the choice between unplanned pregnancy and hormones in my body? I have to go for hormones in my body because that is the lesser of the evils. I don't really trust the pill but at least I am unlikely to get pregnant on it'. Emily echoed this: 'Most people don't like it because it is an artificial hormone that mucks around with your hormonal base ... I know it does, but it is the lesser of two evils'. Heidi shared many of these feelings: 'I know I am putting something artificial into my body and I know I don't want to do it forever ... I really

don't have an alternative at the moment unless I become celibate'. Isabella said: 'It is not great to be putting hormones into yourself, but what is the alternative?' For these women, the pill may have created alternatives yet in reality it seems there was in fact no alternative to the pill. Only when we discussed the ambivalence about choice, did this ambivalence about the effects of the pill become clear: it represented the 'lesser of two evils'. Any anxieties about the pill (though not based on accurate medical knowledge) were overridden by their need to control their bodies in order to 'enter the circuits of everyday life' and to perform their various social roles. Choice was not a choice, but rather a force of circumstance: if you wanted to work, be a lover and a future mother, you had to ensure you did not get pregnant at the wrong time. This suggests it is difficult to think of choice outside the gendered norms and expectations; for instance, no one chose to menstruate more.

This ambivalence about choice was more pressing for those continuous long-term pill users who actively feared their unmedicated bodies. Many continuous users had been on the pill for years and either could not recall or dreaded the return of their unassisted body. Jessica, a continuous user for six years, told me: 'I don't know, like, I don't know what would happen if I came off it, I am just going to stay on it'. Teresa, who had been on the pill for sixteen years, explained: 'The other reason [for taking the pill] is that I feel really good on it and I'm still worried that if I come off it I would go back to irregular periods, bad period pains and all that stuff. I can't be doing with that, so I may as well take it ... I am happy with the current situation somehow it's seems easier to keep going the way I am'. Teresa also remarked: '[T]here's an element that sort of makes it, that I think it's, that I have been out of touch with my body's natural state in a way. But if my body's natural state is a nuisance then it's fine to be out of touch with it as long as it's safe to be, to do that'. These women are accustomed to the medicated body (even with minor side-effects). For them the threat of the potentially disruptive body and lack of control meant that taking the pill and partial bodily control were not so much a choice as a compulsion.

Many continuous users had been on the pill for so long that they felt they did not know what they were like without taking it. Francis, a continuous user for seven years, told me: 'I would be intrigued to see what it would be like [coming off the pill], to see if there were mood swings or anything, see what it does affect me, if there is a link, because you just don't know do you when you've been on it for such a long time? It is

such a bizarre thing, there is nothing else really like it in my general life'. She fears the unknown as she cannot distinguish what is 'natural' and what is 'produced' about herself. Mary, a pill user for nine years, expressed a similar sentiment: 'I was a girl when I went on it, I wasn't a woman ... So it has always happened, as a woman I don't know what my body is like because I have been on something for most of my adulthood'. For her it was difficult to define what is 'normal' as normality is in fact dependent on chemical interventions. She did not know the difference between their real and produced selves. The pill, therefore, had become a part of being their 'normal self' and thus required continual use.

These various ambivalent statements about control and choice relate to the fact that pharmaceutical practices are embodied and, as argued earlier and throughout the thesis, embodiment is gendered. Current analysis of pharmaceutical practices presupposes a form of embodiment and personhood in which the body appears 'isolated in its own performance and disassociated from itself' (Witz et al. 1996: 175). As discussed in the previous chapter this form of embodiment appears gender-neutral and normalises masculine embodiment and hence obscures the embodied character of pharmaceutical practices. Moreover, this masks the gendered nature and experience of self-management and self-discipline practices of pharmaceuticals, premised on normative controlled embodiment. Rather these accounts suggest that these pharmaceuticals' uses do not work on neutral bodies but on gendered bodies and gendered ways of "being in the world". Pharmaceutical practices and related ambivalence are situated within the particularities of female embodiment and the multiple, often contradictory demands of contemporary femininity. Therefore, the ambivalence experienced by these women in taking the pill can be seen as a response to the complexities of femininity and femaleness.

The vivid accounts of bodily control and choice facilitated by the pill can be read as self-management and self-discipline practices, as the women felt that taking the pill afforded them an increased capacity to affect their situation. Yet their accounts of control and choice are more complicated as control is variable and/or partial and their choices occur within limited alternatives. These accounts demonstrate the complicated nature of control and choice in these women's lives – control is experienced as partial and the corresponding sense of choice feels like a compulsion. Rather than simply offering the means for the self-management and self-discipline of a gender-neutral body

in order to attain optimal normality, the ways in which these women use and talk about the pill clearly demonstrate that this pharmaceutical technique is practiced upon gendered bodies infused with natural femininity.

Furthermore, the option to use the pill to change the female body towards a “normal” sort of embodiment suggests a certain political economic dimension. In Tania Luhrmann’s (2000) analysis of current trends in American psychiatry she claims changes driven by the bureaucratic and cost saving priorities of health insurance schemes have resulted in the dominance of biomedical psychiatry (namely biological psychiatry and psychopharmacology) over psychotherapy/ psychoanalysis in American psychiatric care. Though, the NHS provides contraceptives free-of-charge at the point of service delivery, the wider implications of medicating professional women’s bodies may be partly driven by the effectiveness of changing individual women to suit late capitalism over addressing the gender inequalities of the wider political economy to suit working female bodies.

Conclusion: Accounting for Ambivalence and Contradictions

When these women described being on the pill, they depict their uncontrollable bodies and bodily processes as no longer inevitable, but subject to choice and achievement. Through this transformed relationship with their bodies, the women that I spoke to became actors who acted *upon* and *through* their bodies as though they could achieve their own, optimal bodies and thus determine their life circumstances. Yet, often, their desire for bodily control was only partial and their choices were constrained. These ambivalent experiences of control and choice suggest that we should be cautious about accepting the idea that pharmaceutical practices that allow for straightforward self-management and self-discipline. Both Martin’s (2007) notion of pharmaceuticals as self-management and Rose’s (2007) idea of pharmaceuticals as self-discipline are problematic as they do not account for the embodied nature of pharmaceutical practice. As this analysis of the pill has shown, pharmaceutical practices are embodied and gendered, the practice of taking the pill is bound up with normative ideas of femininity, which is itself made up of contradictory parts that are impossible to fully achieve.

These women are not using the pill as a form of medical therapy nor as a form of optimisation but rather to generate bodies to particular needs and desires of the different

facets of their everyday lives, achieving what they understand to be normalcy. Normalcy has a moral quality – something to be strived for that exists within complex social, economic, political and historical relations that define disorder, normality and abnormality. In the different spheres of these women's lives, the pill is used to adjust the body and self to participate in everyday life and within the logic of a particular political economy. Through medically regulating the female body it could be altered to better perform within the performance-based logic of late capitalism.

With more control over the body the women in this study could better participate in social arenas by managing contradictory expectations of femininity. They adjusted and modulated their bodies, with differing degrees of success, towards different expectations of a range of female identities and bodies: one instance of this is the tension of the controlled working body alongside a body that reproduces, sexually interacts and menstruates. For the women in this study, the pill did not resolve the tensions and contradictions of femininity or change their structural circumstances, but rather it permitted them to shape, to varying degrees, their bodies and lives within these contradictory demands. It is precisely because femininity is contradictory and encompasses several competing fields that self-discipline and self-management are not wholly attainable and because the pill is variously operative and effective.

A further interpretation of these ambivalent statements about control and choice is that they have a rhetorical purpose. The rhetoric of choice refers to the idea that with rational human intervention a degree of control can be achieved. Hence, choice and responsibility can, therefore, be exercised without constraint and can be personally determined. Self-management and self-discipline acts of autonomous persons fall under the rubric of choice. In their contraceptive narratives, the women I spoke to suggested associated choice with free-will and control alongside references to the moral order of nature, allied with fixedness and biological constraint. The rhetoric of 'nature' provides a reference point for the idea of an inevitable force beyond individual human intervention and which may therefore be associated with a sense of fatalism. These two types of rhetoric appear contradictory and yet they were employed simultaneously. The sense of control and responsibility associated with 'freedom' of choice in fact made apparent a lack of choice and the impossibility of fully controlling their feminine bodies. Throughout the thesis, these women's simultaneous use of the rhetoric of 'nature' and of 'choice' to interpret their own behaviour, ideas and practices indicates the

merographic (Strathern 1992a) (and seemingly contradictory) character of femininity composed of various, often conflicting ways of being feminine. For the women in this study, being female meant having the capacity to control themselves as well as being a natural woman.

Emily Martin has suggested that ambivalence allows people to play different social roles that are often oppositionally constituted, such as rational and irrational or controlled and uncontrolled. She suggests that '[p]eople who experience themselves as containing multiple centres of action could be said to be capable of performing many different roles' (2007: 74). Similarly ambivalence about choice, the pill and nature enables the women in this study to negotiate the contradictions and contingencies of femininity resulting from contraceptive innovations and the changing political economy. Ambivalence, therefore, is not a question of role confusion but a strategic part of living within the ideological oppositions and blurring of work/family, public/private, modern/traditional, nature/culture and destiny/choice that characterise the world of these women.

The ambivalence expressed throughout these accounts of the pill allows these women to shift between these differently constituted and often dichotomous roles. So, the rational controlled worker can co-exist as the natural good mother. In planning motherhood, there was a tension and ambivalence about balancing the seemingly opposed roles of work and family life. In their sexual lives women revealed how they balanced and negotiated modern and traditional intimate relationships. In their discussions about menstruation, these women described how they manage the distinctions between their private and public bodies. Such dichotomies structure their lives and roles and lead to the experience of ambivalence. Rhetorically maintaining contradiction and ambivalence in their accounts makes available and intelligible a range of differently constituted roles. Femininity, therefore, can be seen as composed of dissonant parts; impossible to achieve since it is contradictory, unrealistic, never-ending and always changing but impossible to ignore without penalty. And using the pill did not resolve these contradictions and tensions of femininity but rather permitted them to physically, rhetorically and conceptually inhabit their impossibly feminine bodies.

Chapter Eight

Conclusion

In the Introduction I stated that this study focused on how a particular group of women who attended a busy Central London family planning clinic talked about how and why they used the oral contraceptive pill. In the preceding chapters I have demonstrated that they did not explain their pill use within the terms of the rational 'economic calculus of fertility decision-making' discourse typical of a public health approach or as part of some kind of 'sexual liberation' as touted in the popular press. Rather, what I came to understand, based on their narratives, was that the pill was part of the daily experience of embodied femininity and integral to who these women were and who they wanted to be.

In recounting their contraceptive narratives from several different angles I have illustrated how for them the pill is more than a therapeutic medicine or a contraceptive method. The narratives show instead that the pill was seen to encapsulate different meanings and practices related to a range of norms and ideologies of femininity. The pill was understood as a complex object with multiple meanings and functions. It affects and is affected by different social domains (public, private, modernity, tradition, nature, choice) and institutions (family, work, sex).

In the conclusion I summarise the main findings of the thesis and discuss their implications for our understanding of femininity as well as 'natural facts' and new reproductive technologies. As this study is an analysis of the pill from the perspective of a particular group of users, the first section reviews why they took the pill and in what domains they felt it had the most implications. Their commentaries focus on the relationship between the pill and 'natural femininity' and reveal the intricate re-workings of the 'natural facts' of femininity, which were seen as under threat in a rapidly changing social context. I then explore what this adds to ongoing discussions about 'natural facts' in anthropology. The intimate association of the pill with ideas and practices of femininity make it a unique lens on to the ways in which femininity is inhabited and embodied across a range of social fields. In the second section, I draw out some of the study's implications for how we understand femininity, with particular reference to the relationship between gender identity and sexual identity. In the final

section, I further explore the finding that the contraceptive practices described by the women I spoke to were conservative in that they worked to uphold gender convention in a time of potential radical change and are contrary to ideas of feminist ideas of agency and empowerment.

Implications of the Findings for Studies of ‘Natural Facts’

As has been evident throughout, when the women I spoke to talked about the pill they focused on their reproductive cycle, including reproduction, sexual relationships, menstruation and other physiological aspects, and also how they used this particular reproductive technology to integrate and reconcile their reproductive cycle into their personal and professional lives. They described their interventions with the pill as acting on the bodily effects of the reproductive cycle, thus rendering many parts of themselves and their lives into a natural or biological idiom. They talked about taking the pill to plan future pregnancies, they spoke of the taken-for-granted destiny of motherhood and how they carefully reassembled the ‘natural facts’ of motherhood to coordinate it with other areas of their lives in order to best demonstrate naturalised maternal love. In their accounts of their sexual relationships, they described how their contraceptive practices were a means of facilitating companionate sexual intimacy and relationships, in which sex, love and reproduction are disassociated from one another. In almost the same breath, they expressed how sex and reproduction continue to be associated by a complex re-naturalisation of sexual pleasure through contraceptive practice. They also explained how the newly optional natural symbol of embodied femininity, menstruation, was optimised with the pill in order to ensure predictable periods suited to ideas of appropriate menstrual conduct and the demands of professional life. Yet many did not opt to rid themselves completely of menstrual hassle and shame as to do so was thought unnatural and instead they naturalised their medicated periods. Across different domains of life, the ‘natural facts’ of the female reproductive cycle (pregnancy, sex and menstruation) were key areas in which the pill was seen to effect change yet these domains were inseparable from other aspects of their lives such as study, work and relationships. On the pill, the ‘natural facts’ of the female body were described as amenable to choice. This optional character of the ‘natural facts’ of femininity was also a threat to the cultural logic of natural femininity. In the contraceptive practices described, this logic was actively retained through a process of re-naturalisation and was incorporated into practices themselves. In this reading of contraceptive practices, the

meanings and practices associated with the pill suggest that references to nature and 'natural facts' are implicitly also references to gender and sexual identities.

These accounts of taking the pill illustrate the intense deliberations that go into reconstituting 'natural facts' and securing 'natural femininity' at a time when they appear destabilised by technological innovations and social, economic and legal transformations. The recombinatory processes described here through which the social and natural facts of femininity are re-naturalised illustrates how 'natural facts' remain central to the weaving together of feminine identities even when they are shorn of their natural moorings. This reassembling of nature and 'natural facts' can be interpreted, as suggested by Faye Ginsburg (1989) in the context of abortion activism in the US, as a way to make sense of the contradictory experiences and demands of contemporary femininity. I would further argue that this active re-naturalisation demonstrates the ways in which people make innovation and change (in this case a proliferation of feminine possibilities) appear natural and normal and thus more acceptable (see Paxson 2004). This is akin to Charis Thompson's (2006) observations of how social categories such as parenthood are legitimised through strategic naturalisation within surrogacy arrangements. Thompson argues that rendering new biological facts and relationships in a biological idiom makes them appear unproblematic and self-evident. In a similar way, the re-assembling of 'natural facts' of femininity through pill use outlined here indicates their continued definitive role in the constitution of femininity, even when other possibilities are available.

There is no doubt that nature and 'natural facts' remain important cultural referents for these women. This is despite the fact that the pill displaces the cultural arrangement of sex, reproduction and gender at the heart of 'natural femininity' by temporarily separating sex and reproduction. The contraceptive narratives and practices presented illustrate how, although destabilised, 'nature' continues to serve as a resource for understanding what makes women 'feminine'. This finding is commensurate with the findings of other anthropologists studying 'disruptive' new reproductive technologies who claim that 'natural facts' continue to have constitutive power and reproduce particular norms, ideologies and statuses (Franklin 2003). Instead of imploding or being flattened, 'natural facts' retain the capacity to effect self-evident distinctions and to differentiate identities and relationships (Strathern 1992b). This leads to the conclusion that nature and 'natural facts' are not being flattened or imploding but rather remain

resilient in their continuous reinvention and ongoing capacity to shape the production of meaning and practice (Dow 2010).

In addition to debates about the state of nature, I would suggest that studies of reproductive technologies are pertinent to this analysis of the pill in another way. In the new reproductive technologies literature, the capacity for 'natural facts' to be re-invented and to ground meaning and practice is indicative of a particular merographic relationship between social and biological facts. Franklin et al. (2000) and Thompson (2005) argue that the continued resilience of nature and 'natural facts' to ground meaning and practice relates to their capacity to bleed into each other and acquire each other's characteristics. This dynamic, which results in the repeated reinvention of 'nature', is a continuation of a long-standing borrowing between nature and culture (Strathern 1992b; Franklin et al. 2000). Hence, these women's accounts demonstrate how femininity is a hybrid identity that encompasses, incorporates and opposes ideas of nature and effects the recombination of social and biological facts. The remaking of 'nature' and 'natural facts' to ground femininity suggested here is evidence of merographic knowledge practices specifically related to femininity. Femininity, like kinship and the new genetics, is constituted merographically through the relational opposition of the social and biological facts of sexual intercourse and reproduction. In showing the merographic relations that construct femininity, I provide a different analytical frame for understanding femininity.

This study of the pill is highly relevant to anthropological debates on new reproductive technologies in providing an empirical account of how 'nature' and 'natural facts' are reinvented with powerful constitutive effects. In the Introduction I stated that I wanted to reunite the literatures on kinship and gender within anthropology through an analysis of the common concern of 'natural facts'. The revival of kinship studies through new reproductive technologies literature has analytically detailed the implications for the relationships between parents and children and the analysis of gender focused on 'achieving' maternity, yet I contend there is more to contribute to understanding femininity. In this thesis, I have applied the insights about 'natural facts' from the new reproductive technologies studies developed to the relationship between the pill and the construction of femininity, bringing the literature back together. I would further suggest that this study of the pill provides a different perspective on key debates within the new reproductive technologies which could open up areas for further examination. This is

because the pill differs from other reproductive technologies in terms of its chronology, its mode of administration and its accessibility.

The mass introduction of the pill predates the availability of all other new reproductive technologies (with the exception of artificial insemination) and can therefore offer a longer historical perspective on new reproductive technologies. One such area for future development would be to assess whether new reproductive technologies (excluding the pill) did separate sex from reproduction and as a result dramatically change reproduction (see Cassidy 2002 and Franklin 2000 for an historical account of intervening in nature). This would raise insights into the 'flattening' of nature and culture. Or did this separation occur with the introduction of the pill and what would this suggestion contribute to our understanding of the relationship between nature and culture? For instance, as discussed in Chapter Two, although this study does not represent a comprehensive sample and several user groups were not captured, the few interviews with women who used the pill when it first became available in the mid-1960s suggest that there have been changes in the perceived impact and use of the pill compared to contemporary pill practice. In the few interviews with first generation pill users, women described how they used the pill in order to have unconventional and casual sexual relationships with multiple married and unmarried partners simultaneously which is markedly different for contemporary uses of the pill that facilitate companionate sexual intimacy and relationships. Therefore, it can be speculated that the pill initially represented a radical rupture of meaning and practice but has come part of producing and reproducing new social conventions. This may suggest a similar fate for all other disruptive technologies.

Unlike most new reproductive technologies which are used by a minority of people, a large proportion of men and women over several generations have experienced the impact of the pill on 'nature' and it is far from the exception. In this way, the pill represents a less flamboyant but much more widespread example of the relationship between 'natural facts' and technology compared to other reproductive technologies. It is also, as argued in the Introduction, a continuation of long documented history of attempts to control and intervene into fertility. This raises the question of whether new reproductive technologies and concomitant 'changes' in 'nature' are a continuation of a long-standing history of attempts to affect fertility and reproductive outcomes prior to biomedical and genetic thinking. And, if so, are they really such a radical conceptual

and cultural departure. Does the inclusion of the pill as a reproductive technology – which can be seen as the link between fertility control and reproductive technologies – expose an implicit ahistoricity to discussions about ‘nature’ and ‘natural facts’ within the anthropological analysis of new reproductive technologies? Finally, the pill is a user dependent technology that does not rely on a third party for its effective administration, and this differs from other reproductive technologies that require different parties. This very individualised technology might offer a unique perspective on choice and enterprise in relevant to understanding biomedical technologies.

Implications for Understanding Femininity

This ethnographic account of the pill illustrates the complex relationship between ‘natural facts’ and femininity and how nature is central to the way the women in this study understand and use the pill. I have emphasised the ways in which naturalised and re-naturalised norms and ideologies of motherhood, intimacy and the female body inform and guide the contraceptive practices of the women I spoke to. From another angle, this study is therefore also an ethnography of a particular contemporary British femininity. It provides insights into how gender is constructed and lived. Of particular note, this study highlights the continuing close relationship between gender identity and sexual identity and how they are reconciled, here with pharmaceutical assistance.

In this ethnography, we have seen that the norms of ‘natural femininity’ define aspirations and guide pill practice. Yet, these norms also reveal a range of other social roles that these women are expected, and want, to perform. This suggests that femininity is a composite of several different, often conflicting, subject positions rather than being a singular and static state. Henrietta Moore’s (1994) discussion of gender discourse and lived gender is instructive here. She argues that gender discourses do not represent actual lived behaviour but are powerful because people are only intelligible (in terms of how they construct themselves and organise their social practices) through a culturally available and historically specific set of categories. Moore suggests that in order to understand gender both as individual lived experience and as a social discourse, we require a concept of the subject as ‘a site of multiple and potentially contradictory subjectivities’ (1994: 55). In this view, different gender discourses and social practices, which vary contextually and biographically, provide different and possibly conflicting subject positions that individuals can take up. Moore further states that:

It seems evident that individuals do constitute their self-representations as engendered subjects through several different subject positions based on gender. It is equally certain that at different times most individuals will be asked to act out a variety of these subject positions and will have, therefore, to construct themselves and their social practices in terms of a competing set of discourses about what it is to be a woman or a man. These competing notions are not just ideas, because as discourses they have both material and social forces. Thus, the enactment of subject positions based on gender provides the conditions for the experience of gender and of gender difference, even as those positions may be resisted or rejected. (1994: 56)

The different qualities of the various feminine subject positions available to women in contemporary British culture emerge through different social situations, so that there is a range of ways of being a woman even within a single social milieu and, though they may be hierarchically ordered, are not equally available to all and cross cut with other forms of difference. These subject positions, though often contradictory as in the example of 'mother' and 'professional', are played off against each other and are constructed in counterpoint to each other. Yet, at the same time, they must be balanced and kept in play.

Through descriptions of how women use the pill, this study illustrates Moore's argument that femininity is a composite of different subject positions which are constituted through multiple gender discourses. Different gendered qualities and values come to the fore depending on the context of a particular social situation and relationships at specific times, which guide and inform how the pill is used. This reflects the multiple social roles and statuses of an individual woman at any given moment – for example, as mother, lover and lawyer – which may be experienced and conceptualised as compatible and inclusive or mutually exclusive and conflictual. In their accounts of using the pill these women described how, by using contraceptive technology, they attempt to inhabit the conventions of natural femininity across divergent subject positions. I have shown that taking the pill is part of an effort to be feminine when femininity is experienced as conflicting and contradictory as a result of performing a range of identities. The plurality of meanings of the pill is both embedded in, and indexical of, the plurality of gender – as both highly fluid identity and a practice. Yet, feminine subject positions are

not neutrally evaluated, and as I have shown, more naturalised positions appear to take precedence.

Moore (1994) suggests that certain subject positions are taken up over others due to their relative satisfaction, reward and benefits, suggesting agency beyond resistance and compliance. I propose, however, that the intense deliberations described to secure more naturalised positions do not reflect questions of relative satisfaction and benefit, but rather attempts to secure femininity at a time when natural femininity appears under threat and unstable from the large scale incorporation of women into the public sphere. Several ethnographies of new reproductive technologies have suggested that conventional gendered norms and ideologies (mostly related to reproduction) are most intensely enacted at times when they are most compromised (see Thompson 2005; Paxson 2004; Ginsburg 1989). In Charis Thompson's study of surrogacy and IVF technologies, she charts how increasingly fluid gender identities are fixed, and argues that 'one way to stabilise shifting notions of what is natural and normal around reproduction is to compensate with extremely conservative or stereotypical – parodic – understandings of sex, gender and kinship' (2006: 142).

Here we have seen how planning and achieving the previously taken-for-granted and inevitable bodily processes that define natural femininity such as pregnancy and menstruation may in fact threaten to displace the 'natural facts' of femininity. Yet these novel options and choices are situated within existing cultural references to nature and come to reinforce conventional values (see also Ragoné 1994; Rapp 1999; Ginsburg 1989). I claim that femininity, though artificial, somehow continues to be 'based on' 'natural facts' as the 'natural facts' of femininity and strategically reinvented in order to achieve and inhabit natural femininity. Ironically, though the pill is often framed as 'liberating' women from natural constraints, it is used in such a way as to incorporate and newly constitute the conventions of 'natural' femininity. The use of technology to perform conventional gender ideals normalises innovation within a context in which the cultural arrangement of sex, reproduction and gender is changing. These contemporary threats to 'natural femininity' may explain why this particular naturalised subject position comes to the fore at this specific time.

The intricate labour of doing femininity portrayed in the contraceptive narratives suggest that being a mother, lover, partner and woman is far from innate for the women

I spoke to; rather, it is something actively achieved with intense effort and meditation. Femininity is, therefore, the outcome of doing. It requires close regulation and intense enactment to make it appear both 'normal' and 'natural'. This can be seen as a continuation of practices to combine the contradictory positions and practices of femininity before and outside of contemporary late capitalism. Yet this study also found that there is comparable labour to control the female body. The respondents were equally concerned about 'being' physically female as they were about 'doing' the various feminine social roles. I suggest that the practices to constitute femininity were closely tied to the generation of femaleness. In the narratives, the physical character and qualities of the female body (here referred to as 'femaleness') remain central to these women's ideas and practices of femininity.

The women in this study clearly expressed that they took the pill to control their fecund, sexual and menstruating bodies, which would otherwise threaten their everyday activities and anticipated futures. They provided graphic accounts of how their bodies 'betrayed' them when aspects of the female reproductive cycle surfaced at inappropriate times, endangering their routines and their affective and professional relationships. They also talked about the different expectations and roles that all had to be enacted through one body. They described how their unique cyclical reproductive physiology and concomitant embodied constraints both structured and limited their performance of their different roles. For the women I spoke to there was no avoiding the fact that their bodies and embodiment were marked by the phenomenological experience of female reproductive physiology. This finding resonates with feminist phenomenologist claims, outlined earlier, that the female body is a material presence that set a range of embodied possibilities, though is not necessarily determinant of social roles.

These descriptions of embodied experience require an interpretation that is not reductive or essentialist nor theorised away with discourse. As a point of departure, I take the view that sexual difference and the female embodied experience are constituted and lived through socially and historically specific valued body, body parts and bodily processes (Butler 1993; Davis 199; Fausto-Sterling; Young 1990; see also Foucault 1978). The way that the body is experienced is foreclosed in culturally specific ways and is, therefore, always culturally mediated. The body and culture are mutually constitutive and relations of power are relayed through the body and interactions between them with normalising effects (Foucault 1978, Butler 1993). In this way, the

body is a medium of culture, not an inscriptive surface, and a locus of social control through bodily and embodied practices. Therefore, embodiment has political, social and moral significance.

The contraceptive narratives showed how the pill was used to 'control' the unruly reproductive cycle yet not so much so as to undermine the conventions of femininity. Instead the pill was used to regulate the reproductive cycle to produce a specific female body that corresponds to a range of feminine expectations. In a sense, the women I spoke to were using the pill to generate a specific bodily identity that can be reconciled with the various subject positions of femininity. Femaleness is performed in parallel to the performance of femininity and both must be reconciled successfully. In this way the pill is used to alleviate the contradictions and tensions between femininity and femaleness. This concrete example of the relationship between gender and sexual identity reveals the double performance (or doing) of femininity: firstly, the performing of expected social roles and secondly, the generation of a corresponding body. This provides a bodily dimension to Moore's (1994) of how gender is constructed in discourse and how it is lived.

We can, thus, interpret the use of the pill as an attempt to reconcile feminine identity with natural identity, with sexual identity and with normal identity. Yet the study also shows that there is not an easy or inevitable relationship between being 'normal', being feminine and being female. This could be read as the performance of gendered norms, which are never complete nor under control (Butler 1993) and, moreover, because femininity crosses several often incommensurate social fields (Moore 1994), is impossible to achieve totally. Given this, should we understand the attempts to control and reconcile the female body with femininity as re-inscribing the inherent instability and impossibility of both feminine and sexual identities? Does using the pill recapitulate the instability of sex and gender in the very process of trying to reconcile and stabilise them? Technologically-enabled choice reveals the fluid character of sex and of gender, the contradictions of its conflicting parts and the impossibility of ever achieving them in whole and the pill, therefore, becomes a symbol of the dilemma of femininity: its inherent impossibility. In the narratives the promise and desire for choice and control emerges from the perceived lack of control over the conditions of femininity and the female body and makes the desire for the pill understandable. Ironically, however,

taking the pill shows the persistent lack of control over the conditions that define femininity and the female body as unacceptable.

Implications for Analysing Empowerment and Agency

The findings about the multiple subject positions of femininity and the strategic uses of 'natural facts' to re-ground gender norms, ideologies and statuses highlight several interesting implications for conceptualising empowerment and agency. In the public health, demographic and economic analyses of contraceptive practices discussed in the Introduction, the availability of modern contraceptives is seen as a tool by which women may enact rational, self-interested action and subsequently gain reproductive and productive autonomy from social institutions. The pill's mode of administration in particular individualises contraceptive and reproductive decision-making and control and is seen to exemplify the exercise of agency, enabled by technology.

A finding of this study is that 'control' and 'choice' have physical, cultural and structural limits. This raises several questions about the purported desire for empowerment, the analytical emphasis on the self-realisation of autonomous will and the emancipatory goals of progressive politics. I have argued throughout the thesis that the women I spoke to represent a unique demographic with unprecedented and extensive educational and professional opportunities and diversified reproductive options. Although their experiences are couched in the complex language of 'choice' and 'control', the experience of choice and control is partial and contradictory. These women described their actions as choices directed towards self-defined goals yet these goals were often relational in nature (whether with a future child, lover or employer). Nor could their 'choices' and acts of control easily be described as emancipatory in that they ultimately reproduced the very norms and structures that they felt constrained them. Rather than challenging norms and ideologies about natural femininity, these women, by taking the pill, are themselves reassembling 'natural facts' and thereby upholding and reinforcing naturalised gender and sexual difference. These practices appear contrary to the principle of self-realisation of autonomous will and emancipatory politics. Taking the pill could be interpreted as an attempt to realise these women's interests within social and cultural constraints or some kind of mystification. Yet I see this type of interpretation as diminishing the overriding positive and fulfilling

descriptions of their experience of control and choice and as neglecting the sense of achievement and self-worth.

In framing the pill practices as paradoxical, this ethnography also offers a comment on the analysis of agency. Specifically, it contributes an illustration of agency understood as actions that must be understood within their own social and moral framework, which creates the conditions for action and through which individuals recognise and define themselves. In other words, the goals and actions of agency cannot be pre-determined by the analyst as those leading to a set idea of empowerment and autonomy. A highly pertinent example of this approach is Saba Mahmood's (2005) research amongst a group of women in Cairo, who were participating in an urban women's mosque movement which formed part of a larger Islamic Revival (the Piety Movement). Her analysis provides guidance in analysing seemingly paradoxical practices and forms of agency. Like the women I spoke to, the women in Cairo were entering new social terrains and acquiring new social roles from which they had been previously excluded and they were participating in a range of practices seen to uphold 'traditional' gendered virtues that were incongruent, even contrary, with these social transformations.

Mahmood (2005) argues that to understand such seemingly 'paradoxical' practices requires a decoupling of agency from its definition as a desire for autonomy and the privileging of emancipatory politics. She proposes that agency should instead be understood as 'the capacity for action that historically specific relations of subordination enable and create' (ibid: 35), which cannot be defined in advance but should emerge through the consideration of the cultural, moral and political conditions in which acts acquire meaning. In this approach she shifts the emphasis towards the cultivation and performance of certain virtues through disciplinary acts and practices on one's thoughts, body and conduct within the moral framework of a particular milieu. Conventional norms and ideal virtues (such as natural femininity and female bodies) form part of an internal moral framework that guides individuals' actions and inform how they define, describe, interpret and judge themselves. Agency is not simply a question of submitting to or resisting social conventions implied by progressive politics but can be rather be interpreted as the actions necessary to properly inhabit conventions. This latter approach better captures the sense of struggle and achievement experienced in the attempt to cultivate and embody certain conventions.

A similar approach to agency has been applied in the study of new reproductive technologies. Several anthropologists have examined how technologies are used strategically by people to achieve conventional norms and identities as these historically situated goals, practices and relationships are the measures by which people recognise and judge themselves (see Carsten 2004; Franklin and McKinnon 2001; Franklin et.al. 2000; Thompson 2005). Charis Thompson (2005) argues that agency is not just the power to act, but 'refers to actions that are attributable to people or claimed for oneself, that have definitions and attributions that make up the moral fabric of people's lives, and that have locally plausible and enforceable networks of accountability assigned to them' (2006: 181). Similarly to Mahmood, she argues that we must look at actions as a form of local achievement of identity without setting or predetermining what the achievement is beforehand. For Thompson technology cannot be reduced to a form of objectification, alienation and loss of personhood resulting from the disciplining and subjugating of the person but is rather an incorporated part of self-making. She vividly describes the social roles and corresponding ontological statuses that people routinely switch between in daily life and in a fertility clinic to illustrate how they, their roles and values are intertwined with the specific environment. The heterogeneity of roles and ontological statuses (in this case professional, patient, body, and/or body part) correspond with a range of forms of objectifications, alienation and agency, which are revisable depending on the state and success of treatment. These different roles, ontological statuses and forms of agency must be coordinated and feed into self-making.

There are parallels between these accounts of taking the pill and Thompson's analysis, in that the women in this study strategically used the pill to act upon their circumstances by deftly balancing and coordinating bureaucratic, kinship, sexual, intimate and professional current and future roles and expectations in order to best inhabit contemporary social conventions of femininity and make claims in different ways. In the various different domains discussed, we see how a specific social role with a corresponding ontological status and sense of agency comes to the fore over others depending on the context. For instance in the clinic, they downplayed their intimate concerns for more biomedical ones and often diminished their professional personas in favour of being 'good patients'. To be successful professional women they actively altered their bodies without referring to biomedical knowledge and minimised the

import of their intimate and kinship relations in generating their desired bodies.¹⁵⁴ As future mothers they emphasised their active altruism over their roles as submissive patients, passionate lovers and professional workers. These different social roles in the clinic and in daily life relate to the different subject positions of femininity and their different ontological statuses and forms of agency, all of which must be coordinated in order to constitute their femininity.

While Thompson's definition of agency is useful in understanding the relationship between agency, identity and technology, it does not capture the importance of the body and embodiment that has repeatedly emerged in this study. In this ethnography, the body and female embodiment crossed different social fields and roles as the reproductive cycle was seen to affect the adoption of certain roles and the pill was used to better regulate this. Here, the work of Saba Mahmood (2001b), who places more emphasis on the body and bodily practice, is informative. In her detailed analysis of the relationship between ritualised behaviour and spontaneous action, Mahmood illustrates how the bodily act of prayer is a site for the purposeful moulding of intentions, emotions and desires in line with virtues of Islamic piety. Through highly prescribed bodily actions of prayer the women of the mosque movement hoped to refine their ethical capacities to better realise piety in their daily lives. Prayer was, therefore, a conscious process intended to induce a desired moral, emotional and bodily disposition. She explains that the repeated practice of orienting acts toward God's pleasure was a cumulative process that creates the desired self. Bodily practices are the way in which moral character is acquired and through which an individual becomes a certain kind of person. The body is thus a site for pedagogic work and the cultivation of certain skills and aptitudes through self-directed conscious training of repeated performance and learning that, thereafter, become part of the embodied disposition (*habitus*) of the embodied subject formed.

I suggest that there are parallels between the principle of self formation in certain bodily practices of taking the pill. Through the repeated practices of taking the pill, the women I spoke to are attempting to orient their desires, their emotions and their bodily gestures in accordance with the conventions of contemporary femininity. In this way, taking the

¹⁵⁴ As I have shown in the ethnography, often the actions and practices of the women were not necessarily related to or determined by medical knowledge, which raises questions about ideas of 'biopower' and 'biopolitics'.

pill aimed to generate a body and bodily comportment through which normative feminine qualities and capacities are acquired. In their accounts, the women I spoke to did not assume that being female and feminine are natural and inevitable but suggested that they must be generated through a set of bodily practices which included using the pill. They described how they feel able to adopt different social roles and allied ontological statuses of femininity when they take the pill. In reconciling the female body with the expectations of femininity, they can be seen to be actively re-orienting themselves and their bodies in accordance with the various norms of feminine conduct. The pill can be seen as a part of bodily practices that cultivate certain skills, aptitudes and embodied feminine dispositions. This differs from Mahmood's analysis in that these actions, rather than religious acts whose explicit reference is to a prescribed submission to God with recognised virtues, are rooted in objectives which are naturalised and hence implicit. This study, by reframing agency beyond the analyst's categories, suggests that the paradoxical practices associated with the pill – recreating gendered conventions – constitute a type of agency through which women may cultivate the capacities and skills to inhabit social norms.

I have argued in this thesis that the women in this study are attempting to inhabit a composite and changing femininity and with the pill they actively learn, embody and demonstrate their femininity. The pill is therefore not a tool of emancipation and liberation, as is implicit in the rhetoric of public health, demographic and economic approaches, but rather a means to safeguard all that makes one feminine (even its inherent instability and impossibility) when this category becomes increasingly unstable. Yet can the revolution of the pill be reduced to a continuation of the 'feminine condition', or has it had an impact on the social conditions of contemporary British women? An area for further research would be to explore how contemporary attempts to be feminine generate new embodied possibilities and open new realms of meaning.

Some Final Thoughts

Throughout this thesis and in the conclusion I have argued that the pill is a technology used to negotiate with the instability of contemporary feminine identity and roles and, at the same time, re-stabilise femininity by continuing to ground it in 'natural facts'. I return to the question raised by Collier and Yanagisako (1987) that I drew attention to in the Introduction: do the 'natural facts' of sexual intercourse and reproduction continue

to play a role in the construction of gender difference for the women in this study? The pill ruptures the 'natural facts' of femininity by separating sexual intercourse and procreation and therefore poses a potential challenge to the cultural logic of femininity and gender difference. Though the core symbol and apparently inevitable explanatory frame of 'nature' has been destabilised, the desires, practices and experiences of the women I spoke to continue to centre on the conventions and contradictions of 'natural femininity'. Moreover, the constant recourse to nature suggests that femininity continues to be constituted as self-evident and unquestionable. Thus, the 'natural facts' of sexual intercourse remain relevant to gender and sexual difference for the 'daughters of feminism', often because they are encompassed within the technological realisation of their desired affective, aesthetic and embodied goals.

This ethnography also contributes an understanding of how a very particular group of women, the 'daughters of feminism', conceptualise and live femininity in the contemporary United Kingdom. Their frank accounts demonstrate how the pill forms an important part of their efforts to balance the often contradictory demands made upon their bodies and persons in various spheres of their lives. The social life of the pill is made up of multiple roles in the everyday negotiation of femininity and is both a source of disruption and a provisional solution. It is part of how these women learn, experience and act out their daily lives as 'modern' women, particularly the cultivation, performance and reconciliation of femaleness alongside femininity.

To conclude I recount an excerpt from a late night chat with a girlfriend that reminded me that the pill is a choice and that social, bodily and symbolic self-management is often experienced and lived as positive and enhancing. My friend explained to me how her pre-menstrual mood and pain were horrible and how she suffered from depression, which was affecting her personal and professional life. But when she started on the right pill, after a long period of trial and error, she told me how things had got better: 'Oh yes, my life has changed. ... You don't know what it is not to feel like a crazy woman anymore'. She reminded me that for her taking the pill meant she did feel like 'a crazy woman' and for her, like many women, it represented a new form of bodily control and hence was experienced as a revolution in how she lived her life well beyond the more obvious sphere of reproduction.

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Appendix One: Respondents' Biographical Details

In addition, 10 male partners of pill users and 15 members of staff from the Margaret Pyke Centre (including doctors, nurses, administrators, counsellors as well as the deputy direct and director) were interviewed.

Profile	Age	Occupation	National	Partner	Name in thesis	Start	# of pills	Continuous use	Period Discomfort	Adapt Periods	Kids	Abortion	Interview location	Interview Length
1	18	Temporary work	British	B		18					0	0	Clinic	30 m
2	19	Fraud detective (opera singer in training)	Australian	B		17 sex	0	2			0	0		28m
3	20	Service sector	Poland	B		19					0	0	Clinic	30m
4	21	Service sector	British	S		17	1		x	x	0	0	Clinic	20 m
5	21	Service sector	British	B		17 sex	3		x	x	0	0	Clinic	1 h
6	21	Actress	Irish	B		21 sex					0	0	Clinic	30 m
7	22	Temporary work	British	B	Jessica	18 sex	1	6		x	0	0	Public/Home	3 h
8	22	Law student	British	B	Tammy	21	2		x	x	0	0	Clinic/public	1.30 h
9	24	Researcher, Government	Taiwanese	C		23 sex	1		x	x	0	0	Work	1.30 h
10	24	Administrator	British	B	Heidi	14 pain	3	8	x	x	0	1	Clinic	40 m
11	24	Lawyer	British	C		17	4		x	x	0	0	Public	1.30 h
12	24	Documentary maker	Cypriot	B		18 sex	2	6	x		0	0	Public	1.45 h
13	24	Personal assistant, Goldman Sachs	British	S	Tania	15 sex	1	9	x	x	0	0	Public/Home	7 h
14	25	Accounts manager, Sainsbury	American	B	Beth	17 sex	1	8	x	x	0	0	Public	2 h
15	25	Medical student	British	B	Nancy	24 sex	0		x		0	0	Clinic	1 h
16	26	Publishing	British	B		20 sex	3				0	0	Clinic	15 m
17	26	Patent lawyer	British	B	Elizabeth	25 sex	1		x	x	0	0	Public/Home	4h
18	26	Stage Manager	British	B	Francis	19 skin	1	7	x	x	0	0	Public/Home	4.30 h
19	26	Banking	British	S		19	2		x		0	0	Work/Public	30 m
20	26	Psychology student	British	S		18 sex	3				0	0	Clinic	30 m
21	26	Accountant	British	C		18 acne	2	8	x	x	0	0	Public	1 h
22	27	Doctor	British	C		21 sex	1				1	0	Home	50 m
23	27	Civil Servant	British	C	Mary	16 pain	2	11	x	x	0	0	Clinic	2.30 h
24	27	Manager private sector	British	S		18	3		x		0	0	Public	2 h
25	27	Student/receptionist	Polish	B		20	2		x	x	0	0	Clinic	15 m
26	28	Circus Artist	British	B	Fiona	14 pain			x	x	0	1	Clinic	1.15 h

27	28	communications manager, Charity	British	B	Isabel	18 pain	3		x		0	0	Clinic/Public	2.30 h
28	28	Legal/Human Rights Charity	Australian	B		28 sex			x		0	0	Clinic	30 m
29	28	Business Analyst	British	B		18 sex		10	x	x	0	0	Public	1.15 h
30	29	project officer, NHS	British	B	Betty	14 skin	3	15	x	x	0	0	Public	2 h
31	29	researcher, UCL	British		Dana	17 sex	2		x	x	0	0		2.3 h
32	29	Civil servant	British	B		15 sex	2				0	0	Clinic	15 m
33	29	Marketing Manager	Australian	B		18 sex	2		x	x	0	0	Clinic	15 m
34	29	Publisher Account	British	S		15	3				0	0	Public	1.30 h
35	29	Image researcher (advertising)	British	C	Tina	16 pain	3		x	x	0	0	Work	2 h
36	30	Lawyer/ Management Consultant	Ukraine	B		23	2	7	x		0	2	Clinic	1 h
37	30	PhD Kings	British	M		15	3				0	0	Public	1.45 h
38	30	Marketing	Kenyan	M			3				1	3	Public	1.30 h
39	30	Housewife	British	M			4		x	x	0	0	Public	1 h
40	30	Publisher Account	Australian	C		19	3		x		0	0	Public	1.15 h
41	30	Events manager, publishing company	British	S	Rachel	17 sex	1	13	x		0	0	Home	5 h
42	31	Sales assistant	Polish	B		20	3	x			0	0	Public	1.30 h
43	31	Management/ Nurse	British	B		18	4		x	x	0	0	Clinic	2 h
44	31	Nurse	Turkish	M		21 sex	3				2	0	Clinic	1 h
45	31	Journalist	Portuguese	M							1	0	Playgroup	15 m
46	32	Speech therapist	British	C	Bianca	19 sex	2				0	0	Home	2.45h
47	32	Personal assistant, Goldman Sachs	Australian	S		19 sex	5				0	1	Public	3.30 h
48	32	Jeweller	British	B		17	2		x		0	0	Public	1.15 h
49	32	Publisher	British	C		18	4	13	x		2	0	Public	1.30 h
50	34	Media planner national radio	British	S	Kate		?		x		0	0	Work	3 h
51	34	civil servant, home office	British	S	Kirsten	16 sex	2	16	x	x	0	0	Public	5.30 h
52	34	Editor/Academic publisher	British	B		21	2		x		0	0	Clinic	45 m
53	34	Events manager	British	B	Rebecca	19 sex	1	10			0	0	Clinic	1 h
54	35	University Research	British	C		15	1		x		1	0	Home	1 h
55	35	Senior administrator, University	Irish	S	Emily	17 sex	3		x	x	1	1	Home	4 h
56	35	Manager private sector	British	C	Louise	17 sex	2	18	x	x	0	0	Public	1 h
57	38	?	British	B		23	4		x		0	0	Clinic	20 m
58	38	Advisor, CAB	British	S	Kim	18 sex	?	4	x	x	0	0	Clinic/Work	2.30 h
59	39	Senior business executive	British	B	Beatrice				x		1	0	Work	1.10 h
60	39	Scientific researcher	British	C							0	0	Playgroup	30 m

61	40	Teacher	British	C		19 sex	1		x	x	2	0	Playgroup	30 m
62	41	Occupational therapist	British	C		17	2	x	x		1	0	Home	1.15 h
63	42	director, advertising company	British	B	Karen	18 pain	1	23	x	x	0	0	Public	1.30 h
64	43	Former advertising exec/ current childbirth coordinator	British	M		17 sex	2	10	x	x	3	0	Home	1.30 h
65	44	Journalist	British	S	Teresa	16 pain	0	16	x	x	0	0	Clinic	1 h
66	45	Research	British	M							2	0		30 m
67	51	mother	British	M		32	2	18	x	x	3	0	Clinic	15 m
68	55	Deputy CEO (charity)	British	S		19	2	16	x	x	0	0	Work	1.30 h
69	70	Retired teacher	British	S		29 sex		34	x		0	0	Home	1 h

S – Single
 B – Boyfriend
 M – Married
 C – Cohabiting

Appendix Two: Content of the Patient Information Sheet distributed during study

Patient Information Sheet

1. Study title

The Social Life of the Oral Contraceptive Pill

2. Invitation paragraph

You are being invited to take part in this research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

If you decide to participate, you will be given a copy of the information sheet and a signed consent form to keep.

Thank you for reading this.

3. What is the purpose of the study?

This ethnographic study is jointly based at the Department of Anthropology and BIOS Centre at the London School of Economics and facilitated by the Margaret Pyke Centre. It is the basis for a doctoral dissertation concerning the use of the Oral Contraceptive Pill. This research addresses the non-medical aspects use of the pill using interviews and observation in order to explore how decisions about use of the pill affect and are affected by reproductive and sexual history, familial and intimate relationships, self-image and notions of responsibility and risk.

In these interviews you will be asked about your contraceptive choices and experiences. We would be interested to hear your views about the pill and the reasons why you choose to take it.

4. Why have I been chosen?

This study is seeking 20 participants who are willing to be interviewed about their decision-making concerning the use of the pill.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive at MPC.

6. What will happen to me if I take part?

If you decide to participate you will be expected to take part in two one-on-one interviews that will last approximately one hour each. These interviews will take place in a private room at the clinic or in place and time that is most convenient to you. You will be expected to answer questions regarding your reproductive and sexual history, familial and intimate relationships, self-image and notions of responsibility and risk.

7. What do I have to do?

This research requires no lifestyle restrictions, medication or medical test. It is simply two conversations about your use of the Oral Contraceptive Pill.

Participants who agree to be interviewed will be interviewed in their homes or at the clinic at their convenience by the chief investigator. You will be asked questions about yourself generally, your reproductive, sexual and contraceptive histories and about the significant events, peoples and issues that

have affected your contraceptive decision-making. The interview is expected to last approximately one hour.

8. What is the drug or procedure that is being tested?

No drugs or procedures are being tested.

9. What are the possible disadvantages and risks of taking part?

There are no possible disadvantages or risks of taking part in this study.

10. What are the possible benefits of taking part?

There is no intended clinical benefit to the patient from taking part in this study

11. Will my taking part in this study be kept confidential?

All the information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will not include your name and address so you will not be recognised. Your identity and responses will be kept confidential and anonymous throughout. Clinical and medical staff do not have access to your responses, and the responses will not be linked to your medical records.

This research is not being conducted by a GP, but we can notify your GP of your participation in the study if you wish.

12. What will happen to the results of the research study?

The results of this study will be analysed and published in a doctoral thesis and in academic journals. The published results will be made available to participants from the Research Director at the MPC. You will not be identified in any report or publication.

13. Who is organising and funding the research?

This research is being jointly organised by the Department of Anthropology and the BIOS Centre at the London School of Economics and facilitated by the Margaret Pyke Centre.

14. Who has reviewed the study?

The Camden and Islington Research Ethics Committee has reviewed and approved this study.

15. Contact for Further Information

If you would like more information, please contact the MPC Research Director or Ms Vicky Boydell:
v.j.boydell@lse.ac.uk

Thank you taking part in this study!