

Thesis submitted for the award of PhD at Lancaster University

**Negotiating the fertile body: Women's life history experiences of using
contraception**

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Declaration

This thesis is all my own work and has not been submitted in substantially the same form towards the award of a degree or other qualificatory work. This PhD has been funded by the Economic and Social Research Council.

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Abstract

British women experience a conundrum in the context of contraception. Despite knowledge about and free access to myriad methods Britain currently has high rates of unintended pregnancy (estimated as high as 2/3 in some cases). This thesis uses a feminist approach and Foucauldian theory to explore this phenomenon by addressing the gaps in current understanding namely the situated and subjective experiences of contraception use over the life course. Using a qualitative life history method and map-making, this research used Listening Guide analysis to understand 15 British women's contraceptive life histories. Three substantive chapters situate these narratives within the political and social landscape of neoliberal Britain over the last 30 years. The first presents 4 individual life stories and drawing on the concept of 'stratified reproduction' indicates how many women's contraceptive choice is not free but is shaped by structural inequalities. The second exposes the meaningfulness of hormonal contraceptive 'side effects', namely the consequence to their sense of self, and argues for a departure from the typically reductive perspectives on the impacts of contraception use. The third chapter highlights the changes over time, or lack thereof, in contraceptive practice as experienced by the women participants and demands a shift from the *rhetoric* of 'contraceptive choice' towards a lived reality of supportive women-centred provision. Finally, these findings are conceptualised as 'disconnections' of a woman from both herself and from contraceptive providers and are theorised in relation to competing neoliberal (masculine) and female subjectivities. I argue that the current circumstances create an impossible position for contracepting women to successfully occupy. In conclusion, the narratives in this thesis compel us to adopt instead a model that approaches contraception use as more than an individual experience and to recognise and address the contextual factors that undermine women's contraceptive choice and compromise sustainable use.

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Dedicated to Jiles – an amazing feminist and friend without whom I would not have applied for this PhD

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Chapter 1 Introducing the contraception conundrum: Exploring British women's life histories of using contraception and managing pregnancy.

"Contraceptive methods allow you to choose when and whether you want to have a baby" (NHS UK 2016)

Over the last 18 years, I have lived out my own experience of contraception first hand to avoid pregnancy. I was 15 when I attended my local sexual health clinic to seek contraception - a consultation that was ultimately distressing and had a profound impact on my experience as a contraceptive user for years that followed. As a young woman, my first independent experience with health services made me feel humiliated, disempowered and frightened of serious ill health. I now understand this event as formative in part for my interest in sexual and women's health today. More recently, I have also been employed as a support worker and advocate in women's specific services and in a national sexual health charity; and have seen the benefits and challenges of contraception provision and use from this perspective. Both personal and professional experience therefore stimulated my interest in this topic and led me to ask questions about the nature of contraception in women's lives; questions that reached for answers beyond the 'what' - such as that represented in the simplistic statement about contraception at the start of this chapter. Indeed, such a conceptualisation of contraception at the very least belies its international significance as an invaluable, even life-saving product for improving the quality of life for women and their families (UNPFA 2012).

Compared to the global population, of whom 220 million are cited to have an unmet need for contraception (IPPF 2015a), women in the United Kingdom (UK) like myself have a wealth of resource in terms of free access to a range of methods. This relatively comfortable position is reflected in the UK contraceptive prevalence rate of 80% - the percentage of women aged 15-49 who are engaged in some form of contraceptive practice (UNFPA 2014). This availability of methods does of course go some way to

mediate the timing of women's pregnancy. However, the current circumstances related to UK contraception use reflect a situation that could, in fact, be considered something of a conundrum.

This conundrum is as follows: despite wide access to a variety of methods for free and with arguably normalised use of contraception as indicated by UK contraceptive prevalence (Lader 2009; NICE 2014; UNFPA 2014), high unintended pregnancy rates persist with as many as 50% of pregnancies in England alone labelled as such (DH 2013). These unintended pregnancies are attributed to no, or inconsistent, use of contraception (Bury and Ngo 2009) and alongside the associated abortions, are very financially costly (DH 2013). In addition, in what has been described as a "perverse consequence" of efforts to tackle teenage pregnancy and a disproportionate emphasis on services for younger women under 25 (APPG 2012; p21) unintended pregnancy is now rising amongst older age groups, such as the over 35s (DH 2013). Therefore, regardless of the free and accessible nature of contraception, UK women are clearly struggling to find acceptable and sustainable methods to suit their needs.

Evidence indicates that past explanations for these phenomena, such as lack of knowledge about and accessibility of contraception, may be of waning relevance for women across the UK where contraceptive provision is free and commonplace (Brown and Guthrie 2010; Middleton 2011). It is, however, known that women frequently stop and switch their method throughout their contraceptive lives and it is increasingly recognised that a more nuanced understanding of women's contraceptive practices is imperative if we are to locate appropriate methods that circumvent unintended pregnancy (Inoue et al, 2015; Wellings et al, 2015; Wigginton et al, 2016). Recent critical review has highlighted how women's experiences with contraception are typically interpreted in a biomedical framework (Inoue et al, 2015) - the dominant model of healthcare that privileges the biological and medical over other social and psychological facets of health (Wade and Halligan 2012). This approach appears to be ineffective considering the rates of method discontinuation and unintended pregnancy. Therefore, it has been recommended that more attention be paid to the socio-cultural, sexual and psychological aspects of contraception use

and that women's subjective accounts may offer ways to better understand contraceptive practices more comprehensively (Inoue et al, 2015).

This suggestion however, as with the biomedical model, is overwhelmingly directed at the individual (see for example Glasier et al, 2008; Okpo et al, 2014; Prati et al, 2014). By default, it neglects the broader contextual influences that shape contraception use. Recent life course approaches have begun to recognise the potential shifts in women's contraceptive needs over time (DH 2013), highlighting the importance of understanding the multidimensionality of the contraceptive experience. The current statistics related to unintended pregnancy and abortion rates, coupled with the stopping and switching of contraceptive methods in the UK, challenge the straightforward assertion that women unproblematically use contraception and choose when to have a baby. Subsequently the evidence base (and its gaps); recommendations for more nuanced and subjective approaches to understanding contraceptive practices; and, the possibilities afforded by life course approaches, present a platform from which to explore so-called 'contraceptive choice' and suggest that new perspectives may be needed to address the issue in a more meaningful way. This thesis seeks to respond to this challenge by aiming to offer detailed accounts of women's diverse experiences of contraception use to gain a situated understanding of the influences that shape women's choices to use, or not use, contraception throughout their reproductive lives.

To go beyond existing conceptualisations of contraception use, I have used a combination of life history methods, map-making and a feminist methodological approach. These methods were designed to meet the key aim of the research: to address the lived experience of contraception use and broader contextual factors to gain a situated and subjective understanding of the influences that shape women's use, or non-use of contraception throughout their reproductive lives.

The specific objectives of the research were to:

- Draw together and characterise the historical contextual factors that may influence British women's contraceptive choice

- Analyse and situate British women's contraceptive experiences in relation to these broader cultural, historical, political and economic factors;
- Explore the effect of individual women's life experiences on their decisions about and practices regarding contraception;
- Identify any transitional life events that have influenced individual women's decisions and practices regarding contraception;
- Explore the impact of women's knowledge about contraception and if/ how the sources of information and nature of their understanding may have changed over their life courses;
- Explore the interplay between determinants of contraceptive choice/use;
- Capture the dynamism of the influences on contraceptive choice/use over the individual life course; and
- To inform policy and practice in a way that is meaningful and relevant to contracepting women.

Because the research required women to have, or have had, a contraceptive need, I focussed on those who engage, or have engaged, in hetero-sex and hence have experienced a risk of pregnancy. Furthermore, to relate to contemporary contraceptive policy, I also focussed on the contraceptive lives of women currently understood to be of reproductive age - between 18 and 45 (Wellings et al, 2013). I adopted a broad notion of contraception so that whatever the woman, herself, defined or practiced was captured. This approach deliberately differed from more rigid definitions of contraceptive methods used in policy allowing for non-biomedical understandings of contraception to be considered.

The project was also conceptualised in relation to British women, and specifically focused on the North-West of England. This is instead of the United Kingdom as the circumstances in Northern Ireland are considerably different regarding access to contraception and policy related to sexual and reproductive health. That said, the foci of research, policy and official statistics that I have drawn on vary, and relate to the UK, Britain, England and Wales and so on – this is highlighted accordingly throughout

the thesis. Although Scotland has its own governance, education and healthcare systems and I acknowledge that it is increasingly seeking to shift away from neo-liberal values to a more social welfare model, it shares, broadly speaking, approaches to contraceptive service delivery and promotion now and over the recent past.

This introductory chapter has laid out what I have termed the 'contraception conundrum.' The following chapters will go on to explore this in more detail as follows:

Chapter 2 starts by outlining the current contraceptive context and challenging dominant assumptions about contraceptive practices; specifically, through the introduction of a critical perspective on individual 'contraceptive choice' and typical clinical and research approaches to contraception use as dependent on fertility intention. This discussion is structured in three main parts. The first sets the scene with regards to contraception at global and national level. Following this, I critically examine the research on women's individual experiences of contraception, with emphasis on what is referred to as 'method acceptability,' including the exploration of side effects. The evidence base is drawn upon to consider factors that are understood to influence contraceptive practices. The final section considers broader (macro) contextual factors that influence contraceptive use including: policy and practice imperatives; emerging contraceptive technologies and their promotion; public health campaigns and health scares; and broader socio-political trends linked to evolving neoliberal values over the period reflected through the contraceptive careers of women aged 18-45. This chapter is illustrated with excerpts and images from archival sources throughout and the material is restricted to those factors that have had an impact on the women who took part in the research - as articulated in their own words. As such, other factors such as the influence of Big Pharma and procurement arrangements are not included.

The third chapter sets out the theoretical perspectives that shaped the approach of the research and through which the fieldwork material has been interpreted. In-keeping with the aims and objectives, this chapter addresses contraception from both

individual and broader cultural perspectives. Thus, in the first part of chapter 3, feminist and constructionist frameworks are used to explore the reproductive roles and shifting expectations placed on women and the purported social and sexual liberation afforded by contraceptive availability. Intersectional theory is drawn on to illustrate how factors such as class, ethnicity and age can influence a woman's experience of contraception. In the second part of the chapter, I explore 'contraceptive choice' using critical approaches to notions of choice inherent in neoliberal discourse. I theorise the nature of some of the factors that constrain and regulate, arguing that social versions of 'good' contraceptive practices mean that choices are expressed within certain parameters. I will also discuss how contraception use creates a platform for intervention on women's bodies and how Foucauldian notions of self-regulation and bio-power are enacted through contraceptive service delivery.

The research methodology adopted in the thesis is the focus of chapter 4. The discussion emphasises how the approach I used was designed to capture in detail women's subjective experiences of contraception. This is distinct from extant research that, to date is very often clinical or quantitative. I demonstrate how feminist qualitative research, in this case multi-stage naturalistic life history interviews, were best suited to capture the full extent of women's experiences with contraception over their lives and the myriad dimensions of influence on their practices. The chapter discusses the merits of map-making, a form of graphic elicitation, and why this was undertaken to complement and prompt the life history meetings. Included here is a full description of the research design and process including the sampling, fieldwork and ethical considerations which arose in the three meetings with each of fifteen participants; women that were recruited from a diverse range of community settings across the North West of England.

Chapter 5 describes the Listening Guide analytical method that was used to interpret the narratives that were collected through my fieldwork. As this approach is infrequently used and little documented, I have included this chapter to offer the reader an insight into its application and to justify the suitability of its use. The

Listening Guide is described both theoretically and is reflected on from my practice experience. Due to the Listening Guide's feminist foundations and emphasis on reflexivity, the detailed accounts of my intellectual and emotional responses and reflection on my positionality are also included in this chapter.

Chapter 6 is the first of the empirical chapters. Here I draw on individual life history narratives to reflect on the diversity of four women's life experiences of contraception use over time. These accounts are approached from an intersectional perspective through the concept of stratified reproduction – a hierarchy which characterises the varying social desirability of different 'types' of women for reproduction (and hence conversely those who are more strongly driven to use contraception and avoid pregnancy). The individual stories are complemented by the participant's maps, which offer visual representations of their life experiences and profound insights into their respective selves. This visual data from the map-making exercise is considered in relation to the verbal narrative and (in)consistencies between the two have been interpreted and presented accordingly.

Chapter 7, the second empirical chapter, sets out the collective account of the women participant's experiences of hormonal contraception use and its impact on their sense of self. These findings suggest the need for a reconceptualisation of the reductionist concept of 'side effects' to reflect a broader more holistic experience of the impacts of hormonal contraception use. Demonstrating how there was a perceived difference between the 'normal' and the contracepting self respectively the findings assert that self-knowing in the form of self-awareness of their body including the nature of their normal and contracepting selves respectively is beneficial, offering more reliable understanding of the impacts of contraception. Theoretically, this chapter suggests that hormonal contraception use creates a tension between these selves (subjectivities) leading to an identity crisis that may undermine method sustainability. The material also illustrates how the disconnection from any sense of 'real' self, is exacerbated by a disconnection between the contracepting women and their practitioners who conceptualise the 'contracepting self' to be inherently 'normal.'

Having set out to consider change over time at both micro and macro levels, and how these influence women's contraceptive practices, these shifts (or lack thereof) are documented in chapter 8 where I present the final body of empirical material. The participant's narratives revealed a somewhat unexpected picture that is unpacked in this chapter. First, that at individual level, the diversity of these women's (contraceptive) needs and lives and the absence of any typical transition points within them, may limit any meaningful deployment of life course models that are currently being proposed in policy to approach sexual health and contraception. In addition, the women's accounts support recent evidence that indicates that contraceptive practices are strongly linked to attitudes to *contraception* rather than fertility intention, and that the main commonality in women's practices over time is the impact of their own personal historical experience with methods or providers, rather than any pre-defined 'life stage.' This chapter then uses excerpts from the women's narratives to indicate how, despite superficial changes such as increased service access initiatives and a proliferation in method options over the last 30 years, at the macro-level, i.e. within the service delivery environment, (bio)powerful practices prevail and shifts in rhetoric towards contraceptive choice are fallacious.

In chapter 9 the theoretical, empirical and methodological contributions of my research are discussed and reconciled through a series of visual representations. This chapter draws out my contributions to the field including: the disconnection thesis – where women can experience disconnections from their sense of self and from their contraceptive providers; the concept of contraceptive dysphoria, a term I use to describe the holistic experience of the impacts of hormonal contraception use; and the 'impossible fertile woman' – a woman with a contraceptive need who is compelled into competing subject positions through contraception (non)use. Based on this discussion I make recommendations about the ways in which women and providers could work together to locate better fitting and more sustainable contraceptive methods. The methodological contribution of this thesis is also included in this chapter as I argue, using excerpts from the women who participated in the research, that my methods have facilitated deeply subjective, women-centred accounts that best capture their experiences in a meaningful way.

In my concluding chapter, I briefly summarise my research findings and make recommendations for future practice and policy.

Considering the thesis as a whole there are also some other factors of note. At the outset of this project, influenced by the orientation of typical discourses regarding contraception non/use, I conceptualised that this research would speak directly to a public health audience – specifically regarding the ‘problem’ of contraception switching and non-use that is cited to contribute to unintended pregnancy. However, my immersion in the fieldwork and research process shifted my initial methodological and theoretical commitments. For example, where initially my thinking and terms used were more congruent with public health, over time I became increasingly critical and dissatisfied with this framework. Thus, where notions of unintended/unwanted pregnancy and management of pregnancy were drawn upon at the outset, my orientation changed to reflect a more women-centred sociological approach and to consider the experience of contraception use as a practice in itself. I began to consider the lived experience of contraception use for women and what shaped it, but outside of the links with (unintended) pregnancy, abortion and other ‘public health issues.’ I increasingly problematised the public health approach and avoided co-opting this language – an evolution which is visible in the variable tone of the final thesis artefact.

In addition, at the outset I planned to draw primarily on the theorisations of Michel Foucault and take a ‘feminist Foucauldian’ approach – as reflected in the theoretical chapter, chapter 3. However, it transpired as the research progressed that this framing was not adequate to understand my research findings fully and once again shifts in this emphasis are observable in the thesis. Whereby my original commitment to Foucault drew my attention to structural issues of power and disciplinary practices and so on, it fell short in facilitating the analysis of women’s individual lives. As such work that focussed on theorising female and neoliberal subject positions and choice were drawn upon more heavily.

Further to this introductory overview I now shift attention to the historical and current policy and practice context and begin with a critical review of the research and relevant socio-political drivers that illuminate the contraceptive culture as relevant to women participants from the North-West of England over the last 40 years.

Chapter 2 “The importance of being historical” (Weeks 2010): Exploring contraceptive practices over time.

‘Today’s methods of birth control make it possible for a couple to choose whether or not to have a child.... And if you decide to plan a family you know the baby will be wanted and loved.’ (Family Planning Information Service (FPIS) 1982)

Despite its outmoded style, this 1982 Family Planning Information Service (FPIS) statement represents much contemporary, mainstream thinking about contraception. This extract reflects two key assumptions that underlie conventional understandings of contraceptive practices. First, the statement uses the language of choice. This implies that decisions about contraception are made freely and at an individual level: reproductive choice, including contraception, is recognised as *‘the credo in most countries’* (Hardon 2006, p626) and is widespread within the international research context (Borrero et al, 2014; Peipert et al, 2012; Krings et al, 2008; Trussell and Guthrie 2014). This assumption, however, neglects the myriad contextual factors (social, economic and political) that shape contraceptive practices. Second, there is an implicit assumption of a direct link between fertility intention and contraception use; i.e. whether a woman ‘wants to have a baby’, informs her contraceptive practices. Although counterintuitive, empirical research has troubled this association; indicating that the relationship between fertility intention and contraceptive use are more complex and that attitudes to contraception more strongly influence its use (Bruckner et al, 2004; Borrero et al, 2014).

Some literature *has* addressed the importance of the broader socio-political and economic context in relation to contraception (Winetrobe et al, 2013; Free et al, 2005; Heise 1997; Granzow 2008). Others have highlighted the role of fertility intention in relation to contraception use (Lois and Becker 2014; Berg et al, 2013; Helferrich et al, 2014; McQuillan et al, 2011) and the problematic nature of reductionist assumptions about links between the two (Bruckner et al, 2004; Zabin 1999; Frost et al, 2012). In

addition, it is increasingly acknowledged that contraceptive practices are dynamic, hence more nuanced life-course approaches are being increasingly recommended in sexual health research (Helferrich et al, 2014; Mercer et al, 2013; Buhr and Huinink 2014) and in policy (DH 2013). Despite these gradual shifts, however, the two common assumptions underpinning the introductory statement continue to be re-cycled in contraceptive policy, research and the media.

This chapter is therefore structured around a critique of these two assumptions and draws on a research agenda proposed almost two decades ago by Lorie Heise (1997) who identified three “spheres of influence” (p7) that interplay in method use: the individual woman; the specific contraceptive technology; and, the service delivery environment. In the absence of much, if any, literature that considers all these factors, this chapter will consider the matrix of these factors in addition to the broader political, economic and social landscape around contraceptive practice. Thus, in the following section, I provide an overview of the wider international contraceptive context before focusing on setting the current scene as relevant to the women involved in this research. Following this, I will critically examine research on women’s individual experiences of contraception, with specific emphasis on what is referred to as method acceptability. Finally, contextual factors of service delivery and method availability will be explored in relation to wider socio-political and economic forces.

2.1 Contraception in context

In contemporary reproductive and sexual health discourse, contraception is represented, especially in relation to 'most effective' methods, in a way that evokes modernity. Indeed, contraceptive and reproductive 'choice' (and low birth rates), are considered a hallmark of modern life and progress (Sheoran 2015; Russell and Thomson. 2000; Fisher 2006). This tendency however overlooks contraceptive practices that have been widespread globally as long as people have been having (hetero)sex (Jutte 2008; Ruhl 2002). When referring to contraception in the context of this chapter therefore, I mean specifically 'modern contraception'; that is, technologies that have developed since the introduction of the oral contraceptive pill (OCP) in the early 1960s. These are situated, often problematically, in contrast to 'traditional' or 'indigenous' methods (such as withdrawal) that are implied by default to be ineffective and out-dated despite their continuing value to many (Russell and Thomson 2000). 'Contraception', in this thesis will refer to "*the use of drugs, chemicals, devices and surgery- that control fertility amongst heterosexual people*" (Russell and Thomson 2000, p4) unless stated otherwise; and is my preferred term over more value-laden descriptors such as 'birth control' or 'family planning'.

The global enthusiasm for 'modern methods' has been driven by the "*unacceptably high rates of unintended and unwanted pregnancy*" (Sitruk-Ware et al, 2012; p1). An estimated 40% of pregnancies globally are 'unplanned' (Masson 2011) and although not necessarily *unwanted*, this phenomenon is problematic at individual, social, economic and political levels. Mediated by a country's specific infrastructure and policy regarding reproductive health and abortion, unintended pregnancy contributes significantly to outcomes including: risky 'backstreet' abortion; poverty; abuse; and, maternal and infant mortality and morbidity (Crissey 2005; FPA 2012; Guttmacher Institute 2010). Internationally the unmet need for contraception, estimated to be approximately 220 million women in the developing world alone, represents a major risk to quality of life globally (IPPF 2015a). However, how the demand of these populations for contraception has been captured is difficult to determine from the

published literature. It is also recognised that such estimates tend to represent married women and hence may underestimate demand overall (IPPF 2011).

Nonetheless there is a consensus that 'contraceptive security', i.e. "*when individuals can choose, obtain and use quality contraceptives when they need them,*" is highly cost-effective (IPPF 2011) and contributes significantly to reductions in maternal and child mortality and improvements in quality of life (IPPF 2008; Guttmacher Institute 2010). Working in alignment with the Millennium Development Goals (MDGs) and the 'Post-2015 agenda', a United Nations poverty reduction initiative (MDG and Beyond 2015), organisations such as the International Planned Parenthood Federation (IPPF) and the United Nations Population Fund (UNFPA) are influential providers of contraceptive services globally. Through fundraising, campaigning and programme delivery these bodies seek to address deficits in sexual and reproductive health, including unmet need for contraception. For example, the IPPF aims to provide universal access to, and informed use of, contraception and indicates that contraceptive prevalence has increased from 54% to 63% in women aged 15-49 between 1990 and 2007 (IPPF 2015b). Similarly, the UNFPA situates voluntary access to safe 'family planning' as a human right and their 'Choices not Chance Family Planning Strategy 2012-2020' (2013) is currently tackling 69 countries with low rates of contraceptive use as a priority.

Comparative to the less economically developed countries that are the typical focus of such global initiatives, the UK is arguably a world leader in service delivery and method access and the UK government is credited as a 'galvanizing force' in the address of global unmet family planning needs (UNFPA 2013; p1). From this powerful position, it is difficult to conceptualise why women in the UK, particularly Britain where reproductive/sexual health service delivery is less limited than in Northern Ireland, may have any 'unmet needs' for contraception. Offering 15 methods free at the point of access through channels that include: GP's, midwives, specialist sexual health service (NHS and voluntary sector providers) and pharmacies, the UK is, relatively, very privileged. However, this is undermined by statistics about unintended

pregnancy and abortion; evidence that suggests that British women, *despite* contraceptive security, still have difficulties finding and sustaining methods.

Evidence from the National Survey for Sexual Attitudes and Lifestyles (2013) indicated that little more than half of all pregnancies of women aged 16-44 years old in Britain were 'planned' (54.8%) defining the others as 'unplanned' and 'ambivalent.' Similarly, Marie Stopes, an established abortion service provider, reported that nearly half of all pregnancies in England and Wales were unintended (Bury and Ngo 2009), congruent with Department of Health estimates of 50% for England (DH 2013). On abortions, most recent statistics indicate that there were 185,331 for residents of England and Wales in 2013 – not insignificant figures that vary little in comparison to previous years, with 98% funded by the NHS at significant cost (DH 2014). Interestingly, unintended pregnancies and abortions have increased in older aged women, so whilst abortion rates for women aged 15-19 years decreased from 2000 to 2010 (DH 2012), older populations are increasingly having abortions with an estimated 79% of abortions taking place in non-teenage women since 2010 (APPG 2012). Women's (mis)perception of reduced fertility and increasing prevalence of intentions to delay childbearing (Everywoman 2013; Marteau 2013); differing trends in relationships, for example decreasing rates of marriage (ONS 2013); and more voluntary childlessness (Gillespie 1999; 2003) may explain unwanted pregnancy in older women to some extent. However, these factors do not then explain why contraception is not used to avoid these unintended pregnancies, although the results have been attributed to non-use or 'misuse' of contraception (Bury and Ngo 2009; p2).

To better understand women's contraceptive practices recent longitudinal research, informed by the fact that "*contraceptive use in the UK is high but unintended pregnancy is common*" (Sadler et al, 2011; p6), has been conducted. The 'Contessa study' explored factors contributory to method stopping and switching in England, indicating that 'stoppers and switchers' were younger, better educated and more likely to be single; and method changes were linked to ease of use, reliability, side effects and health concerns (Wellings et al, 2015). This research is one of few that highlights the need for better understandings of the influences on 'successful'

contracepting; a recommendation that is especially important given the current economic climate, where fiscal austerity and cuts in public health expenditure threaten to have a “*devastating effect on sexual health and contraceptive services*” (FPA 2015). Moreover, it is also evident that nationally, unintended pregnancy imposes significant personal, social and wider economic costs (FPA 2013a).

Therefore, there are strong practical and economic reasons why a more thorough, situated understanding of women’s contraceptive practices is (still) required. What explains the contraception conundrum - why British women, despite their access to and free availability of methods, struggle to locate best-fit sustainable options that allow them to avoid unintended pregnancy? In the next section, I seek to critically evaluate insights from the relevant available published literature.

2.2 Contraception and wellbeing: individual women’s experiences.

As mentioned, the assumption that contraception use is linked to fertility intention is challenged by evidence that individuals’ attitudes to *contraception* itself may be more influential (Bruckner et al, 2004). In this section I explore the available evidence about women’s lived experiences of contracepting that may shape their attitudes, recognising that this varies between women and over the lifetime. Current British trends in coitarche (first sexual intercourse) and childbearing mean that women now spend approximately 30 years avoiding pregnancy (Wellings et al, 2013) – a substantial timeframe that demands contraceptive acceptability as a prerequisite and recognition that for some, no method may be preferable for part, or all, this time. Despite this however, most research evaluating method experience is cross-sectional, failing to capture the life experiences that women have with contraception and how this may shape their decision making around method use. This represents a significant gap in the literature.

Internationally, significant numbers of women report dissatisfaction with their method (Lessard et al, 2012; Snow et al, 1997), typically selecting the ‘least worst’ option accessible to them (Heise 1997; Walsh 1997; McDaid et al, 2014). Of those

available it is frequently assumed the most effective method is also most desirable (Higgins 2014) and initiatives are often preoccupied with promoting the former, rather than that most suitable (Peipert et al, 2012; Hillard 2013). Yet, drawing on research from the USA, method selection may have little, or no, basis in method efficacy (Matteson and Hawkins 1997); although, admittedly, this finding could be linked to knowledge gaps about 'method efficacy' (Eisenberg et al, 2012). Thus, whilst there is some indication of what does *not* matter - or rather which factors policy-makers and health professionals may overstate the importance of - the literature offers little evidence about what *is* meaningful to women themselves regarding contraception - another significant gap (Belfield 2009; Wellings et al, 2015). Additionally, where knowledge about, and access to, contraception has been cited as reasons for non-contraception use (Eisenberg et al, 2012) these issues may now be of little relevance in Britain where contraception is free and practices are so culturally embedded (Brown and Guthrie 2010; Middleton 2011; Wellings et al, 2015; Sadler et al, 2011). Therefore, there appears to be a disconnection between knowing about, and accessing, contraception and its uptake/sustained use (Belfield 2009). Some of the possible influences that may account for this are considered below.

2.2.1 Nothing but a nuisance? Bodily impacts of contraception

Along with method efficacy, ease of use and safety are characterised as important factors in contraceptive desirability (Glasier 2008; Wellings et al, 2015). However, many side effects, particularly of hormonal contraception, may compromise acceptability and lead to discontinuation (McDaid et al, 2014). I use the term 'side effects' critically throughout the thesis as it implies that these impacts are secondary in comparison to the 'primary' impact of pregnancy prevention. This may not be the experience for many women. The impacts vary by method and may be disputed or minimised to avoid discontinuation or switching to less effective methods (Asker et al, 2006; Hoggart et al, 2013a). Conversely non-contraceptive impacts may be experienced as health benefits (Sitruk-Ware et al, 2012).

First, as an example, mood disturbances are a frequent challenge for hormonal contraception users, cited as reasons for abandonment and dissatisfaction since the

introduction of the oral contraceptive pill (OCP) - "*the pill has now got such a reputation for causing depression that this is the commonest reason given by women who stop using it.*" (Guillebaud 1980; p87). Admittedly, early OCPs contained much higher doses of synthetic hormones than their modern counterparts: the *monthly* dose of some pills now contains fewer hormones than *one* pill from the early 1960s (Quarini 2005). However globally mood disturbances continue to affect hormonal contraceptive acceptability, despite unclear clinical associations between contraception and 'mental disorder' (Hoggart et al, 2013a; Free et al, 2005; Kane et al, 2009; Sanders et al, 2001; McDaid et al, 2014; Svendal et al, 2012).

Qualitative research offers some detailed accounts of mood disturbances; for example, Hoggart et al, (2013a) described one woman's self-harm and how another had "*locked herself in her room for days*" (p7) – attributed to use of the contraceptive implant. Although potentially of profound significance to users, clinical and research discourses generally downplay such impacts referring to them as 'nuisance' side effects (FSRH 2006; Walsh 1995). In contrast, hormonal methods can be protective against mood problems for some women (Svendal et al, 2012).

Irregular bleeding is also common, particularly in relation to Long Acting Reversible Contraception (LARC) – a group of methods that includes the contraceptive implant, injection and intra-uterine contraception. Little has changed since the introduction of the contraceptive implant in the early 1990s (Hardon 1992) as 'nuisance bleeding' remains the main reason for discontinuation internationally (Grimes 2009; D'Arcangues et al, 2011), similarly with other progestin-only contraceptives (Hoggart et al, 2013a; Hoggart et al, 2013b Hoggart and Newton 2013; Kane et al, 2007). Irregular bleeding is problematic for myriad reasons including: decreased productivity/activity; socio-cultural reasons such as menstruation being valued as cleansing (D'Arcangues et al, 2011); and, perceptions of 'abnormality' or the 'unnatural' (Cheung and Free 2005). Tolerance to bleeding disruption may differ culturally; for example, women in Europe and USA have demonstrated a growing acceptance of alternative menstrual patterns (Ibid), whereas other cross-cultural evidence indicates women largely preferred a regular period (D'Arcangues et al,

2011). However, research typically draws on attitudes towards the hypothetical situation of bleeding not lived experience; *expectations* of tolerance may differ from the reality (Hoggart et al, 2013a). Once again, bleeding changes including amenorrhoea (non-menstruation) are not always unacceptable for women and can also be desirable or convenient (Melo et al, 2015; Watkins 2012; Glasier 2003). In what, arguably, epitomises the pharmaceuticalised nature of contraception today, unscheduled bleeding can be managed using other drugs, including alternative contraceptives. This strategy is often encouraged for 'short term' bleeding management in the UK with 'treatment' regimens proposed in the first three to six months of hormonal contraception use as they "*may encourage women to continue with the method*" (FRSH 2009, p8) ultimately avoiding 'loss of compliance' (Abdel-Aleem et al, 2013).

Method administration may also influence acceptability. Women may feel embarrassed or anxious, especially when a vaginal examination is involved, such as during the fitting of Intra-Uterine Contraception (IUC) (Glasier et al, 2008; Asker et al, 2006). Indeed, IUC insertion can be painful - arguably wholly reasonable grounds for anxiety (Bednarek et al, 2015; FPA 2014). Women may perceive a 'challenge to bodily control' (Hoggart and Newton 2013), exacerbated when requests for removal are ignored and/or delayed (Asker et al, 2006; Hoggart et al, 2013a). Provider dependent methods (such as IUC) sit in contrast to user dependent methods (such as OCPs) that allow women to stop immediately of their own volition. These challenges to acceptability are deeply personal to women and in the case of resistance to removal have been suggested to verge on a violation of human rights (Higgins 2014). The tone of some literature about contraceptive acceptability exemplifies how women's concerns may not be taken seriously:

"The invasive nature of the insertion of implants and IUD's/IUS and the need for injections of Depo-provera should not be a barrier to a generation of young women who are happy to get tattoos and piercings even in the most intimate parts of their anatomy" (Glasier et al, 2008; p217).

Trials have been underway to reconfigure provider-dependent methods as user-dependent where possible, for example: through self-administered subcutaneous injections of Depo-Provera (Williams et al, 2013), recently licensed in the UK as Sayana Press (Pfizer 2015); and through self-removal of the Intra Uterine Device (IUD) (Foster 2014). LARC may also be problematic due to its perceived 'hiddenness' and some UK women report anxiety about reliability due to this (Asker et al, 2006). Again, in contrast, for other women 'forgettable' contraception is an attractive characteristic (Grimes 2009).

In relation to LARC the eagerness to dispel 'myths and misconceptions' about these methods seems to result in mixed messages about the methods; for instance Russo et al. (2013) refer to the claim of LARC induced menstrual irregularities as a 'misconception' yet then immediately comment that '*menstrual disturbances are indeed one of the most common side effects of LARC methods*' (S16). This is an example of what leads Higgins (2014) to note how LARC's 'boons' should not be privileged by clinicians at the expense of individual women. Weight gain is a common contested effect linked to hormonal contraception use (Brown et al, 2007; DH 2013), characterised as more problematic than the fear of pregnancy; concern about compromised fertility can also be significant (Glasier et al, 2008; Aiken et al, 2005). Despite the lack of robust clinical evidence regarding these associations however, perception significantly influences acceptability and use - "*When people define situations as real, they become real in their consequences*" (Thomas 1932 in Plummer 2010).

Contraceptive practices inherently code sex for purposes other than procreation and pleasure is an undeniably central motivation (Meston and Buss 2010). However, the 'pleasure deficit', i.e. the neglect of pleasure from contraceptive research, policy and practice has been increasingly highlighted (Higgins and Hirsch 2007; Hanbury and Eastham 2015) despite acknowledged direct sexual side effects of contraception; for example, the patient information leaflet for the Progesterone Only Pill (POP) Cerazette notes that decreased sexual drive is common for its users (MSD 2014). In contrast, trials of hormonal contraception for men have been quickly abandoned

when pleasure or function was compromised (Higgins et al, 2008) - an inequality that has been duly noted (Higgins and Hirsch 2008). Additionally, non-hormonal contraception such as condoms may have physically undesirable bodily impacts such as vaginal dryness and discomfort during penetrative sex (Higgins and Davis 2014; Higgins and Hirsch 2008). Men, like women, are cited to experience physical side effects such as reduced sensation because of condom use and condoms generally may be a 'turn off' to both, with condom-less sex usually preferred (Randolph et al, 2007; Crosby et al, 2008). Explanations for the omission of pleasure in relation to contraception (i.e. the desexualisation of contraception) include: assumptions that women privilege effectiveness most (Higgins 2014); that hormonal contraceptives are detached from the act of sex (Rawlinson 2010); and the embarrassment/risk associated with discussing sex favours a desexualised consultation (Jutte 2008). However, in the context of this discussion, compromised pleasure also compromises acceptability. Although some recent work is striving to safeguard pleasure (Higgins and Hirsch 2008; Higgins and Davis 2014; Gubrium 2011; Wellings and Johnson 2013), the impacts of contraception on sexual experience remain peripheral in research and practice agendas, especially in Britain (Hanbury and Eastham 2015).

Hormonal contraception may also undermine women's sexuality indirectly. Considering irregular bleeding as an example, there are various challenges associated with negotiating sex during menses. 'Menstrual shame' has been associated with decreased sexual experience and increased sexual risk taking (Schooler et al, 2005). In USA research, only 40% of women stated they were happy to have sex during menstruation with others communicating "*discourses of disgust*" relating to hygiene, messiness, and self-consciousness (Allen and Goldberg 2009; p539). Despite this evidence regarding the effects of vaginal bleeding on sex, 'bleeding irregularities' research rarely explores the compromise of pleasure. Psychological effects are also contributory but rarely addressed; self-esteem and self-confidence are important aspects of sexuality and can be impacted by contraceptive use (Higgins et al, 2011) specifically via low mood, weight gain or skin blemishes (Higgins 2007). I would suggest, therefore, that if the outcome of using contraception for some is *no* sex then the method is unfit for purpose. Contraceptive practices are crucial components in

heterosex (Lowe 2005a) and best-fit methods can enhance sexual pleasure, through reducing pregnancy fears or facilitating spontaneous sex, amongst other things (Higgins et al, 2008). Thus, centralising sexual pleasure may be a meaningful way to improve contraceptive acceptability and understand contraceptive decision-making (Higgins and Hirsch 2008; Hanbury and Eastham 2015).

This section has characterised just some of the experiences that women live through or anticipate in relation to contraception. However, there are a host of other factors that may also be influential in women's decision making, explored next.

2.2.2 Situated meanings – abstract factors that influence contraceptive practices

"The ways that they (contraception) work, and are perceived to work are mediated by a variety of relationships, institutions, knowledge and beliefs" (Russell and Thompson 2000; p6)

2.2.2.1 Personal understandings and beliefs

The influence of peers, family and partners is well recognised in method choice internationally, shaping decision-making and use through information sharing, peer pressure and so on (Charmaraman and McKarney 2011; Bolton et al, 2010; Baxter et al, 2011; Asker et al, 2006). However, different meanings may be ascribed to contraception, the symbolism of which can communicate the nature of a relationship or (mis)represent the user. In their work on contraceptive scripts, Conley and Rabinowitz (2004) characterised the counter/normative progression for contraceptive practices in close relationships in the USA, highlighting how transitioning (i.e. changing or discontinuing contraception) may be a symbolic event. The transition from pill to condom use may symbolise distrustful, negative relationships with uncertain futures and/or abandonment of condom use can represent relationship commitment and intimacy, as perceptions of fidelity contribute to a circumstance where STIs and/or pregnancy are feared less (Bolton et al, 2010). These meanings vary depending on place and time (and have been little

explored in the British context). Individuals/cultures that do not value monogamy, for example, may not ascribe meanings of trust and commitment in these ways.

Despite the desexualisation of contraception in practice settings such as contraceptive service providers, its use intrinsically represents sexual activity; the stigmatising threat of which is still manifest in sexual and reproductive health (Cook and Dickens 2014; Slater and Robinson 2014). Thus, fear or experience of judgement based on sexual activity are a recognised barrier to contraception seeking (DH 2013) and can lead women to rationalise or justify decisions through non-contraceptive health discourses such as menstrual regulation (Heise 1997; Brown et al, 2007). Women may also be reluctant to carry condoms for fear of being judged as sexually promiscuous (Coy et al, 2010; Free et al, 2005; Curtis et al, 2005) and the contraceptive implant, which in some cases can be seen through the skin, has sometimes been referred to pejoratively as a 'slag tag' (Kavanaugh et al, 2013; NHS Coventry nd, p22). Consequently, 'single' women fearing judgement, may quickly abandon their method when a relationship ends (Falk et al, 2010).

Other values and beliefs also impact strongly on contraceptive decision-making (Cheung and Free 2005; D'Arcangues et al, 2011; Beutelspacher et al, 2003). Women's 'lay' knowledge and social networks often possess greater currency than 'official' sources of information (Asker et al, 2006; Carter 2012; Lowe 2005b). Preferences for a 'natural' body may mean by default that the artificiality of the contraceptive experience is unacceptable (Baxter et al, 2011; Hoggart and Newton, 2013). Beliefs about fecundity, or that of their partner, may also shape decision-making about contraception and perceived infertility may lead to contraception non-use (Polis and Zabin 2012; Rocca and Harper 2012). These factors may lead to deliberate contraception non-use as explored in the next section.

2.2.2.2 'Unprotected sex' – what counts as contraception?

There is a tendency to presume that all women *want* ideally to use contraceptives; a supposition that confounds our understanding of women that deliberately engage in

'unprotected sex' despite wanting to avoid pregnancy (Foster et al, 2012). Unprotected sex whilst undesirable and poorly understood from a public health perspective may be the most acceptable practice for some women. In addition to perceived health risks, other psychosocial factors may be relevant. These include a desire for intimacy, 'testing' fecundity and perceived infertility (Foster et al, 2012) and positive emotional impacts (Higgins et al, 2008) - although it is interesting to note how these explanations are stereotypically female.

Many practices are not reified as methods of contraception and classification has shifted over time. Withdrawal, or coitus interruptus, for example, was a crucial method prior to the introduction of 'more effective' hormonal options, but it is no longer formally identified in this way (Sobo and Russell 1997; Rogow and Horowitz 1995; Cook 2005). Evidence of pregnancy risk associated with viable sperm in pre-ejaculatory fluid largely discredited withdrawal as a legitimate method - an evidence base that has since been identified as limited and methodologically weak (Bissell 2003). Lack of protection from STI's, especially following the emergence of HIV in the early 1980s, also affected its popularity. Nonetheless, it has been suggested that there is a marked underestimation of the use of withdrawal as a method of contraception (Rogow and Horowitz 1995). (Re)interest in withdrawal is evidenced through increased research, especially in the USA, which has highlighted how it is relatively widespread and may have significant consequences for reproductive health (Liddon 2013; Jones et al, 2014; Martin et al, 2009; Robinson et al, 2010; Kane et al, 2009; Higgins and Wang 2015). Recent findings support the 'mis-definition' thesis noting how young American adults do not classify withdrawal as 'contraception' and as such do not disclose its use when asked about 'contraceptive' practices (Carter et al, 2012). However, where some findings associate withdrawal with sexual risk taking (Liddon 2013) other research links it to increased vigilance for pregnancy prevention, used in tandem with other methods to ensure pregnancy prevention (Jones et al, 2014). Where 'withdrawal' is included as a survey variable there is little exploration of the practice in any detailed way (Martin et al, 2009; Robinson et al, 2010; Kane et al, 2009) possibly because there is little incentive to invest in research about a method with no market value (Trussell 2009; Freundl et al, 2010). However, encouraging

withdrawal in practice when individuals are having, or are going to have, unprotected sex may be preferable than no effort to avoid pregnancy at all (Freundl et al, 2010).

Withdrawal is classified in the broader category of 'natural family planning' which includes fertility awareness methods (FAM). This umbrella term comprises: the calendar or rhythm method; sympto-thermal methods; cervical mucous methods; and the temperature method – all which use a series of 'rules' to identify fecundity and purport abstinence or protected sex during the fertile period (Freundl et al, 2010). Despite still being cited as a 'method of contraception' in information over recent decades, practices such as the calendar method have also been repositioned against hormonal methods, as ineffective, outdated and thus synonymous with risky (irresponsible) sex (Hughes 1988; Russell and Thomson 2000). Although more recently fertility apps on mobile phones are increasing the popularity of natural methods - see for example <https://www.kindara.com/avoid-pregnancy>).

However, types of FAM vary and where the calendar method may be unreliable due to variations in women's individual menstrual cycles, so-called sympto-thermal methods that rely on measurements such as basal body temperature are cited by some practitioners to be as effective as methods such as the pill (Weschler 2003). Frequently, though, these 'traditional' practices are perceived to be anachronistic and struggle to compete with the hegemony of the pill and other hormonal contraceptives (Tone 2012) despite having no side effects or costs (Freundl et al, 2010). FAM information also tends to unhelpfully conflate the specific methods, which vary considerably in efficacy rates when best practiced (Grimes et al, 2004).

Other strategies - emergency contraception, oral sex and anal sex - if deliberately undertaken as an effort to prevent pregnancy, could also be defined as contraceptive practices. There is therefore a tension between practices that are undertaken contraceptively and the definition of contraception - a disconnect that may compromise meaningful understandings of contracepting. Factors that shape choice may not be deemed 'rational' to the outsider and unprotected sex may be especially problematic from a public health perspective (Russell and Thompson 2000).

Nonetheless, women have their own varied experience and perceptions of contraceptive methods. The challenges, stress and impacts of which may lead to abandonment or inconsistent use, whereas perceived benefits may determine or sustain method choice.

Despite some good research regarding the factors that shape contraceptive acceptability there are significant gaps. The wider evidence base is overwhelmingly quantitative, offering little in the way of the detail and meaningfulness of contracepting. There is also a tendency to approach contraception use in a piecemeal way (Free et al, 2005), i.e. focussing on one influencing factor or method at a time, thus overlooking the dynamic, context-specific, multifaceted influences which interplay and shape personal decision-making. The literature is predominantly cross-sectional, capturing a snapshot, often of a hypothetical situation, with little emphasis on women's histories and how this may have shaped their current contraceptive practices. Finally, the preoccupation with contraception use as an individual level experience obviates the influence of broader contextual factors that have also changed over time. There is in fact far more that shapes a woman's method use than her attitude towards it; and it is to these factors that I turn my attention to in the next section.

2.3 "Your sex life is political" - mapping developments and agendas shaping contraceptive practices¹

'Many of the current problems in family planning are likely to continue or worsen in the next decade. If current social trends continue- as seems likely- with further cuts and threats to provision of services; continued unemployment, problems with regard to contraception advice for young people; restrictions on advertising etc.' (FPIS 1991)

¹ (Livingstone in Brookes 2013)

This quote illustrates how contraceptive provision is mediated by the wider socio-economic climate and although it could easily be mistaken as a comment on contemporary Britain, was taken from the Family Planning Information Service (FPIS) 'Report of Activities 1985-1990.' Popularly 'Thatcher's Britain', a Conservative period of "radical reform" (Jackson and Saunders 2012, p7) was characterised by increasing free-market policies, including: deregulation; privatisation of government services; and systematic reduction in trade union powers. This section will examine further how structural factors have mediated contraceptive practices over recent decades and what the culmination of these developments means for contracepting women in Britain today. Greater emphasis is placed on recent periods that have consolidated the model of contraceptive service delivery most directly relevant to contemporary women. Archival research at the Wellcome Library, London, has informed the development of a critical historiography and where relevant, figures are included as references and to illustrate the nature of the historical moment with regards to contraception; specifically, how policy has changed over time and how contraception was promoted to public audiences. This discussion should be seen as complementary to previous parts of this chapter, which drew on the clinical and social research to offer insights into women's personal experiences of contraception. To re-iterate, although valuable, such individual-level perspectives fail to capture the extent to which wider conditions (policy drivers, practice cultures and method availability etc.) also shape women's contraceptive experience. Thus, the following discussion reviews other circumstances that have affected contraceptive provision and impacted women in Britain over time.

2.3.1 A brief history: the conception of contraception services

Historically, repressive sexual attitudes limited contraceptive development as practices and methods were implicitly associated with sexual and moral impropriety and promiscuity (Mort 2001; Cook 2005). However, from the second half of the 19th century moralist perspectives were largely replaced – but never entirely eliminated – by other pressing social and political challenges including: population growth anxiety; a preoccupation with eugenics; women's suffrage and equal rights; economic development and increasing participation of women in the workforce; and health

outcomes such as maternal and infant mortality (Barrett and Harper 2000; Cook 2005; Jutte 2008; Brookes 2013; Leathard 1980; McLaren 1990; Quarini 2005).

The first 'birth control' clinic in London in 1921 opened by Marie Stopes provided devices such as condoms and contraceptive caps (Cook 2005; Quarini 2005; FPA 2011) and thereafter, charitable organisations delivered services, largely to middle-class women, to facilitate pregnancy planning (Cook 2005). Classed disparities were obvious from this point, with largely middle-class women accessing contraception to meet their needs for 'family planning'; in contrast to eugenic concerns that motivated control over the fertility of lower class people (Barrett and Harper 2000; Ziebland 1999; Cook 2005). Later, post-war Britain, amidst a 'rediscovery' of poverty (Brookes 2013) and in association with the founding of the 'Welfare State' (Timmins 2001) including the formation of the National Health Service (NHS) in 1948 offered a shifting social, economic and political landscape that lent itself to favourable changes in contraceptive provision.

Where the Christian Church in Britain had been crucial in mediating sexual morality during the Victorian period (Draper 1972), the early 20th century saw social and economic factors supersede the influence of orthodox religion (Cook 2005). Simultaneously women's roles were shifting to allow greater autonomy and greater access to education and increasing participation in the labour force. Synergistically, these shifts were facilitated by, and promoted, improved access to contraception; dramatically altering the structure of the family from the mid-1960s onwards (Cook 2005). A major driver of this was the introduction of 'modern' oral hormonal contraception (OHC) or 'the pill' in 1961 (FPA 2011; Leathard 1980). Reproductive health and rights began to receive increased attention from feminists who demanded contraception and abortion services as cornerstones of women's liberation (Berer 1997; Hoggart 2003); the availability of which is widely credited as instrumental in a 'sexual revolution' (Cook 2005). Although health activists and advocates such as the FPA also raised the profile of contraceptive services (Leathard 1980) the (international) collective efforts of feminists in industrialised nations exerted significant pressure on the State for change (Hardon 2006; Cook 2005).

However, despite increased activism and development, sex was still significantly circumscribed by social norms that conferred right and proper sexual practices, i.e. hetero-sex within marriage (Draper 1972). The pill (OCP) also divided religious authorities, provoking outrage in those who perceived it as contrary to God's will. Therefore, OCP prescription was initially restricted to married women (Barrett and Harper 2000; Cook 2005; McLaren 1990) until 1964 when the Brook Advisory Centre started to provide contraception to all (FPA 2011). Subsequently there were some significant liberal shifts in legislation with 1967 being referred to as an "*annus mirabilis of sexual reform*" (Brookes 2013, p146). Amongst other things, 'The NHS Family Planning Act' meant that Local Health Authorities could provide contraceptive advice to unmarried women and 'The Abortion Law Reform Act' relaxed legislation around abortion (FPA 2011; Cook 2005). Additionally, more church leaders shifted their position to tolerate contraception, with liberal members justifying contraceptive services as congruent with Christian concerns for family wellbeing (Cook 2005; Draper 1972).

Although feminist commitments to contraception were important, narratives that position women's rights as the crux of shifts in provision may be misleading, as other evidence suggests developments were grounded in shrewd economic concerns. The 1972 book, 'Birth Control in the Modern World' by Elizabeth Draper, for example, made little reference to the women's movement or women at all, instead focussing on population control. Drawing on the grossly pessimistic predictions of biologist Paul Erlich who predicted "*the United Kingdom would simply be a small group of impoverished islands*" (p16) by the year 2000, Draper positions 'birth control' as the "*humane alternative to war, disease and starvation*" (p16). Whilst the economic and demographic impetus for the legitimisation of contraception in Draper's text (1972) is clear, other accounts also support the economy/poverty model as a major driver of change (Weeks 1981 in Cook 2005; Brookes 2013; Edouard 2009). Indeed, some women's rights organisations are believed to have exploited population control rhetoric to realise service expansion (Cook 2005; McLaren 1990). Resource saving was one social advantage of contraception, but free access also allowed women to

participate more in the labour market, contributing directly to economic growth and poverty relief (Bailey 2006).

The introduction of 'the pill' (OCPs) also instigated a critical shift in service delivery. Specifically, oral hormonal contraception repositioned contraception from a private matter, to one directed by health professionals. The prescribed pharmaceutical nature of OCPs increasingly 'medicalised' provision and consolidated a relationship with pharmaceutical manufacturers that has shaped method procurement and provision since (Tone 2012; Watkins 2012). The pill also marked a departure from more user-controlled methods (condom/diaphragm) to provider-controlled methods. Although this shift in control over the reproductive body is arguably a *result* of the development rather than a motivator, these technologies are integral in the regulation of reproduction (Takeshita 2011; Granzow 2010). This possibility, considering historic support for eugenic practices including by key contraception advocates such as Margaret Sanger and Marie Stopes, cannot be ignored as a factor in contraception achieving legitimacy (Higgins 2014; Ruhl 2002 Weeks 1981 in Cook 2005).

The goals of advocates such as the Family Planning Association (FPA) were realised in 1974 when 'family planning' was included in the NHS Reorganisation Act. Thereafter all contraceptive advice and methods provided by the NHS were free, irrespective of age or marital status (FPA 2011). General Practitioners (GPs) became service providers in 1975 (Quarini 2005), consolidating the general model of contraceptive service delivery we recognise today.

2.3.2 Free to all contraception in Britain

Currently, through this service delivery model, most British women aged between 16-49 years of age use at least one contraceptive method at any time, illustrating how embedded contraceptives are in this setting (FPA 2007; HSCIC 2013). The pill's 50th birthday in 2010 marked it as the most used method for women in Britain, but it is no longer the only hormonal option in the repertoire and contraceptive devices and pharmaceuticals have proliferated (HSCIC 2013). Method uptake has been influenced

by factors including: access; information; policy; publicity; and wider health imperatives – which have in turn been shaped by political and economic conditions. The next section builds on this historical account to critically map the developments in methods and service delivery that have evolved in the post-pill era.

2.3.2.1 Sex, death and Thatcher's Britain

Following the period of fairly liberal policy-making around contraception and sexual health in the 1960s and 1970s, there was a period of Conservative governance from 1979-1997 led by the first female UK Prime Minister, Margaret Thatcher (1979-1990), followed by John Major (1990-1997). Consistent with Conservative ideology, this period was characterised by political efforts to roll-back State involvement and reinvigorate 'traditional' values (Timmins 2006). Thatcher's government in the UK, and Ronald Reagan's United States government (1981 to 1989), are credited with cementing the ideological shift to neoliberalism (Steger & Roy 2010). This term - now used extensively in political and sociological discourse - generally refers to a fundamental belief in the superiority of free markets and private enterprise as a form of economic governance and emphasis on individualism, personal responsibility and 'consumer choice' (Steger & Roy 2010). The latter, the "remaking of the citizen as a consumer", is emblematic of neoliberalism (Clarke 2007; p239). Congruently, Thatcher's government began reorganising the NHS in 1989 towards a more market-oriented and consumerist model (Mold 2011).

This era saw very little in terms of addressing gender inequality and provision of woman-centred care, including sexual health and contraception. In fact, this period was notable for resurgence in moralising sentiments (see for example Dyer 1985; Brahams 1985; Richardson 2000; Jackson and Saunders 2012) that coincided with a period of significant reductions in contraceptive funding (FPA 2011). However, throughout this period, contraceptive technologies also proliferated. As Figure 2.1 illustrates, the FPIS boasted 8 methods available at this time, including an increase in provider dependent methods such as IUDs.



FIGURE 2.1 – CONTRACEPTION INFORMATION LEAFLET 1982-1987 (FPIS 1982; 1984; 1985; 1987)

Despite these developments there were no specific policy initiatives regarding contraceptive service delivery. Hence other factors shaped contraceptive experiences during this period including a greater association between contraception and health particularly the emergence of the 'Human Immunodeficiency Virus' (HIV) and transition to 'Acquired Immunodeficiency Syndrome' (AIDS). First identified in the early 1980s, HIV had a profound impact on public health globally and nationally. The morbid government campaign 'AIDS: Don't Die of Ignorance' was launched in 1987 (DHSS 1987). Figure 2.2 illustrates the visual way that this health promotion campaign forged a threatening link between sex and death.



FIGURE 2.2: AIDS DON'T DIE OF IGNORANCE MONOLITH (CROWN COPYRIGHT 1987)

This tactic however, also raised the profile and desirability of condoms. Previously marketed at men in male spaces such as barbers' shops, both men and women were reconceptualised as condom users (Ziebland 1999). There was an increase in varieties of condom, including the female condom released in 1992 (FPA 2007), and access was considerably extended to supermarkets, pharmacies etc. Popular media, as illustrated by Figure 2.3, in conjunction with official health promotion information regarding 'safer sex' such as that in Figure 2.4, meant condom use rose after a period of low prevalence linked to the introduction of the pill (FPA 2007). This provides clear evidence of the association between wider contextual factors and contraceptive practices (albeit driven by desire to prevent infection rather than pregnancy).



FIGURE 2.3: EXCERPT FROM YOUNG PERSON'S MAGAZINE (NOW MAGAZINE 1991)



FIGURE 2.4: FPIS CONTRACEPTION LEAFLETS BEFORE HIV IN 1982 (LEFT) AND AFTER HIV IN 1987 (RIGHT) (FPIS 1982; 1987)

The seriousness of HIV/AIDS also ensured its inclusion on the agenda of the 1994 United Nations International Conference for Population and Development (ICPD) (UN 1994; Aggleton and Parker 2010) - credited with the development of the 'Cairo paradigm,' a global strategy prioritising women's sexual and reproductive health and rights (Roseman and Reichenbach 2011). Thus, myriad drivers for change characterised this period including contraception as an agent for greater prosperity; as a matter of 'consumer' choice; and as disease prevention.

The 1980's and 1990's were also notable for impacts related to perceived adverse side-effects from contraception, again distributed widely through the news media (Figure 2.5) including: evidence about the carcinogenic potential of the pill, with one undated FPIS annual report suggesting that 20% of the 3 million UK pill users shifted to 'less effective methods' following the 1983 cancer scare (FPIS 1991). Similarly, evidence regarding higher risks of venous thromboembolism from pill use resulted in method cessation/switching which in turn had a measurable increase in unintended pregnancies (Furedi 1999).



FIGURE 2.5: NEWSPAPER ARCHIVES CIRCA 1990 (INDEPENDENT 1990; DAILY TELEGRAPH 1990; UNKNOWN ND)

Method licenses, i.e. the standards and guidelines for use of the contraceptive, also differed at this time compared to contemporary Britain. For example, during this

period, efforts were made to increase product use by shifting the license of injectable contraception (Depo-Provera) to long-term from a short-term anti-fertility agent. This was contested by an activist group, the Coordinating Group on Depo Provera (CGDP), due to concerns about safety and human rights. In a comment taken from archival correspondence, amongst other objections, there were claims it was used '*on West Indians, Asians and promiscuous school girls,*' without their consent (Robinson 1979). Indeed, the Wellcome archive holds original complaints from women who were given the injection in this way, the impact of which was reflected in the official contraception information at the time (Figure 2.6).

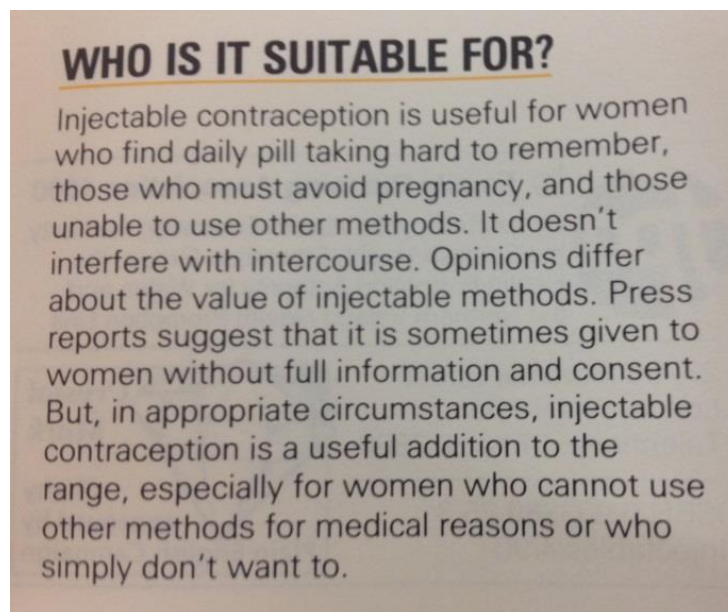


FIGURE 2.6 INJECTABLE CONTRACEPTION LEAFLET (FPIS 1988A)

The Intra Uterine Device (IUD) or 'the coil' was also subject to bad press following the USA's Dalkon Shield 'tragedy' in the 1970s in which the structure of the device conferred an infection risk that resulted in the life-limiting illness (and 15 deaths) of thousands of women (Takeshita 2011). Although confined to the USA, and the Dalkon Shield subsequently withdrawn, the IUD became contraindicated internationally for young nulliparous women, i.e. those who have not had children (Booth et al, 1980) and became synonymous with older users. This was reinforced throughout the decade in official information and media reports (Figure 2.5 and 2.8). Hence it was

only fitted for older women who had children – an arguably paternalistic strategy that by default dictates the risks and terms of childbearing.

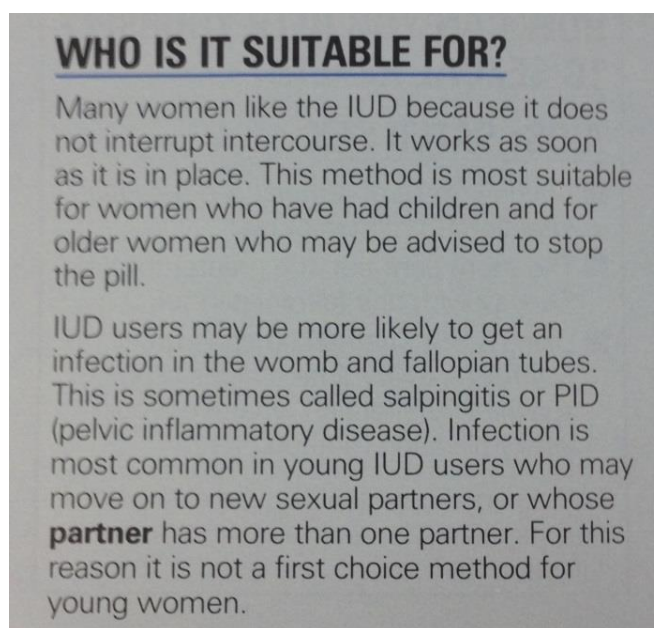


FIGURE 2.8: IUD LEAFLET (FPIS 1988B)

Notably as illustrated through these examples and figures, and in an pre-internet age, women's access to information at this time was restricted to, aside from their own experience, official information and media reporting.

2.3.2.2 New Labour, new strategies?

Then New Labour, under the leadership of Tony Blair, made efforts to differentiate themselves from recent Conservative governments and instead occupy a position "*on the side of modernity*" (Carabine 2007, p967). Blair insisted that he did not "*desire to return to an age of Victorian hypocrisy about sex... as the ill-fated campaign of the conservatives attempted to do*" (Blair in Carabine 2007; p967). Therefore, sexual health and contraception services, perceived by many as in a state of crisis by this time was a priority (Armstrong and Donaldson 2005). This commitment to modernity, for all its rhetoric about transformation and choice, largely mimicked the policies of the previous government with a continued stress on 'family values' (Brookes 2013; Moore 2012a). New Labour's policies were also underpinned by a clear economic agenda, albeit one couched in risks of social exclusion rather than overpopulation (Levitass 2005 in Middleton 2011; Harden et al, 2006; Wilson and Huntington 2006). In fact, the

neoliberal approaches initiated under Thatcher/Major, although dressed differently, were evolving under this government rather than being rejected as Blair maintained. One indirect driver for renewed investment in contraception was borne out of the pursuit of a 'classless society', in which it was suggested social tensions and inequalities would be ameliorated (Turner 2013). Congruent with this thinking, a specific Social Exclusion Unit (SEU) was launched in December 1997 with the somewhat vague aspiration of providing '*joined up solutions to joined up problems*' (SEU 2004). The SEU's role was to develop coherent cross-governmental strategies for dealing with poverty, unemployment, poor housing and poor health to reduce costs to the state from welfare benefits, housing support and ill health. The Teenage Pregnancy Strategy (TPS), published in 1999, was one such initiative to emerge and was lauded for its innovative framing of teenage pregnancy within the paradigm of public health (Hoggart 2012). At this time, Britain's teenage conception rates were the highest in Western Europe and the TPS aimed to halve the under-18 conception rate over a ten-year period to address the in/direct social and economic costs of pregnancies and births to young socially excluded women (SEU 1999; TPS 2010; Middleton 2011; Carabine 2007). This concern, however, was again not unfamiliar; the former Conservative government had also recognised teenage pregnancy as a target in their Health of the Nation initiative (Hoggart 2012).

Two firsts in policy implemented by New Labour, the 'Sex and Relationship Education' strategy (DfEE 2000) and 'National Strategy for Sexual Health and HIV' (DH 2001) cited information about, and access to, effective methods of contraception as instrumental in reducing rates of unintended/teenage pregnancy and abortion, and for reducing social and economic costs. Concerns about young women's sexual impropriety had, on paper at least, been replaced by an "economic morality", typically framed in terms of risk to health and wellbeing (Middleton 2011, p297). These new policies drove an expansion of services with specialist 'Contraception and Sexual Health (CASH)' provision tailored to local need (Ross et al, 2014). In-keeping with the preoccupation with teenage pregnancy, resources and research were overwhelmingly focussed on young people with many commissioners adapting service delivery to cater specifically for the under 25s (APPG 2012).

These policies played out in various ways in women's contraceptive lives. For example, although not officially part of the TPS, easy access schemes for emergency hormonal contraception (EHC) increased- a possible solution to unintended pregnancy (Glasier 2000). Despite introduction in 1984 it was not until 2001 that EHC was made available without prescription through pharmacies (Bissell and Anderson 2003; Ziebland et al, 2005). This was controversial, especially for some religious groups who perceived EHC to function as an abortifacient; and indeed, providers did, and still can, conscientiously object to its provision for this reason (GMC 2013; Deans 2013). By this time less, if any, emphasis was placed on the church in such matters and the largely secular British society meant women were perceived likely to privilege their wellbeing over faith in circumstances of potential unwanted pregnancy (Furedi 2012). Resultantly, British women have relatively broad access and are now cited as more likely to have used EHC than women from other countries (Kavanaugh and Schwarz 2008).

Long Acting Reversible Contraception (LARC) was another significant introduction during this period, also corresponding with teenage/unintended pregnancy policy objectives. LARC methods include: the contraceptive injection; sub-dermal implant and intra-uterine contraception devices (IUC); the intra-uterine device (IUD); and, intra uterine system (IUS). The 'undeniable' cost effectiveness of sustained LARC use and negligible 'user failure' epitomised its desirability from a public health perspective (Lipetz 2009; NICE 2005a). Thus, better LARC access was recommended by the National Institute of Care Excellence (NICE 2005a) to save an estimated £100 million per annum (NICE 2005b; p17). Although LARC's nomenclature has been recognised as an exercise in rebranding of extant methods (Hillard 2013), 'LARC' was still positioned as a 'revolutionary' solution for unintended pregnancy and abortion (Beynon-Jones 2013a).

Clinical guidance by the Faculty of Sexual and Reproductive Healthcare (FSRH) 'Contraceptive Choices for Young People' comments on how "young people should be informed about all methods of contraception, *highlighting the benefits of long*

acting reversible contraception (LARC).” (FSRH 2010, iii; emphasis added). However, the legacy of past policy and bad press persisted as many users and providers internationally continue/d to perceive the IUD as unsuitable for young women (Kavanaugh et al, 2013; Hubacher 2007; Russo, Miller and Gold 2013).

To improve uptake, ‘counselling’ about LARC was included as a GP Quality Outcome Framework (QOF) indicator in England from 2009/2010 - a voluntary annual reward and incentive programme for GP surgeries (Arrowsmith et al, 2014). This drive towards provider-dependent methods is paradoxical considering the increasing emphasis on individual choice and personal responsibility in health in recent decades. The ‘patient-as-consumer’ trope was firmly established by the end of the 1990’s and continued to be amplified through discourses of patient choice, exemplified by schemes such as the ‘Patient Choice Initiative’ (launched in 2001) whereby patients in England can select a specific site for their hospital treatment (Newman and Vidler 2006; DH 2007). With regards to contraception, method information re-enforced similar notions of consumer choice and responsibility as illustrated by the language used in Figure 2.9, a condom information leaflet.



FIGURE 2.9 CONDOM SENSE BOOKLET (BROOK 2009)

Considering the modes of information delivery, it is important to note that booklets such as that set out in Figure 2.9 were being surpassed by the availability of information on the internet. The FPA, formerly the FPIS, for example, celebrated its 75th anniversary in 2005 and by this time was hosting all relevant information about contraception on its web platform (FPA 2005).

Although admittedly under New Labour there were more developments *specific* to contraception compared to previous years, other perceptions of change may be misleading. To reiterate, despite Blair's desire to abandon the approaches of the Conservative government, many of the ideological positions remained the same; exemplified by a continued enthusiasm for the underlying values of neoliberalism including a privileging of 'consumer sovereignty' and 'choice' (Bryson et al, 2014). The similarities with previous Conservative approaches, however, were obfuscated through a shift in language - away from moralising traditional sentiments to those of 'risk' associated with social exclusion and (patient) 'choice.' Therefore, New Labour's core values echoed those of the previous Conservative government but were packaged differently.

2.3.2.3 40 years on: we can't go backwards

By the end of 2015, NHS Choices, the UK's biggest health website run by the NHS, that provides advice to health professionals and general public, provided separate guidance on 16 different types of contraceptive (NHS Choices 2016); although this apparent wide choice belies the fact that many are so called 'me too' methods, i.e. 'non-innovative' technologies that all rely on synthetic hormones and thus are ultimately the same in their impact despite differing modes of administration into the body (Sheoran 2015; Watkins 2012). Reviewing this extensive range of options one could be forgiven for assuming that British contraceptive provision was universally and readily available, untrammelled by issues related to access and funding. However, current financial instability threatens to confer retrograde shifts in sexual health and contraceptive service delivery through "stealthy funding cuts" and "sneaky policy changes" (Brook and FPA 2013).

These 'stealthy funding cuts' are largely a consequence of recent government measures to reduce public expenditure, ostensibly as a way of decreasing public sector borrowing, which rose sharply in the UK when a major global financial crisis in 2007/08 rapidly precipitated a period of deep economic recession (Nesta 2015). In response, recent UK governments – the Conservative/Liberal Democrat Coalition from 2010 to 2015 and the Conservative-only government since mid-2015 - have pursued a vigorous austerity agenda aimed at lowering government spending. These spending reductions are to be achieved through direct cuts to contraceptive services and planned 'efficiency savings.' The arguably unclear nature of 'efficiency savings' may mean that affected agencies would interpret such impositions as 'stealth cuts.' Thus, despite the unequivocal evidence supporting the cost-effectiveness of contraceptive services (Kishen and Belfield 2006; NICE 2005; Armstrong and Donaldson; Lucas 2013), the impacts of austerity measures including "worsened access" to contraception could cost an additional £299 million by 2020 (Lucas 2013, p6). In addition, in 2010 despite falling short of their intended target of a 50% reduction in pregnancy rates, but observing a decline to the lowest rates since 1969 the TPS also ended (FPA, 2012).

The 'sneaky policy changes' feared by contraceptive service providers are less easy to identify. Indeed, superficially increasingly broad and holistic approaches to sexual health and contraception appear to have been incorporated into policy. For example, the recent Framework for Sexual Health Improvement in England (DH 2013) suggests using a life course approach; provides a model of influences that shape sexual practices; and, explicitly recognises the diversity of individual needs. The commitment to (user) 'choice' is retained, but is now combined with an increased emphasis on personal responsibility and resilience – the imperative and capacity to 'bounce back' from public and private adversity (Hanbury and Ronan 2014).

Sex and relationship education has been almost entirely neglected and commitments to updating policy have wavered; the DfEE's outdated guidance from 2000 is still to be replaced. In addition, policy generally is still disproportionately directed at young

people with suggestions that this focus has resulted in the “perverse consequence” of increased unintended pregnancy rates amongst older age groups of women, such as the over 35s (APPG 2012). NICE (2014a) recently released commissioning guidance (NICE 2014b) to specifically meet the contraceptive needs of under 25s in which use of the Commissioning for Quality and Innovation (CQUIN) payment framework explicitly recommends improved uptake of contraception “as appropriate” (3). CQUIN allows NHS commissioners in England “to reward excellence” by linking a proportion of a healthcare providers' income to the achievement of local quality improvement goals (NHS England 2016). Such preoccupations with performance targets may translate to impacts on the user; explaining to an extent, for example, provider’s reluctance to remove the contraceptive implant (Hoggart et al, 2013a; Hoggart et al, 2013b).

Incentive schemes for contraception provision, introduced originally under Blair’s Labour government, now have data that allow us to observe their impact. For example, the aforementioned QOF scheme abandoned the incentive for LARC counselling in 2014/2015, following suggestions that it is now suitably embedded in contraceptive practice. Uptake had risen by 4% annually from the introduction of this QOF indicator - an estimated 110,000 women have been prescribed LARC as a direct result (Arrowsmith et al, 2014). Although such evidence allows us to identify possible associations between policy/practice and women’s contraceptive experience, limited literature highlights this relationship directly, or critiques these strategies on individual women.

Of notable exception is Jenny Higgins (2014) who wrote a cautious message about LARC, highlighting how these methods should not be taken as a panacea for unintended pregnancy. Although relating to the USA, the circumstances mirror current British commitments to improving LARC uptake. Higgins (2014) acknowledged the distinct shift in contraceptive counselling: from options-based to directive, in which now “one or two LARC methods are recommended over all others” (p238); and towards more provider-dependent methods, expressing concern about this tendency if we ignore the “legacies of racism and eugenics” associated with

contraception and possibilities for abuse (Higgins 2014, p2; Rocca and Harper 2012; Hardon 1992). Nonetheless, LARC continues to be enthusiastically promoted. As Figure 2.10 illustrates, recent campaign materials aimed at British women arguably indicate the way that LARC is increasingly purported to be *the* option of choice in the UK/Britain.



FIGURE 2.10 'LOVE LIFE AND LARC' CAMPAIGN (FPA AND MSD 2013)

Despite accumulating literature since the inception of 'LARC' generally speaking there is limited, if any, evidence explaining the shift away from earlier concerns in the 1980s about long-term use of the contraceptive injection and contraindications for IUD use in young nulliparous women (Booth, Beryl and Guillebaud 1980; Hubacher 2007). Indeed, LARC methods (including the IUD) are now promoted as especially suitable for young women, compatible with the demands of their lifestyles, that are frequently represented as 'chaotic' (Okpo et al, 2014); a target group that is arguably reflected in some of the method information like that exemplified in Figure 2.11.

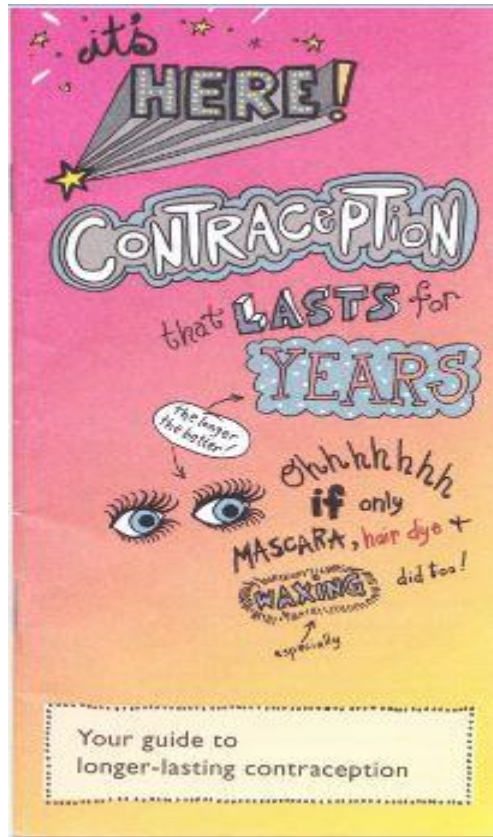


FIGURE 2.11 LARC GUIDE (NHS SCOTLAND 2013)

2.4 Drawing together the 'spheres of influence.'

Over 15 years ago Heise (1997) noted that *"it is now increasingly understood that contraceptive choice is determined at any given moment by a complex interplay between a woman, available contraceptive methods and the service delivery environment"* (p10). This chapter is premised on the notion that the consideration of all factors, or 'spheres of influence' continues to be overlooked. Following Heise (1997) the contextual factors must be considered *alongside* the personal experiences and attitudes of individual women to construct a meaningful picture of any given woman's 'choice.' Jeffrey Weeks (2010) captured the 'importance of being historical' when he noted that *"without a sense of history, and an understanding of the ways we lived in the past, we have no benchmarks by which to measure the magnitude of change, no way of really understanding the present or preparing ourselves for the future"* (p28). It is thus important to recognise that contraceptive practices are shaped by the past experiences of individual women and shift in response to the changes in their lives over time, a circumstance that confers relevance to this thesis and underpins the aim of the research (DH 2013; Free et al, 2005). But it is also equally significant to recognise

that real impacts on women's lives are conferred by social, political and economic agendas that have impacted the availability, access and information about contraception over the last 50 years. The historical summary presented in this chapter brings us up to date and is captured schematically in the timeline presented in Figure 2.13 which charts the contextual shifts over this time-period.

This timeline and the content of this chapter, provides just a flavour of the possible influences on women's contraceptive choices. It indicates how methods have proliferated over time and the social and political landscape, reflected through contraceptive policy, has become increasingly liberal. The current environment is a cumulative product of an evolving neoliberal ideology since Thatcher's Conservative Britain. Contemporary contracepting women are immersed in this context and hence their contraceptive decision-making is susceptible to its forces. The expansion of this 'neoliberal project' is characterised by an ever-increasing emphasis on individualised responsibility and free choice, liberal economic policies and a decline in the welfare state (Hall 2011) *all* of which have implications in the main spheres of influence - contraceptive services, methods and users respectively. Where this chapter has laid out the individual and contextual circumstances at an experiential, material and ideological level, the next will develop these discussions at a theoretical level starting once again with the individual broadly speaking through feminist critiques of gender roles and contraception.

Chapter 3 - Contraception and the (M)other: Thinking theoretically about contraception use from individual and state perspectives.

'The essential basis of all women's inferiority lies in the immanent nature of childbearing'
(Firesmith in Granzow 2010; p46)

In the key feminist text, *The Second Sex* (1977), Simone De Beauvoir articulated how the reproductive responsibilities of women hindered their capacity to be liberated, autonomous and crucially, equal with men. The lived experiences of women using contraception as captured in the previous chapter will be theorised using feminist critiques such as that of De Beauvoir and constructionist theories of gender. Thus, the first part of this discussion will explore women's shifting roles in relation to reproduction and sex and the interplay of contraception with women's social and sexual liberation. Specifically, I will illustrate how contraception use is now culturally embedded as a key expectation for the enactment of successful versions of womanhood. Intersectional theory will be drawn on to illustrate how characteristics such as class, education, age, race, and location may mediate a woman's capacity to contracept in the most socially desirable way.

Then, in a mirror of the structure of chapter 2 the discussion shifts to consider the bigger picture, the contraceptive context; critiquing and theorising the prevailing neoliberal discourses and the dominant procreative ideology of the 'willed pregnancy' (i.e. planned pregnancy) (Ruhl 2002) which situate and influence the contraceptive experience for British women. I will demonstrate how these factors constrain and regulate, circumscribing contraceptive choice to be expressed within certain parameters. Drawing on Foucauldian notions of self-regulation and bio-power, I will also indicate how contraception use is another site of intervention on women's bodies, increasingly so in an era that favours ever more provider dependent technologies.

Various critiques identify incompatibilities between Foucault and feminism (McLeod and Durrheim 2002; Soper 1993; Ramazonoglu and Holland 1993) - the androcentric tendencies in his work for example (Soper 1993). However, it is difficult to theoretically approach sexual and reproductive health (medicine), sexualities and gender – all key parts of this research – from a social perspective without encountering Foucauldian theory or other theorisations that have drawn on Foucault. There are also numerous points of convergence between Foucauldian and feminist preoccupations including: critical perspectives on the rational self; sexuality as a site of political struggle; and an interest in the politics of 'everyday' lives (McLeod and Durrheim 2002) – once again all relevant facets of this research. Thus, this chapter will adopt a Foucauldian Feminist approach as characterised by McLeod and Durrheim (2002) in their work on governmentality - one which they highlight has resonance in considering micro and macro levels of power, a further concern of this thesis. Therefore, in short, I understood this approach to be suitable as it conferred a multifaceted (multi-layered) consideration of the (gendered) power relations that take on diverse forms at micro and macro levels, congruent theoretically with the objectives of this research.

3.1 Modern women: disembodiment, desexualisation and 'doing gender.'

Expectations regarding women's role and femininity, have shifted considerably over time; the nature of these shifts vary significantly depending on the socio-cultural context, which itself may also be in a state of flux. Whilst this discussion may have resonance for other socio-cultural settings, the norms as discussed within this chapter relate to women in Britain. Once again this site is the orientation rather than the whole of the UK as Northern Ireland has considerably different socio-cultural and religious imperatives. In addition, although these women may broadly share socio-cultural circumstances, they occupy multiple positions (neoliberal, capitalist, patriarchal) which vary according to specific times and sites in the wider (dynamic) context. The category of 'women' also requires attention in that, conscious of critiques of essentialism, the plurality of women's roles and feminisms must be

considered (Gunnarsson 2011; Letherby 1994). Therefore, by 'women' I refer to a normative, culturally dominant, version including 'traditional femininity'- which will be theorised later in this section.

3.1.1 Woman-womb: Control and separation as liberation?

Feminists and contraception advocates throughout history have hinged key women's liberation arguments on the potential for women to control and manage their reproductive bodies (De Beauvoir 1977; Cook 2005; Ruhl 2002; Letherby 1994; Granzow 2010). In this context, contraception facilitates the departure for women from traditional roles in domestic sites as mother, wife (Friedan 1963) to 'modern' autonomous women able to control or forgo reproduction and pursue education, employment and lifestyles congruent with their male counterparts (Granzow 2010). As mentioned briefly in chapter 2 there have been significant social shifts for women in Britain, and internationally, since the introduction of modern contraceptives in the 1960s such as increased participation in the labour market and education (Cook 2005; Bailey 2006). These shifts have also resulted in a perception of increased control and regulation of women's fertility, a notion that I approach critically as I explore de Beauvoir's assertions of a separation of an autonomous 'self' from body.

Certainly, many of the discourses around contraception and pregnancy imply (self)control and agentic practices for women, particularly in Britain (Petchesky 1995; Ruhl 2002; Medley-Rath and Simonds 2010; Marshall and Woollett 2000). This varies according to cultural context as, for example, anthropological literature indicates how heterosexual Japanese women's notion of control relates instead to their relationships with men, rather than their bodies (Jitsukawa 1997). Many have challenged the bodily control thesis, such as Rosalind Petchesky (1995), who, in writing about reproductive rights, notes that radical feminists can reject the language of control as it mimics the 'language of property' - a masculine co-modification and ownership approach which positions women as objects or goods. A second objection, and that which I wish to focus on here, relates to how this perspective '*rests on the illusion of agentic, coherent, physically bounded selves*' (Ibid p387); the 'physically bounded self' being a potentially illusory concept. For many (post)Foucauldian

theorists, self and subjectivities are discursively constructed and mediated through normative discourse, power and social processes (Petchesky 1995; Bryant and Schofield 2007; Maxwell and Aggleton 2010). Hence agency and control are limited as *'the subject has no ontological substance beyond the discursive'* (Butler, 1990; 173 in Bryant and Schofield 2007). In a Foucauldian framework, the individual is *"an effect rather than an essence"* (Mills 2003; p82). For many women, Petchesky (1995) notes how their bodies/selves are so enmeshed in social relations, they cannot be constructed as autonomous; their identities, especially due to their roles as primary carers and nurturers, may be partly or entirely *"dissolved in kinship structures"* (Ibid; p402).

However, there has been increasing critique of the Foucauldian 'subject as discursively constructed' convention as empirical evidence has revealed this approach to be 'overly mechanical and determinist' (Bryant and Schofield 2007; p322) and represents the (unhelpful) substitution of biological with discursive essentialism (Williams and Bendelow 1998). In work regarding female sexual subjectivities, Bryant and Schofield (2007) draw on other empirical research, and their own life history study, to highlight how praxeological aspects of sex are central to sexual subjectivities, and how this advances notions of the body that are key for understanding the agential subject. They indicate that although discourses of sexuality *are* enacted through women's sexual lives, there is also a distinct corporeality to the practices involved in making (agential) sexual subjectivities over time – *"it is in their bodily practice of sex that discursive meanings are engaged, negotiated and given full meaning"* (Ibid. p331).

Similarly, work regarding young women and their sexual relationships by Maxwell and Aggleton (2010), characterises these 'binary' approaches to agency as 'Butlerian' and 'Bourdieuian'; with the former noting, *"discursive agency occurs when the subject who has been so named (for instance, as a girl) is then able to name another"* (Butler, 1997; p29 in Maxwell and Aggleton 2010; p328). In the latter (Bordieuian) approach, notions of praxis are considered in relation to social agents (as opposed to subjects). Drawing these two perspectives of agency together, Bryant and Schofield (2007) comment

that “*certainly the body and its practices are shaped by the regulatory discourses of the social world, yet embodiment is also constitutive of social meanings which are associated with sexual practice and identity*” (p338). Although both approaches stress that agency must be contextualised and that *moments* of agency exist everywhere; Maxwell and Aggleton (2010) suggest a ‘third way’ to conceptualise agentic practice. Namely that identifying more sustained agentic positions through ‘agency in action’ (2010), i.e. by identifying agency as grounded in subject/agent’s understanding of power, control etc. may be helpful in this way. Through their discussions with 54 young women regarding their sexual and intimate relationships they suggest: ‘*Feeling powerful, understanding and describing your personality as being powerful and strong, and being able to retell experiences in which you positioned yourself as in control, may offer some of the young women in the study the possibility of being agentic in a more sustained way over time and across their relationships.*’ (Maxwell and Aggleton 2010; p339)

I have briefly outlined these perspectives to indicate possible challenges to typical conceptualisations of agentic contraceptive practice and reproductive control. Moving on from this it is necessary to look at the body as a site for those notions of control. Empirical research indicates that embodied experience is central to contraception use. For example, Lowe (2005b) evidences how women privilege embodied knowledge over textual knowledge in relation to contraception, i.e. what women live out is more influential than the clinical evidence base (Lowe 2005b). Similarly, two corporealities - the fertile and the sexual body were described by emergency contraception users (Keogh 2005). In the same way that Keogh (2005) notes the competing interests of these two bodies, it is interesting to consider the nature of the contracepting and non-contracepting/‘natural’ bodies respectively. However, it has been noted that sociological and feminist theory, through its preoccupation with the discursively constructed notions of self, has long ignored the ‘problem’ of the body (Williams and Bendelow 1998).

An increasing catalogue of work is seeking to address and theorise the body and its agentic potential and to determine how the physical and discursive co-operate and/or interplay (Maxwell and Aggleton, 2012) – a perspective largely overlooked in relation

to contraception. In a development of their 'agency in action' concept, Maxwell and Aggleton (2010) characterise how young women's sensate and emotional experiences of their sexual bodies can stimulate agentic practice. Drawing on other similar literature that has positioned the body as integral to agency Maxwell and Aggleton (2012) comment how "*a crucial step to being agentic within sexual and intimate relationships is for young women to feel connected to their bodies*" (p308).

However, according to De Beauvoir "*true autonomy is only possible if one achieves control (and a degree of separation from) one's body*" (in Ruhl 2002; p652). Radical feminist thought has historically positioned women's reproductive body as antagonistic, the key to their oppression (Letherby 1994; Granzow 2010) arguing, that "*women should be freed from the "tyranny of their reproductive biology" by any means available*" (Firestone 1971; p223 in Letherby 1994). This is interesting considering more recent departures from Cartesian dualist thought, currently unpopular in sociological and feminist scholarship (England 1989; Maxwell and Aggleton 2012), as sentiments such as those of De Beauvoir strongly resonate with notions of mind/body separation. As Granzow (2010) notes, "*In accepting ideals for individual autonomy, universal equality and human agency, liberal campaigners for women's rights accepted the notion that the body was split from and subordinate to the mind*" (p46). Indeed, in other research about reproductive medicalisation, Emily Martin (1987) noted that women felt distinctly separated from their bodies especially in relation to menstruation, menopause and birth (1987).

The 'corporeal dilemma' (Williams and Bendelow 1998; p115) situates on one hand, women's bodies as disadvantaged relative to men and in *need* of separation and control for purposes of equality. On the other hand, it is suggested that women should not aspire to be like men at all and should affirm and celebrate their bodies, including their reproductive potential (Williams and Bendelow 1998). Therefore, contraception can be argued to offer possibilities for agentic practice, self/control and regulation of the antagonistic, problem body. This 'separation' of the autonomous self (mind) from the 'tyranny' of reproduction (body), facilitates myriad lifestyle choices and increases power and agency. Conversely, it can be argued that the medicalised version of

reproductive control has disempowered and alienated women from their bodies by shifting its regulation to the medical discipline (Marshall and Woollett 2000; Diamond 1994; p69 in Ruhl 2002) - a perspective that troubles conventional thinking about contraception as emancipatory. Theoretical challenges aside, Weeks (2010) makes a valuable remark regarding the importance of acknowledging the reality of changes in women's lives (education, health, employment) afforded by access to modern contraceptive technologies. Real shifts in women's sexual lives have also been facilitated through contraception and it is this, the sexual self/body in relation to contraception that will be theorised in the next section.

3.1.2 Contraception - Sex for whose pleasure?

In chapter 2 I mention briefly some of the ways that contraception allowed for shifts in women's sexual roles namely through the so-called 'sexual revolution' that facilitated women's engagement in sex for pleasure without risk of pregnancy (Cook 2005; Weeks 2010). Women's shifting sex roles can be theorised further. Constructions of women's sexual identity are historically founded in the binary dichotomous discourses of 'good' and 'bad' where women are cast as either 'Madonna'/virgin or 'whore' (Barrett and Harper 2000; Bryant and Schofield 2007; Vanwesenbeek 2009). Here, female sexuality is associated with danger and evil. 'Ideal' women demonstrate respectability through chastity, virginity or responsiveness to male desire and 'bad' women are associated with sexuality, promiscuity and labelled as nymphomaniacs, lunatics and prostitutes (Barrett and Harper 2000; Bryant and Schofield 2007; Mort 2000; Lowe 2005b). In addition to this demonisation of women, any expressions of female sexuality have been historically, and continue to be, pathologised (Moynihan 2003), as explored further in section 3.3. These stigmatising perspectives are those which confer the ways in which the initial introduction of modern contraception to Britain was considered a moral threat to women and society, offering potential for unregulated and undesirable sexuality (Leathard 1980; Cook 2005). Where previously the chaste 'Madonna' figure functioned as a passive recipient during sex, modern contraception enabled women to be active in ways which had not been possible before.

Despite women's sexual freedom *now* being a celebrated benefit of contraceptive availability (at least superficially), it can be argued that normative discourses of 'feminine' behaviour continue to favour historic ideals of female sexual identity (Fisher 2006; Mort 2000). This includes subdued expressions of sexuality, passivity, few sexual partners, chastity and practices that socialise women to feel ashamed and suspect about their sexual desires (Barrett and Harper 2000; Tolman 2002; Higgins 2009). This contrasts with experiences for men (normatively speaking) where predatory heterosexual activity is constructed as a characteristic of idealised hegemonic masculinity to which men should aspire (De Visser et al, 2009) and boys learn early in life they have the 'right to pleasurable sex' (Higgins and Davis 2011; p3) - a 'double standard' that is inherently sexist and hypocritical (Holland et al, 1998; Cook 2005). Historically these differences were conceptualised through the determinist 'biological imperative' perspective that explains (male) sexual behaviour as biologically needs driven (Weeks 2002). However more recently, sociological perspectives have highlighted the socio-cultural context and discursive constructions of sexuality (Higgins and Davis 2011; Weeks 2010); challenging established 'facts', for example, that men have a greater libido than women.

Due to the focus on contraception, my thesis explores female sexuality specifically in relation to hetero-sex - a problematic version of sex for many feminists who perceive it as a site of inherent oppression and victimisation of women, androcentric and impossible to change within the context of patriarchy (Higgins 2007). Theorising women's experiences in heterosex, recent literature tends to characterise female sexuality, especially that of young women, as expressed through Holland et al's concept of 'Male in the Head' (1998), i.e. that women defer their own sexual needs to privilege their male partner's pleasure (Tolman 2002; McClelland 2011). This concept is congruent with the 'Madonna' responsiveness to male desire (Bryant and Schofield 2007). Similarly, many argue that contraception such as the pill, despite relative risk to health, is a product of coercion as women internalise male dissatisfaction with condom use (Lowe 2002) where inherent power imbalances make demanding condom use difficult or impossible for women (Holland et al, 1998; Higgins 2007). 'Inauthenticity in relationships,' where women avoid 'unfeminine' behaviours such as

challenging or disagreeing with a partner, can also influence sexual and contraceptive practices (Impett et al, 2008). Although I accept that women's sexuality is shaped by the legacies of patriarchal and heterosexist norms, I maintain that one must be cautious to avoid perpetuating the notion that women are devoid of sexual agency. Recent empirical work indicates that even though women may negotiate their sexuality under conditions of patriarchal inequality, passivity cannot be assumed (Jewkes and Morrell 2012; Lowe 2002; Higgins 2007). Referring back to Maxwell and Aggleton's (2010) concept of 'agency in action' for example, offers a way to imagine women's sexually agentic practices despite patriarchal context.

Although typically more empirical than theoretical, the work of Jenny Higgins focuses specifically on contraception in relation to female sexuality, namely sexual pleasure (2007; 2014; Higgins and Davis 2007; Higgins and Hirsch 2008). Her 2007 publication theorising hetero-sex highlights that women were not only pleasure focussed, but sought contraception that would specifically maximise their enjoyment. Similarly, Lowe (2005a) indicates how the emphasis on intercourse, and male sexual fulfilment in sexual health/contraception discourses, perpetuates the male as the active and the female as passive participant. The passive female is also deemed as suitably responsible for contraception compared to the uncontrollably sexual male - a paradox if we consider the chaotic and dangerous ('whore') version of female sexuality that persists and the perceived irrationality of women (Lowe 2005a; Johnston-Robledo and Chrisler 2013; Longhurst 2010).

These stereotypes are also reconstructed and reinforced through discourse, for example, through medical fears of 'abuse' of contraceptive methods and 'non-compliance' with contraceptive regimes (Lowe 2005a). Normative gender roles are also reflected in clinical trials for prospective male hormonal contraception, which, when compromising male sexual pleasure and function, are dismissed as unacceptable, whilst many women's hormonal methods are acknowledged unproblematically to compromise sexual wellbeing (Higgins 2014; Higgins and Davis 2011; Higgins and Hirsch 2008). Arguably, any expectations that women should endure compromised pleasure to privilege pregnancy prevention further subjugates

women to the role of a passive (infertile) sex object and reinforces the 'biological imperative' and sex for male pleasure.

These are just some examples that indicate the ways in which sexual pleasure is gendered, specifically the subjugated position of female sexuality and desirability of passivity. In the same way that there are norms around female sexuality, there are also ideal versions of female gender more broadly, which interplay with contraception use and are considered in the next section.

3.1.3 Contraceptive responsibility as cultural intelligibility

'Gender is not a style or a game that can be played. It is a forced reiteration of norms, the repetition of regulatory fictions that constitute the subject' (Butler 1993; p95)

In this section, I theorise what doing (female) gender has meant for women over the last fifty years since the introduction of the pill. In doing so, I indicate how ideal femininity still positions childbearing and fertility as central, albeit within the context of the modern procreative ideology that privileges the 'willed pregnancy' (Ruhl 2002). Constructionist approaches to gender that are helpful to consider in relation to contracepting include notions of performativity, i.e. the iterative process of acts that constitute gender (Butler 1990) and the multiplicity of femininities including socially dominant versions such as Holland's 'fluffy femininity' (2004); or Connell's 'emphasized femininity' (1987) as constituted within the contexts of (masculine) power hierarchies (Jewkes and Morrell 2012). These approaches allow us to observe how 'doing gender' (Butler 1993) or rather 'doing gender *correctly*' is reliant upon different performances at different times and in different sites. In writing about the introduction of the contraceptive pill, Julia Cream (1995) noted how, at that time, doing gender correctly meant being heterosexual, married and childbearing. Despite some increased flexibility and equality regarding sexual orientation and marital status (Weeks 2010), fertility and motherhood are still defining characteristics of ideal femininity and women are frequently defined in relation to their role as mothers (Rance 1997; Letherby 1994). Voluntary childlessness (although increasing) is unusual

or, at worst, deviant (Gillespie 2003) and infertility can undermine a woman's sense of female identity (Letherby 2002). As such, fertility (as a prerequisite for motherhood) needs not only to be regulated, but to be cherished and protected. As the 'antithesis of womanhood,' abortion is also seen to challenge the concept of the ideal maternal woman (Timpson 1996). In short, fertility and childbearing remain fundamental components of female identity.

The expression of this fertility is, however, circumscribed in a way particular to the British context. Facilitated by the complement of free women-specific methods available, childbearing is expected to be planned and conform to the paradigm of the willed pregnancy as an ideal (Ruhl 2002). In Chapter 2 I indicated how the introduction of the pill shifted contraception into the hands of the medical discipline but, where previous contraception was a largely male practice, it also conferred gendered expectations that women should take responsible contraceptive action to prevent unintended pregnancy (Lowe 2002; Beynon-Jones 2013a; Olsen 2007). Cream (1995) suggests that contraceptive practices (in her case oral contraceptive pill use), conform to Judith Butler's concept of 'intelligible gender' and that through this contraceptive practice, women's bodies are made 'culturally intelligible.' Building on Cream's (1995) notion of pill use as culturally intelligible, contraceptive responsibility can be perceived as part of the normative performance of femininity, the ideal version of 'doing gender,' for modern reproductive age British women. This is supported by Granzow's (2010) observations that contraceptive responsibility '*is now part of the script that defines the heterosexual middle class White woman – the woman who values liberal ideas regarding the importance and freedom attached to planning*' (p49). Indeed, for western women, the 'hegemonic status of the pill' has been duly noted (Lowe 2002). In this way through the ritualised process of women's contraception use, not only is the fertile body regulated, but the female subject is re/constituted. Contraceptive practices, discourses and experiences interplay with social divisions such as class and race re/producing more nuanced female subjectivities.

In the same way that Cream (1995) discusses the cultural intelligibility of the pill, there have been shifts that illustrate how this intelligibility may vary depending on historic

time and site. For example, more recent clinical discourse around contraception encourages abandonment of the seemingly out-dated method that is 'the pill' due to, amongst other things, the propensity for 'user failure.' Instead, technological developments have meant that practice culture has started to favour newer, 'more effective' LARC methods. Therefore, drawing on a specific example from chapter 2, in the 1970s and 1980s for example, (self-regulating) pill use was seen as modern, ideal and thus intelligible, and IUC use deemed highly inappropriate for young women and women without children. As IUC is now cited as ideal for all women, including the young and nulliparous, the pill is increasingly reconstructed as riskier due to its inferior efficacy thus starting to redefine that which is culturally intelligible in the context of contraception.

However, despite its desirability, being contraceptively responsible can also offer challenges to idealised femininity and incite the transgression of gender norms. For instance, as desirable femininity still involves passivity and limited sexual agency, this may confound women's efforts to use or seek contraception (as evidenced in chapter 2.2.2.1), as this involves the disclosure of sexual activity; specifically sex for pleasure. Other contraceptive impacts may also challenge idealised versions of feminine expression. For example, weight gain is incongruent with the social emphasis on slimness, desirable for women in western society (Higgins 2007); erratic and sustained bleeding contradicts discourses of 'menstrual disgust' and challenges women who have been socialised to hide their leaky bodies (Allen and Goldberg 2009); perceptions of compromised fertility challenge the social importance of women as reproducers and mothers, mentioned earlier (Letherby 1994, 2002; Timpson 1996; Rance 1997).

Thus, despite the purported benefits to women's lives, from theoretical perspectives we can trouble the assumption that contraception unequivocally offers (more) freedom for users. In fact, increasing medicalisation further to the introduction of the OCP and shifts towards more provider-dependent technologies such as LARC, have arguably compromised the extent to which contracepting can be considered an agentic practice. In addition, the normative expectations and stereotypes about

female gender, which fundamentally remain remarkably unchanged over the last 50 years, may further shape women's contraceptive practices.

Therefore, through a theoretical lens, contraception is important at an individual level as a means for 'doing gender,' intersectionality theory can further highlight some of the ways that the situated experience of the individual is shaped.

3.2 More Than a Woman - Intersectional approaches to understanding contraceptive practices

First I wish to stress that I use the concept of 'identity' within this thesis tentatively, conscious of a critical alternative to identity politics; one which is categorised by tendencies to focus on differences between groups at the expense of 'intra-group differences' (Crenshaw 1991 in Prins 2006; p278). My focus in the chapter so far on theorising gender and sexuality as key facets of women's identity is driven by the topic of my research, as experiences of modern contraception and managing pregnancy are inextricably linked to (female) gender and sexuality. However, there are myriad other characteristics that shape individual women's experiences.

'Intersectionality' (Crenshaw 1989) identifies that individuals and their experiences cannot be explained through single categories/social locations and as such argues that, "*it foregrounds a richer and more complex ontology than approaches that attempt to reduce people to one category at a time*" (Phoneix 2006). This 'more complex ontology' is inclusive, anti-essentialist (Ludvig 2006) and crucially, facilitates the address of differences and inequities that exist between (in this case) women (Hankivsky et al, 2010) - so called 'intra-group differences' (Crenshaw 1991 in Prins, 2006; P278). When using this approach, it is necessary to consider the intersection of the multiple categories occupied by any one individual; their gender, race, class, age, religion to name a few, and captured more fully in Figure 3.1 below.



Intersectionality Displayed in a Wheel Diagram (CRIAW, 2009, p. 5)

FIGURE 3.1 INTERSECTIONALITY WHEEL (CRIAW 2009)

As such, when using an intersectional approach 'additive,' fragmented approaches to identity are rejected in favour of the perspective that these categories (gender, age, class etc.) co –construct each other. These intersections are then considered in relation to wider social locations, systems and processes (such as sexism, racism, homophobia). As such the relational and multidimensional nature of social positions can be illuminated (Phoenix 2006; Hankivsky et al, 2010). Constructionist interpretations of intersectionality also reject a static view of identity categories noting how these meanings and the systems in which they are embedded are fluid and shift over time (Prins 2006).

Despite its popular status amongst many feminist researchers, intersectional approaches are not unproblematic. For example, the empirical application of intersectional theory has received limited attention (Bryant and Hoon 2006; Hankivsky et al, 2010; Hankivsky 2012; Davis 2008). However, Davis (2008), celebrates this 'weakness' noting that although 'good theory' is typically perceived as "coherent, comprehensive and sound," (p78) "Intersectionality initiates a process of discovery alerting us to the fact that the world around us is always more complicated and contradictory than we could have anticipated" (p79). Specific critique of its use in sexual health research has identified various pitfalls. Anna Bredstrom's (2006) work,

whilst acknowledging the importance of Holland et al's (1998) thesis for sexual health, critiques the intersectional approach of Holland et al's 'Male in the Head' (1998). Bredstrom (2006) argues that their descriptive approach to race/ethnicity and class, in addition to their key foci of gender and sexuality, means that these concepts are treated in a 'pre-theoretical' way (p235) and lack analytic meaning, i.e. the "*differences are acknowledged as empirical realities but theoretically overlooked*" (p235). The work is perceived by Bredstrom (2006) as maintaining a theoretical position where it is possible to separate gender and sexuality from other characteristics. In addition, when other social divisions are identified, it is in a way that highlights them as problematic or deviant and as such reinforces the normative. For example, "*issues of culture and religion are only brought to bear on some women whose experiences then are continuously measured and compared in relation to what becomes an unspoken norm.*" (p235). Others fear the consequences of intersectionality. For example, Hankivsky (2012) notes how some researchers' worry that de-centering the category of gender will render it invisible and unimportant.

In the context of contraception, intersectionality is important in understandings of, for example: how some women are abler than others to negotiate their sexuality or contraception; how women's contraceptive choices are circumscribed; and/or how they may be discriminated against depending on their social location – a circumstance that links to the concept of stratified reproduction which is discussed further in section 3.3. As such, despite theorisations specific to female sexuality and gender noted earlier in this chapter, I acknowledge that these are also unstable, unfixed categories and cannot be viewed in isolation or assumed to be of profound importance to the individual woman. Intersectional perspectives may therefore be meaningful in challenging assumptions regarding gender and sexuality in the experiences of contraception and managing pregnancy (for example, Holland et al, 1998).

3.3 Our bodies, ourselves? Contracepting for the state.

'The woman swallowing the oral contraceptive pill was now not only maintaining the health and happiness of her family but also the future of the whole world' (Cream 1995; p166)

I have highlighted previously that women in Britain are coached into exercising contraceptive responsibility within the context of the willed pregnancy. Specifically, planned-parenthood following the achievement of successful educational and career milestones has been positioned as the ideal for British women (Ruhl 2002; Draper 1972; Wilson and Huntington 2005). Although it may appear that conceptualisations of 'ideal' circumstance may vary from person to person, and such decision-making is a matter of private and personal preference, in this section I argue that there is also a socially prescribed version of events and that the politics of reproduction are very much a matter of public interest. I discuss attempts to mediate 'contraceptive choice' through discursive strategies such as responsabilisation and explore how the production of contraceptively responsible women is reliant on a form of self-governance that is heavily mediated by the medical discipline. In conclusion, I discuss the '(M)others' (Wilson and Huntington 2005) that are positioned outside of this normative paradigm through 'choice'/'irresponsibility' or circumstance and how this is problematised from a state perspective.

3.3.1 Neoliberal context and the dominant procreative ideology.

In contrast to the organisational and technocratic characteristics of neoliberalism as related to contraception mentioned in chapter 2, here, I theorise the implications of this ideology and how it has reconceptualised subjects as rational and knowing (Weeks 2010; Ruhl 2002; Carabine 2007). Responsibility, individual freedom from the state and increasing consumerist approaches (to contraception) (Granzow 2010; Hall 2011) are explored congruent with feminist critiques that identify these tendencies as reflective of a masculine perspective *'that privileges patriarchal interests and exalts separateness over connection'* (Roberts 1995; p1005). Foucauldian critiques of

neoliberalism and the ways in which subjectivities are discursively constructed through dominant regimes of power, are also drawn on (Weeks 2010).

Despite the current absence of explicit external constraints such as laws regarding reproduction and sexuality in Britain, Foucauldian perspectives identify *self-governance* as the main means of social regulation. This includes the notion that (sexual) subjectivities are, and have been, discursively regulated through: sex education (Moore 2012a); policy and initiatives (Crowley and Kitchin 2008; Granzow 2010; Carabine 2007), religious doctrine (Crowley and Kitchin 2008) and marketing (Medley–Rath and Simonds 2010; Padamsee 2011), to name a few. Disciplinary power is invoked to reinforce the legitimacy of these messages. For example, despite being historically *desirable* for young women to have children, teenage pregnancy is now discouraged through the vehicle of ‘scientific’ and ‘medical’ discourses (Wilson and Huntington 2005). The individual internalises and then acts in normative ways as constructed through these discourses (Richardson 2004 in Weeks 2010) which are frequently couched around feminist notions of choice and control (Medley-Rath and Simonds 2010). The norms, once again, shift in relation to site and time as well as being shaped by class, race etc. For individual women, and their reproductive bodies, this means self–governance through taking responsibility for contraceptive practices and planning pregnancy. Rose (1999 in Weeks 2010) suggests that in neoliberal states the individuals “*become entrepreneurs of themselves shaping their own lives through the choices that they make among the forms of life available to them*” (p230). However, reproductive and contraceptive choices shape more than individual’s ‘own lives.’ The state, has historically taken an interest in, and shaped, the regulation of reproduction for populationist, eugenic and economic reasons (Ruhl 2002; Brookes 2013) - the paradigm of reproductive liberty can be challenged for various reasons if we explore societal expectations regarding reproduction.

Although efforts to control reproduction are nothing new, the way that a society wishes to organise reproduction has been defined as the ‘procreative ideology’

(McLaren 1990; in Ruhl 2002; p23) which in neoliberal states is currently the 'willed' or planned pregnancy (Ruhl 2002). Expanding on the notion of contraception as synonymous with modernity, Stephen Brooke's (2013) exploration of family planning and the British left characterises how, in the post-war period, acceptance of contraception started to be reflected in discourses of modernity and future planning. Family ideals were purported as those "*deliberately conceived by intelligent citizens with modern outlooks and modern interests*" (p123). Hence large families and uncontrolled reproduction were associated with hardship, poverty and low standards; all of which post-war Britain was eager to leave in the past. Such populist agendas were analogous with 'family planning' and thus, willed/planned pregnancy represents the state - its modernity, prosperity and high standards.

In addition, conceptualisations of liberal rational subjects also favour the planned pregnancy ideology. In the same way that the female reproductive body may be 'separated' and controlled, "*the liberal individual operates outside of time, space and bodily circumstances: the mind (rationality) floats above these particularities and can freely engage with other minds, which are also on this suitably universal plane*" (Ruhl 2002; p645). These individualistic liberal subjects are governed through their capacity and willingness to self-regulate, also called 'liberal governance' through inculcation and the habit of self-control (Ruhl 2002; Nadesan 2008) - exemplified in contraceptive pill use (Granzow 2010). Liberal governance can be operationalised through the paradigm of planned pregnancy and demands that women internalise responsibility for reproduction in a way that assumes forethought and planning (Ruhl 2002). As such, other approaches to pregnancy (unplanned, accidental etc.), despite their *wanted*-ness, are problematic. Although the planned pregnancy ideology is not necessarily unhelpful or threatening, it can be argued that for the female liberal subject, her position is one of reproductive *restriction* circumscribed by this procreative ideology rather than reproductive liberty. The planned pregnancy imperative is mediated through various discursive strategies - discourses of 'choice' being the most common.

3.3.2 Consuming contraceptive choice.

"If there is a shift from a desire to plan to an obligation to plan, there is a diminishing of choice" (Granzow 2010; p50)

Western citizens generally live in an 'era of choice' (Solinger 2001). Consumerist values and rhetoric have been appropriated in various ways including for the healthcare sector (Newman and Vidler 2006) and 'contraceptive choice' is purported as one of the key facets of reproductive health and rights more broadly (Rodriguez et al, 2014). However, according to Valverde (1996; p8 in Ruhl 2002), *"liberal citizens have been granted the freedom to make choices precisely because they can be trusted to make the right sort of decision."* Critiques indicate how supposedly free choice is bound by many societal pressures and that choices are granted or limited based on several factors (Weingarten 2012; Granzow 2010; Marshall and Woollett 2000). In this context, the pressure is to make the 'right sort of decision,' to use contraception and plan pregnancy. Choosing *well*, involves conforming to a *"middle class, educated and scientifically orientated worldview"* (Ruhl 2002; p656) reflected by evidence based medicine, and internalising the normative ideology of planned pregnancy. Choice also hinges on the idea that we (and others) have autonomous 'selves' and a responsibility for that self (Granzow 2010). In her work on deconstructing choice, Kara Granzow, (2010) suggests that women's use of the pill is not agentic practice but an act of repetition which supports the dominant (patriarchal) ideology as defined in the context of neoliberalism. Agency is moulded by notions of obligation and acceptability, which in turn affect the choices that are made (Sen 1990 in Beutelspacer et al, 2003). The responsabilisation of women for reproduction and their individual contraceptive choices are linked; as Ruhl (2002) suggests: *"women then, need to uphold their end of the bargain of reproductive freedom; contraception in exchange for the guarantee to act responsibly where reproductive decisions are concerned"* (p656). Consequently, women who do not 'act responsibly' are subject to victim blaming (Marshall and Woollett 2000), marginalisation and stigmatisation (Carabine 2007), the prospect of which may shape choice considerably.

Limits are also imposed by the material, economic and social conditions in which choices are made (Weeks 2010; Chandiramani 2010) – “*We do not all have choice in the same way. Choice in itself is gendered, classed, aged, cultured, and available only in accordance to ability and access*” (Granzow 2010; p52). Holland et al (1998) indicated how young women’s choices are shaped by existing gender inequalities, which inform early heterosexual encounters. For example, they do not feel confident to demand condom use and/ or don't feel that their partners will be receptive to their requests in the context of their relationships.

Finally, introducing Shellee Colen’s concept of ‘stratified reproduction’ (1995 in Ginsburg and Rapp 1995), I wish to highlight how the choices available vary depending on the individual and/or group. As noted previously, ‘contraceptive choice’ is a construct that describes white middle-class women’s experience and ‘stratified reproduction’ refers to how some women are perceived as more suitable for reproduction than others (Ginsburg and Rapp 1995; Beynon-Jones 2013b). Beynon-Jones (2013b), in her work on abortion services, uses this concept to explore these strata, namely in this instance: youth, age, parity and class, indicating how abortion services function as a site of stratified reproduction. ‘Choices’ are constructed as rational or irrational depending on a woman’s position/strata and this can translate into direct influence on the individual. For example, abortion is characterised as rational in youth when pregnancy is perceived to be inhibitory to aspiration. However, for older women it is more problematic as discourse stigmatises older mothers who have ‘selfish’, ‘risky’ or ‘ignorant’ delayed pregnancy (Beynon-Jones 2013b). In these ways, I suggest that stratified reproduction links closely to intersectionality in that how an individual’s characteristics intersect also reflect how that person may (not) be desirable for reproduction.

In section 3.1 I suggested that reproductive control was a somewhat illusory concept and here I have theorised the ways in which concepts of contraceptive and reproductive choice may also be misleading. Granzow (2010; p49) also notes how ‘*the*

language of choice makes submission to medical/technological intervention sound intentional and informed' and it is the nature of contraception as an intervention that will be explored in the next section.

3.3.3 Whose control? Surveillance, intervention and the state.

The proliferation of techniques for the subjugation and control of bodies and populations was referred to by Foucault (1978) as 'bio-power'. He argued that through this, regimes of power are played out through regulation at bodily level (Bell and Figert 2012; Nadesan 2008; Mills 2003). The two inter-related aspects of bio-power are: 1) macro-level population control; and 2) micro-level bodily control (Macleod and Durrheim 2002). This concept links clearly with contraceptive technologies that have been developed specifically to regulate reproduction (population control) and women's bodies. Foucault characterised how, from the 18th century, the state began to perceive and treat citizens as a 'population' (Moore 2012a). Currently, the neoliberal planned pregnancy ideology reinforces the value of (contraceptive) 'technologies of the self.' This concept, also Foucauldian, describes the ways in which individuals self-regulate rendering themselves subjects of neo/liberal governments (Nadesan 2008; pg). Although in Foucault's work the body is discursively constructed, this does not serve to render it passive and various forms of embodied resistance are characterised (Mills 2003). In addition, Foucault (1980) suggests that power is not *possessed* by an individual or institution and is instead relational – a circumstance that offers an opportunity, therefore, for (dis)empowerment as powerful-ness is not a fixed condition. Critics of Foucault however, highlight how concepts of resistance and power are unsatisfactorily explained (Williams and Bendelow 1998; Ramazonaglu and Holland 1993) although concepts such as 'agency in action' indicate how agentic practice may indeed be instigated and change/ resistance affected (Maxwell and Aggleton 2010; 2012).

Rose (1996) described three forms of self-technology: relating to the self epistemologically (know yourself); despotically (master yourself); and attentively (care for yourself). These 'technologies of the self,' especially since the advent of

modern contraception, are strongly mediated by the state, namely the medical discipline. It is under this surveillance or 'gaze' that normalising judgments are embedded in dominant discourses and subsequently internalised by the individual. As explained by Foucault: "*There is no need for arms, physical violence. Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end up interiorising to the point that he (sic) is his own overseer, each individual thus exercising surveillance over and against himself*" (Foucault 1980; p155 in McLeod and Durrheim 2002).

Reproduction and contraception is a key site of this regulation through 'medicalisation' (Marshall and Woollett 2000; Tone 2012; Padamsee 2011) – a concept developed in the 1970s that refers to the involvement of medicine in the management of society (Bell and Figert 2012). Hormonal contraceptives and devices such as IUC require not only medicalised encounters, but sustained surveillance over women's lives (Lowe 2005b). Feminist sociologist Anne Oakley (1993 in Lowe 2005b) identified how these developments marked a distinct shift from contraceptive practice which was historically reliant on non –medical interventions. Today, the power relations between women and medicine are not straightforward and further complicated by issues such as patient complicity in power/knowledge production (Lowe 2005b) and increasingly consumerist approaches to healthcare (Newman and Vidler 2006; Lowe 2005b). In addition, Lowe's (2005b) work regarding the contraceptive consultation highlights how this encounter is further complicated as "*ongoing prescriptions for the 'well' means that the role of embodiment in establishing trust and expertise may not be generalizable to other doctor/patient relationships*" (p376).

However, women's subordinate structural position in society, and sexist conceptualisations of women's bodies and sexuality, inform discourses around contraceptive practice and shape both women's and the medical subject positions (Lowe 2005b). Typically, in contrast to the perception of masculine rational subjects, women have been perceived as threatening and unruly "*By virtue of the physical processes of reproduction, from menstruation to pregnancy to menopause, women were classified as inherently natural (i.e. more animalistic) and therefore incapable of rational thought*" (Granzow 2010; p45). Femininity represents the non-rational 'other' and

occupies a disorderly and 'animalistic' body that demands regulation and control. This perspective is manifest in the pathologisation of women's bodies, particularly sexuality where, for example, past preoccupations with hysteria, nymphomania, masturbation etc. could, in the extreme, lead to surgical intervention (Studd 2007). It can also be observed in contemporary 'pharmaceuticalisation' for example, of female sexual dysfunction (Moynihan 2003) or for menstrual suppression (Mamo and Fosket 2009) (although admittedly the same markets exist for men with Viagra for erectile dysfunction and the economic gain of Big Pharma is central). These preoccupations and stereotypes mean that women's bodies have been subject to disproportionate intervention in contrast to their male counterparts. Rose's work on medicalisation (2007 in Bell and Figert 2012) notes how "*some people are more medically made up than others, women more than men*" (p777). For this reason, the development of modern contraceptive technologies using women's bodies as sites for intervention rather than those of men can be viewed as inherently sexist (Ruhl 2002). The similarly sexist outcome is then that it is the female body that is coded as contraceptively responsible rather than that of the male (Beynon-Jones 2013a).

Marshall and Woollett's (2000) discourse analysis of texts related to pregnancy indicates that women are positioned with limited agency, as unknowing about their bodies and are unlikely to trust their own embodied knowledge. This is unsurprising if we consider observations like those of Williams and Bendelow's (1998) that indicate how 'experts' (historically men) have regulated women's pathological bodies to compensate for the perceived irresponsibility and ignorance of the everyday (fertile) woman. The 'rhetoric of choice' however (Granzow 2010; Marshall and Woollett 2000) makes what is submission and compliance sound active and knowing (Granzow 2010; p49) – a type of passivity in relation to medicine that can also be a facet of normative femininity (Howson 1998 in Lowe 2005b) and is reinforced through contraceptive discourses that refer to 'compliance,' 'user failure' etc.

Finally, drawing on concepts of: a) the planned pregnancy procreative ideology as typifying white, middle class values (Ruhl 2002); and b) notions of stratified reproduction that privilege the reproduction of certain individuals over others

(Ginsburg and Rapp 1995; Beynon-Jones 2013b), it is possible to identify how contraceptive practices may have eugenic effects. As eugenics can be defined in terms of intention or effect (Mittra 2007), despite the absence of any deliberate reproductive control policy in Britain, there may be unintended eugenic consequences from the exercise of bio-power. Duster (1990 in Mittra, 2007; p165) explores notions of 'backdoor eugenics,' i.e. eugenic effects that may emerge through *"cumulative decisions of individuals who may or may not be considering the broader fate of the gene pool."* Mittra (2007) then acknowledges that *"to embrace a consequentialist definition of eugenics is to problematize the libertarian presumption that individual choices have amoral, innocuous or politically neutral consequences"* (p166); highlighting another challenge to notions of liberal, individual choice. Eugenic consequences are possible if we consider those financial incentives suggested in the USA for women on welfare, homeless women etc. (Diclemente and Young 2012) if they use a LARC method of contraception (Higgins 2014). This can also even be understood to occur through the types of provider incentives offered for LARC counselling as detailed in chapter 2 and how these play out in practice. It has also been noted in British contraceptive service delivery that women are judged on a social rather than medical basis (Lowe 2005b). This was evident in Barrett and Harper's (2000) study regarding provider attitudes to women seeking emergency contraception – provision was circumscribed by provider's judgements about women's sexuality; or in the Beynon-Jones's (2013b) study regarding abortion provision in Scotland – where providers had different approaches depending on age, class etc. of the abortion seeker. Social and moral judgments that shape contraceptive practices are also made when normative roles and practices are transgressed. The outcomes of this will be explored in the final section where I discuss the concept of the 'deviant (m)other' (Wilson and Huntington 2005).

3.3.4 Bad (M)other/subject?

In a Foucauldian analysis of Ireland's sexual landscape in the early 20th century, regarding unmarried mothers, Crowley and Kitchen (2008) caution how *"It is a mistake to assume that all subjects bowed to the disciplining regime."* Certainly, many

women, intentionally or otherwise, transgress the normative models of gender or sexuality including contraceptive responsibility. They may also subvert expectations about planned pregnancy. The result of this 'irresponsibility' or deviance has been mentioned briefly and includes victim blaming (Marshall and Woolett 2000), marginalisation and stigmatisation (Carabine 2007). Referring back to notions of agency, control and 'choice' it is important to consider again how "*we do not all have choice in the same way*" (Granzow 2010; p52) and therefore for some women, transgression, resistance etc. may be more deliberate than for others. Jewkes and Morrell (2012) note how "*there are social rewards and sanctions which flow from adoption of particular femininities, enforced through local moral discourses as well as the threat and use of violence, which constrain the element of choice for women*" (p1730). The normative is set against alternatives for which consequences may be severe.

In modern-day neoliberal Britain, it could be argued that the 'teenage mother' has now replaced the 'unmarried mother' as the 'popular' deviant figure - one who "*embodies historically familiar and contemporary anxieties about female sexuality, reproduction, fertility and "racial mixing"*" (Tyler 2008; p17). She is not only 'irresponsible' through her failure to self-regulate and her subversion of procreative and gender ideals, but she may be cruelly vilified as, amongst other things, 'disgusting,' 'a slag' (Tyler 2008) and 'unfit to mother' (Wilson and Huntington 2005). The historical foundations of this deviant subject are rooted not just in notions of chaotic and unregulated female sexuality, but in associations with poverty and illegitimacy (Wilson and Huntington 2005). Brookes (2013) characterises the classed aspect of this (m)other succinctly as he notes that "*working class sexuality, [was] perceived as chaotic, uncontrolled and potentially dangerous both for working class people and the nation*" (p123) – a direct contrast to the middle class, educated woman's planned pregnancy. Interestingly, concerns regarding the 'epidemic' of teenage pregnancy have in fact, coincided with a decline in the teenage birth rate (Wilson and Huntington 2005; TPS, 2010), a phenomenon that (in addition to economic drivers noted in chapter 2) may be motivated by changing political and

social perspectives regarding the roles and responsibilities of women (Wilson and Huntington 2005).

However, any social and moral objection towards undesirable mother figures is rarely explicit and is instead couched within discourses of risk and 'good' choice; for example, regarding risks of poor maternal and child health outcomes (Wilson and Huntington 2005) or risk of pregnancy (Ruhl 2002). The responses to deviant versions of femininity and associated contraceptive practices or lack thereof, echo the sentiments of stratified reproduction (Ginsburg and Rapp 1995; Beynon-Jones 2013b). Indeed, it is not just working class young woman who may be stigmatised in this way. Letherby (1994) documents feminist acknowledgments that "*women are only considered fit to mother if they meet the appropriate criteria*" (p526). Although these 'appropriate criteria' vary, Britain currently privileges white middle class contraceptively responsible versions of femininity as expressed within the planned pregnancy procreative ideology. Therefore, regardless of the purported clinical risks, the social risks also reinforce the imperatives for and desirability of contraception use in this way.

3.3.5 Concluding Comments

In this chapter, I have explored the dominant normative discourses regarding contraception at an individual (woman) level and facets of the planned pregnancy ideology at a social (population) level. In addition, the interplay between the two i.e. the importance of the intersection of an individual's characteristics within the context of wider social systems and processes, has been highlighted. Ultimately, in this chapter I have sought to illuminate the meanings of (non)contraception use to individual women and also the fallacy of notions of contraceptive choice. Some of the potential social consequences of transgressing British/neoliberal norms and ideals are in fact risks, which in turn, circumscribe the lived experience of contraceptive practices. Therefore, in conjunction with chapter 2, I have begun to unpick the assumptions inherent in typical contraceptive research, i.e. that contraception is an individual-level free choice.

I have highlighted how Foucauldian Feminist theorisations were instrumental in going beyond the typical understandings of contraception, i.e. as an intervention to mediate fertility, and in uncovering its multidimensionality. This in turn has shaped the method design and analysis of my thesis, specifically by ensuring the diversity of meanings and experiences of contraception be adequately captured. How this was undertaken will be addressed in chapter 4.

Chapter 4 Telling stories and doing 'homework': feminist methods for researching women's contraceptive lives

Understanding the interplay of myriad factors on women's contracepting over time was the key aim of this thesis and has been explored at individual, social, historical and theoretical levels in the preceding two chapters. I sought to design a method to address the gaps in understanding and draw these influences together by capturing the temporal, situated and subjective experience of individual women. Justifications for using qualitative methods, as a feminist approach for researching women's experiences of contraception were driven by the need to collect highly subjective, detailed accounts of private life events. I characterise the research design and the specific methods, namely life histories and the use of 'graphic elicitation' or map making. Then, the recruitment and sampling strategy is described, followed by an explanation of how the participant's data was validated and a discussion of any ethical concerns. Departing from the structure of a traditional methodology chapter, the data analysis and reflections on my role as researcher are considered separately in chapter 5. Due to the relative novelty of the analytical method this was deemed to be the most helpful way to detail the research process and to how this was shaped by my own position.

4.1 Using contraception and managing pregnancy: the need for a holistic approach demands qualitative research

The specific research question(s) I am exploring in this thesis required a method with the scope to capture in-depth and contextual factors, informed by the premise that women do not make decisions about contraception in a vacuum. First, as a reminder, it is helpful to re-visit the aims and objectives of the research in this thesis. The overall aim of this project was to address the lived experience of contraception use to gain a situated and subjective understanding of the influences that shape women's choices to use, or not use, contraception throughout their reproductive lives.

The following specific objectives of the research were designed to capture the nuance of these circumstances and included:

- Draw together and characterise the historical contextual factors that may influence British women's contraceptive choice;
- Analyse and situate British women's contraceptive experiences in relation to these broader cultural, historical, political and economic factors;
- Explore the effect of individual women's life experiences on their decisions about and practices regarding contraception;
- Identify any transitional life events that have influenced individual women's decisions and practices regarding contraception;
- Explore the impact of women's knowledge about contraception and if/ how the sources of information and nature of their understanding may have changed over their life courses;
- Explore the interplay between determinants of contraceptive choice/use;
- Capture the dynamism of the influences on contraceptive choice/use over the individual life course; and
- To inform policy and practice in a way that is meaningful and relevant to contracepting women.

The complex individual-specific matrix of micro and macro level factors are difficult, if not impossible, to access without the subjectivities and detail afforded by qualitative methods. Drawing on the evidence base discussed in earlier chapters, there is substantial (quantitative) research that captures the individual level, cross-sectional experience of contracepting which, although offering a generalised wider picture of contraception use, fails to capture the situated meanings of contraceptive practices.

Quantitative research of this nature places emphasis on measurement and determination of causal links between variables (Denzin and Lincoln 2005) and fails to illuminate *why* phenomena occur. Hence, this does not allow for the development

of initiatives and policy that could function meaningfully in the lives of women. I suggest that this kind of investigation lends itself instead to feminist qualitative research.

Contraception use and managing pregnancy are issues that fall under the umbrella of 'sexual health', defined holistically by the World Health Organisation as:

"A state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence." (WHO 2006)

Although widely cited, this approach to sexual health is yet to be successfully incorporated into public health practice (Wellings and Johnson 2013). Undertaking narrative research, Gubrium (2011) recognised that the shift towards a holistic and 'human' approach means that contraceptive users should be (re)positioned as *"social agents with needs and desires to be fulfilled rather than passive statistics with attitudes, beliefs and behaviours to be prevented"* (Gubrium 2011; p321). Operating within an interpretivist paradigm, qualitative research allows us to consider the 'how' and the 'why' and to access the subjectivities of women's life worlds and the meanings that they attach to their experiences more-so than quantitative research (Denzin and Lincoln 2005; Pope and Mays 2006; Lincoln and Guba 1985). It can also be used to approach sexual health, including contraception, in the holistic way purported to be best practice as per the recommendations above from the World Health Organisation (2006). As such, both need to use a holistic approach to sexual health and the specific research questions, demand a qualitative approach.

Qualitative research has also been described as a fitting way, by some the *only* suitable way, to address issues of women's (marginalised) position, experience and oppression in society (Ackerley and True 2010; Ribbens and Edwards 2006; Maynard and Purvis 1994). Gender, specifically women and their experiences, are at the heart of this project. Without denying men's participation in the realm of contraception,

women's lived experiences are starkly different, as for instance: in determining rates of unintended pregnancy or abortion it is women's bodies that are counted; only women have the embodied experience of pregnancy; only women have the embodied experience of hormonal contraception and so on. Therefore, as the research question seeks to address the diversity of *women's* experiences and to contextualise the experience considering their position as a woman in society, this research is inherently feminist. For these reasons, and as a feminist woman researching women, qualitative methods were again the most appropriate choice.

4.2 Telling stories and 'doing homework'- Using life history methods and graphic elicitation in qualitative research

4.2.1 Life history method- the personal is political

The research question requires a detailed, subjective approach that captures both the micro and macro, the public and the private contexts in which women's choices about contraception are made, i.e. the political, economic and broader social influences *and* the embodied experiences, the personal preferences, the idiosyncrasies, all which interplay to influence the choices that are made. In turn, these contextual factors are not fixed and may shift over time, changing the standpoint and the decisions that are made. Experience and life choices are a "*fluctual praxis, always in flow and ever messy*" (Plummer 2001; p7). With this in mind, life history methods, combined with graphic elicitation techniques, were selected as suitable approaches for accessing these dimensions of experience.

Narratives are recognised as good access points to gain insight into individual life worlds (Milligan et al, 2005; Sosulski et al, 2010; Gubrium 2011). Specifically, narratives related to health allow us to access the experiences of individuals that are often otherwise dominated by the 'voice of medicine' (Hyden and Brockmeier 2008; p3) in a non-reductionist, holistic fashion, congruent with the aims of this research. Although much qualitative research handles 'narrative' in one form or another, Chase (2005) identifies life history as a mode of 'narrative enquiry;' the data elicited being

not only prosaic, but centred around a commitment to biographical detail, structured temporally and narrated by those that live them.

Considering the research objectives, life history methods were justified for the following reasons. First, they offer the opportunity to deeply contextualise individual experiences and situate them within wider social and historical context over time (Hatch and Wisniewski 1995; Sosulski et al, 2010; Sparkes 1994). As demonstrated by Pamphilon's (1999) 'Zoom Model' for life history analysis, this method considers the crucial micro and macro factors influential in a life and the material elicited represents the *polyphonic* voice of an individual; the public, the personal and the private that constitute one self (Plummer 2001; Miller 1999). Although the findings of life history research do not claim to be generalisable to wider populations, and are, in fact, highly individualised, the resulting holistic perspective can reflect the 'bigger picture', i.e. the impact of politics, history and wider society onto the lives of individuals which allows policy makers to attend to the complexity of factors that affect individual lives (Frost and De Vries 2011). Life history methods also can 'reach beyond' (Sosulski et al, 2010, p30) the typical conceptualisations of a phenomenon, allowing the narrator to talk in detail and *around* an issue and novel themes and alternative understandings to be uncovered (Musson 2004). In this instance life histories offered a way to 'reach beyond' current understandings of contraception non/use.

However, there are permutations in what constitutes a 'life history.' Descriptions of the method and the terminology vary, for example: life histories, life stories, self-narratives, biographical methods, oral histories etc. (Plummer 2001; Chase 2005) 'Life history methods' are my preferred term, congruent with guidance given by Plummer (2001), who explicates varying *types* of life history. Thus, in this thesis the life histories are: 1) 'short' i.e. gathered through multiple in-depth interviews, typically one to three hours long, and presented in shorter vignette format; 2) 'researched/solicited,' i.e. specifically gathered with a social research goal in mind; and 3) 'topical,' in that narration is focussed on a particular subject, in this instance contraception (Plummer 2001).

This method is also consistent with a feminist approach, not least because of the qualities of subjectivity, individuality and focus on lived experience. It has been referenced as prominent amongst feminist researchers, due to the process of life history method functioning as 'political action' (Plummer 2001). In other words, life histories can liberate, empower and 'voice,' experiences of marginalised groups and those who are silenced due to their position in society (Chase 2005; Leavy 2007). This is also congruent with feminist 'consciousness raising', i.e. accessing and sharing the 'hidden' understandings of everyday lives, whilst raising the profile and improving understanding of an issue (Ackerley and True 2010; Stanley and Wise 1993; Hesse-Biber and Leavy 2010).

Edwards and Ribbens (2006) note that issues characterised as 'female' or 'women's matters' are typically pushed to the margins of academic, public and mainstream concern. I argue that contraception exemplifies such 'women's matters' and is therefore ideal to address using life history approaches. However, Sparkes (1994) comments that simply 'giving voice' is insufficient, and life histories offer the *contextual* factors crucial for a feminist approach as, "*just "giving voice" is not enough because although the telling of life stories may describe the world as perceived by the person involved, it may also confine them within these perceptions and so provide them with little that they do not already know*" (p108). As mentioned in chapter 2, research and policy makes direct reference to the use of 'life course approaches' for best practice in sexual health (HM Government 2010; APPG 2012; DH 2013; Wellings and Johnson 2013) as "*For women, lifestyle changes and personal relationships will vary throughout their lives*" (APPG 2012; p31). It is for these reasons that life history methods were selected. However, as with any other method, the life history presents challenges.

First, the fragility of memory and the bias associated with re-call may limit the material collected. Details may be censored, altered or forgotten and experiences may be assigned more or less importance in retrospect. However, the risk of this reconstructive bias is inherent in any research with human participants (Bryman 2008). Moreover, I suggest that their understandings of past experiences, however

altered from the 'reality,' will be the influencing factor in contemporary decision-making about contraception and hence are equally relevant.

The relationship between the researcher and participant is crucial and has been described as more important in life history methods than any other due to the depth and intimacy of the information shared (Plummer 2001). The need for excellent relations was particularly important in this case because of the sensitivity of the subject area. Next, the level of commitment required by the participant, to build an adequate life history, could act as a barrier to recruitment or completion of the process.

Finally, in relation to the product/data produced by life history methods there are also issues to address. A common critique of life history methods is that they are *uselessly* individualised, rendering them redundant to wider use (Plummer 2001). However, unless the participant lives in total isolation, their experiences cannot be detached from the social world (Plummer 2001; Thomas and Znaniecki 1927). Hence, the stories are inherently shaped by, and represent, the wider political, social, cultural and economic climate and how that changes over time. According to Musson (2004), ontologically speaking, life histories address the dialectical relationships between human beings and their worlds. As the world is already constituted through 'typifications,' such as cultural norms and meanings, there is both reflection of, and constitution of, the wider system/society, presented in a life history. Indeed, Hatch and Wisniewski (1995) argue that the practical use of life histories is superior to other methods in that the resulting product is meaningful, coherent *and* accessible to a wide variety of audiences. The life history method was complemented by a map-making exercise which will be discussed next.

4.2.2 Map-making

Plummer (2001) notes how life history methods can be enhanced with 'accessories' such as photographs, drawings, letters; and how these 'documents of life' have enormous potential for "exploring concrete social experience" (p74). Typical qualitative methods such as interviews privilege language/articulation as the means

of communication whereas visual approaches can access and represent alternative non-verbal dimensions of experience. Using this method therefore facilitated access to contributions from participants that would not have been offered verbally (Crilly et al, 2006). Mays et al., (2011) reviewed various studies that collectively indicate how “*visual representations provide a window into themes that are not easily or comfortably expressed through words*” (p330). Due to the potentially sensitive and private nature of sexual health experience and contraception, this constitutes such a theme.

Map making was thus selected as an adjunct to the life histories. This technique is a form of ‘graphic elicitation’ – an umbrella term for creative methods used to stimulate recall and act as a prompt throughout the research process (Crilly et al, 2006; Copeland and Agosto 2012). This was the initial purpose of the maps in this research, but very early in the fieldwork it became clear that the maps themselves had value as data, hence their use evolved within the research design as described in section 4.4.3. Congruent with the objectives of the research, and recommended approaches to sexual health (WHO 2006), these visual methods offer a ‘holistic narration of self’ (Bagnoli 2009; p566) and allowed for a different perspective on the phenomena/experience to be achieved within the study, referred to by Harper (2002) as ‘breaking the frame.’

Life maps such as these have been used to good effect in health research and the production is also important with visual representations as dynamic as a verbal narrative. For example, Guillemin (2004) used drawings to explore women’s experiences of heart disease within which it was recognised that “*The drawing is an embodiment of the heart disease within a particular space and time*” (Guillemin 2004; p225), this is the same for the life map in this thesis. Each represents life experiences as understood at the moment of production, hence if asked to repeat the activity, the maps could have been notably different. This is arguably characteristic of any qualitative research data - a snapshot of perception and re-call; and the intrinsic characteristics of individual life worlds. This is a specific focus of the research that is valued accordingly, i.e. that circumstance and attitudes can change over time.

Despite these benefits, this method is not without its challenges and the time constraints and pressure of such a setting may be inhibitory for some. Also, some participants may struggle to communicate verbally; others may be intimidated by the prospect of map making (Guillemin 2004; Mays et al, 2011; Bagnoli 2009) – issues circumvented in this research as described in section 4.4.2. However, the individualised, holistic facets of life history and map-making in tandem, and the possibility to 'go beyond' typical conceptualisations of the phenomena in question, conferred the selection of these approaches. The maps in association with the verbal life history narration were thus seen as having the potential to produce a rich and trustworthy 'whole.' Exactly how this was undertaken is discussed next.

4.3 Introducing the participants

4.3.1 Participant characteristics

Drawing on the characteristics of life history methods, it was decided that the sample should include women across an age range from 18-45 (adult women across the 'reproductive age' range) to ensure the opportunity for exploration of the differences in women's experience *over time* was maximised. Furthermore, as highlighted in chapter 2, as unintended pregnancy is increasing in older age groups this arguably points to the importance of focussing on women beyond their teenage years. Thus, fifteen 'reproductive age' women aged between 18-44 years were selected. The lower age limit was selected to represent adult women at the lower end of the age spectrum and classified as a 'young person,' but still with scope for them to have a reasonable contraceptive history to discuss. The upper limit was selected as 44 years within the limits typical 'childbearing age' (Wellings et al, 2013).

Across the three age groups, the sample consisted of:

- 5 women aged between 18-24 years old representing 'young women,' as youth services and literature regarding 'young people' focuses on those aged up to 25 years.

- 5 women aged between 25–34 years old, who represent the 25+ year old women currently cited to be experiencing increasing unintended pregnancy rates and speculated to be disadvantaged because of service provision being disproportionately tailored towards younger women (APPG 2012).
- 5 women aged between 35-44 to represent the older group of reproductive age women who have been indicated as experiencing 'new' trends in sexual health including increasing unintended pregnancy, abortion rates and rates of sexually transmitted infections (Wellings et al, 2013; DH 2013).

Fifteen women were deemed to be a sufficient sample due to the multi-stage nature of the research. Each woman met with me on three occasions, constructed a 'life map' in their own time, of varying detail and intricacy, and on average provided approximately 3 hours of data. So, in sum, a total of around 45 hours of data and 15 life maps were collected, sufficient data to ensure theoretical saturation– specific details are discussed in section 4.4. In addition, however, due to the depth of data gathered from each participant, it would not have been practically possible to gather any more narratives or do justice to the analysis of the material within the time constraints and confines of this thesis.

To explore the socio-economic, cultural and political context of these women's experiences, a theoretical sampling strategy was adopted (Silverman 2000; Bryman 2008). Participants were selected to represent relevant characteristics as established in the broader literature. Whilst age was one feature, this also included a range of factors theorised to be linked to sexual health/contraceptive use such as: ethnicity; educational status; marital status; and parity (the number of times a woman has given birth). The intersection of these characteristics may be integral to the life history and allows for interpretation in a way that is specific and relevant to the individual. In addition to the age requirements, inclusion criteria for the research included a history of (hetero)sexual activity through which they have made efforts to avoid pregnancy. Identification as 'heterosexual' and/or current sexual activity was not necessary. Participants also needed to be able to speak English to allow for detailed narration,

clear understanding and the development of a good relationship with the researcher that is required for life history research.

These requirements were clear in the flyers and participant information sheet (Appendix 1). Specific characteristics were captured on a demographic monitoring form completed by the participant at the first meeting. Figure 4.1 and 4.2 indicates the demographic questions asked.

1) Date of Birth (Please State) _____

2) Ethnicity (Please tick in the box to the right of the option that applies)

White British	<input type="checkbox"/>	Asian Indian	<input type="checkbox"/>	Black British/Scottish/Welsh	<input type="checkbox"/>
White Scottish	<input type="checkbox"/>	Asian Pakistani	<input type="checkbox"/>	Any Other Black Background	<input type="checkbox"/>
White Welsh	<input type="checkbox"/>	Asian Bangladeshi	<input type="checkbox"/>	Mixed White and Black Caribbean	<input type="checkbox"/>
White English	<input type="checkbox"/>	Asian Chinese	<input type="checkbox"/>	Mixed White and Black African	<input type="checkbox"/>
White Northern Irish	<input type="checkbox"/>	Asian British/Scottish/Welsh	<input type="checkbox"/>	Mixed White and Asian	<input type="checkbox"/>
White Irish	<input type="checkbox"/>	Any Other Asian Background	<input type="checkbox"/>	Any Other Mixed Background	<input type="checkbox"/>
White Gypsy/Traveller	<input type="checkbox"/>	Black African	<input type="checkbox"/>	Arabic	<input type="checkbox"/>
Any Other White	<input type="checkbox"/>	Black Caribbean	<input type="checkbox"/>	Any Other Background	<input type="checkbox"/>

3) Sexual Orientation (Please tick in the box to the right of the option that applies)

Heterosexual	<input type="checkbox"/>	Gay or Lesbian	<input type="checkbox"/>	Bisexual	<input type="checkbox"/>
Other	<input type="checkbox"/>				

FIGURE 4.1 DEMOGRAPHICS MONITORING FORM PAGE 1

4) Religion or Belief (Please tick in the box to the right of the option that applies)

Atheism	<input type="checkbox"/>	Buddhism	<input type="checkbox"/>	Christianity	<input type="checkbox"/>
Islam	<input type="checkbox"/>	Jainism	<input type="checkbox"/>	Sikhism	<input type="checkbox"/>
Hinduism	<input type="checkbox"/>	Judaism	<input type="checkbox"/>	None	<input type="checkbox"/>
Other	<input type="checkbox"/>				

5) Highest Level of Education (Please tick in the box to the right of the option that applies)

Primary	<input type="checkbox"/>	Secondary	<input type="checkbox"/>	Further	<input type="checkbox"/>
Higher (University)	<input type="checkbox"/>				

6) Employment Status (Please tick in the box to the right of the option that applies)

Full Time	<input type="checkbox"/>	Part Time	<input type="checkbox"/>	Unemployed	<input type="checkbox"/>
Voluntary Work	<input type="checkbox"/>	Retired	<input type="checkbox"/>	Student	<input type="checkbox"/>

7) Marital Status (Please tick in the box to the right of the option that applies)

Single	<input type="checkbox"/>	Married	<input type="checkbox"/>	Living with a Partner	<input type="checkbox"/>
Divorced	<input type="checkbox"/>	Civil Partnership	<input type="checkbox"/>	Widowed	<input type="checkbox"/>

8) Number of Children (If any) (Please State) _____

9) Postcode (Please State) _____

FIGURE 4.2 DEMOGRAPHICS MONITORING FORM PAGE 2

The 15 women that took part in the project are thus represented in Figure 4.3, in the ways that they defined *themselves* on the monitoring form in the table.

Pseudonym	Age	Ethnicity	Sexual Orientation	Religion or Belief	Highest Level of Education	Employment Status	Marital Status	No.Children
Cara	21	Any Other White	Heterosexual	Christianity	Higher	Voluntary/Part-Time/Student	Single	0
Rosie	20	White British	Bisexual	None	Further	Full Time	Single	0
Emma	22	White British	Heterosexual	Christianity	Higher	Part Time /Student	Single	0
Chloe	19	White British	Heterosexual	None	Secondary	Unemployed	Single	1
Gem	22	White British	Heterosexual	None	Higher	Part Time/Student	Single	0
Marie	34	White Gypsy/Traveller	Heterosexual	Christianity	Secondary	Unemployed	In a Relationship ¹	2
Megan	33	White British	Heterosexual	None	Higher	Student	Married	0
Sam	27	White British	Heterosexual	Atheism	Higher	Full Time	Single	0
El	28	White British	Heterosexual	Atheism	Higher	Full Time	Single	0
Angela	29	White British	Bisexual	None	Higher	Unemployed	Single	2
Helena	35	White British	Heterosexual	Atheism	Higher	Part Time/Student	Divorced	0
Chardonay	37	White British	Heterosexual	Christianity	Primary	Unemployed	Single	2
Kelly	40	White British	Heterosexual	Christianity	Further	Full Time	Married	1
Joanne	36	Any Other White	Heterosexual	None	Higher	Full Time	Married	2
Dotty	45	White British	Heterosexual	None	Secondary	Full Time	Divorced	0

FIGURE 4.2: CHARACTERISTICS OF PARTICIPANTS

One of the women volunteered at age 44 and had become 45 by the time we met and completed the demographic monitoring form. During recruitment, it became clear that there were limitations accessing certain women and with the monitoring tool as a means of capturing meaningful information about the women's circumstances. As the demographics of the sample reveal, various characteristics warrant address.

First, the sample is largely White British and ethnic diversity is limited. Although the study does not purport to be generalisable to the wider population, I had hoped that there would be some volunteers from non-white backgrounds that would offer insight into how this factor may shape contraceptive experiences. I made specific efforts to recruit non-White British women for example, by targeting recruitment in ethnically diverse sites such as the Levenshulme Inspire Centre, Manchester, a community Centre; and accessing the 'Manchester Black and Minority Ethnic (BME) Network that unites BME organisations across Manchester. Despite extensive scholarship on the topic, it was through my own experience with the Manchester BME Network that I

gained the best understanding of the challenges to research recruitment regarding women from non-white communities. Through attending an information sharing event about abortion and South Asian communities (Manchester BME Network and CLES 2013), I became aware of how communities have varying perceptions of the acceptability of discussing personal/sexual matters. Also, my status as a white female researcher likely functioned as a further barrier due to distrust of the 'other' and lack of relevant cultural/religious understanding on my part. It is argued that BME women experience their oppression in society as patriarchal *and* racist (Aziz 1997) an issue that, due to my own characteristics, I was not qualified to address. For me to conduct research with these women as an outsider could have compromised any credible representation of their experience. I thus took the decision to focus only on women from White ethnic backgrounds.

Second, sexual health outcomes like other health inequalities are related to socio-economic status (DH 2013) and hence it is also important to consider these implications in the study. The demographic monitoring form provided to participants did *not* ask women to directly identify their socioeconomic status or class. As there is a recognised fragmentation of and incoherence to contemporary models of social class (Savage et al, 2013) it was of concern to me that volunteers may find it difficult to situate themselves in any one position. I expected instead that the detailed narratives of the women would offer more meaningful insight into their circumstances, once again accounting for any variation over time; something that predefined socioeconomic/class categories abstracted from a set of aggregated data, fail to offer.

It became apparent upon listening to the narratives that this type of demographic data did indeed fail to represent the richness of the women's backgrounds. Data such as 'Highest level of Education' may be used as a proxy for class or socioeconomic status but the narrative data problematised assumptions like these. For example, one participant told me of the vocational course at University she was currently undertaking but also of the social problems and high teenage pregnancy rates associated with where she lived; a very deprived area of Greater Manchester. In

sharing experiences of her own 'teenage pregnancy' at 17 years of age, she indicated how the termination of this pregnancy and the pursuit of further education clashed with the 'normal' behaviour of many of her peers. Other participants revealed similar experiences that challenged accepted socio-economic classifications.

Congruent with a feminist approach and following Maynard and Purvis (1994) I also wanted to avoid assumptions of homogeneity and strove to approach these women individually. I was also committed to privileging and respecting the detailed information *told* to me by the women about their lives and histories, over the reductionist data captured in the 'tick which applies' demographic monitoring form. For these reasons, I maintain that the backgrounds of the women in this study are far more heterogeneous than may be assumed from the demographic data presented.

4.3.2 Recruitment

The participants were recruited via flyers and e-flyers distributed amongst service users and staff from various community and third sector organisations in the North West of England- largely Manchester, Lancaster and Preston. The selection of these sites was guided by my own knowledge and experience of community-based and voluntary sector work with women and sexual health in Manchester. The locations for recruitment of participants were selected based on personal contacts and access and where available, venues with women specific clientele. Wherever possible, I attended sites and meetings such as the Manchester BME Network as mentioned above, in order to speak about the research and encourage participation face to face.

The (potentially) sensitive nature of the topic, combined with the commitment required to be involved in the project (3 meetings, map making etc.), led me to anticipate that recruitment may be problematic. From the literature and my own experience working with women, such (sexual) life histories could include emotional and distressing experiences. Despite these possible barriers many more women volunteered to participate than were required for the study. This allowed me to adopt a more purposive approach to recruitment by drawing on additional information

elucidated during preliminary discussions about the project. For example, in some of the first contacts via phone and email, I asked for them to complete the demographics form and/or they shared details of their backgrounds in conversation which allowed me to select as diverse a range of participants as possible.

4.4 Research Design and execution

4.4.1 Overview

My specific research design was determined further to a small pilot study of two women. By way of summary, the final multistage process involved: a preliminary meeting; two further in-depth interviews meetings; and life map making. The multistage approach was selected to allow trust to develop between myself and the participant; and to offer time for the participant to reflect on their life experiences and maximise re-call and thus develop a comprehensive and detailed narrative. Also, congruent with principles of feminist research, this facilitated the space to develop a (more) collaborative research relationship as the participants had the opportunity to validate and alter details as they wished. In this way, I hoped that the women would feel increased ownership of their final story.

The process was directed in terms of both logistics and content, by the woman sharing her story; as characteristic of life history methods that are narrator driven and researcher facilitated (Bayer et al, 2010). Congruent with understandings that interviewees may be inclined to speak in generalities rather than specifics (Chase 2005) and adopt an interviewee role (Oakley 1981) I stressed the value of their *personal* experience and freedom to guide the process as they wished throughout. The time between meetings was not fixed and arrangements were made to accommodate their needs with all data collection being completed over 7 months in total, from May to November 2013. In recognition of their time and commitment, participants were thanked at the end with a £50 gift voucher of their choice; a gesture which is increasingly recognised as good practice in research and volunteering more broadly and has been argued as especially important in life history research as a facet of ethical practice (Scanlon 1993).

4.4.2 Meeting One

Prior to the first meeting the participant was sent the participant information sheet to confirm their interest in the project and so informed consent could be sought. The first meeting was then a preparatory meeting to allow for: completion of the consent form (Appendix 2); completion of the demographics form (if this had not been undertaken previously via phone or email); confirmation of understanding of and comfort with the study; and provision of materials including a basic prompt to assist them with the task of developing their life map. The life map idea was adapted from similar exercises in which timelines, relational maps and drawings have been developed by research participants to allow them to communicate and structure their experiences in a way that is meaningful to them (Bayer et al, 2010; Guillemin 2004; Bagnoli 2004). From a practical perspective at this first meeting stage, a resource kit for map making was given to each woman along with written instructions and verbal guidance as shown in Figure 4.3.

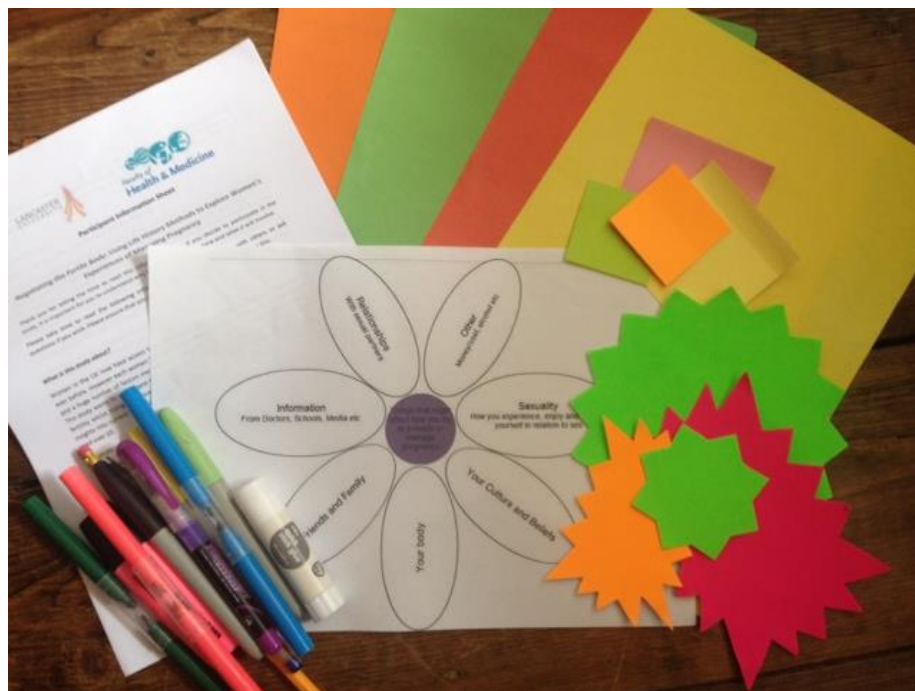


FIGURE 4.3: AN EXAMPLE OF THE LIFE MAP KIT

In the planning phase of the research, I mapped out some of the possible influences on contraception a priori from the research literature (Figure 4.4) which provided themes for possible exploration within the context of the interviews.

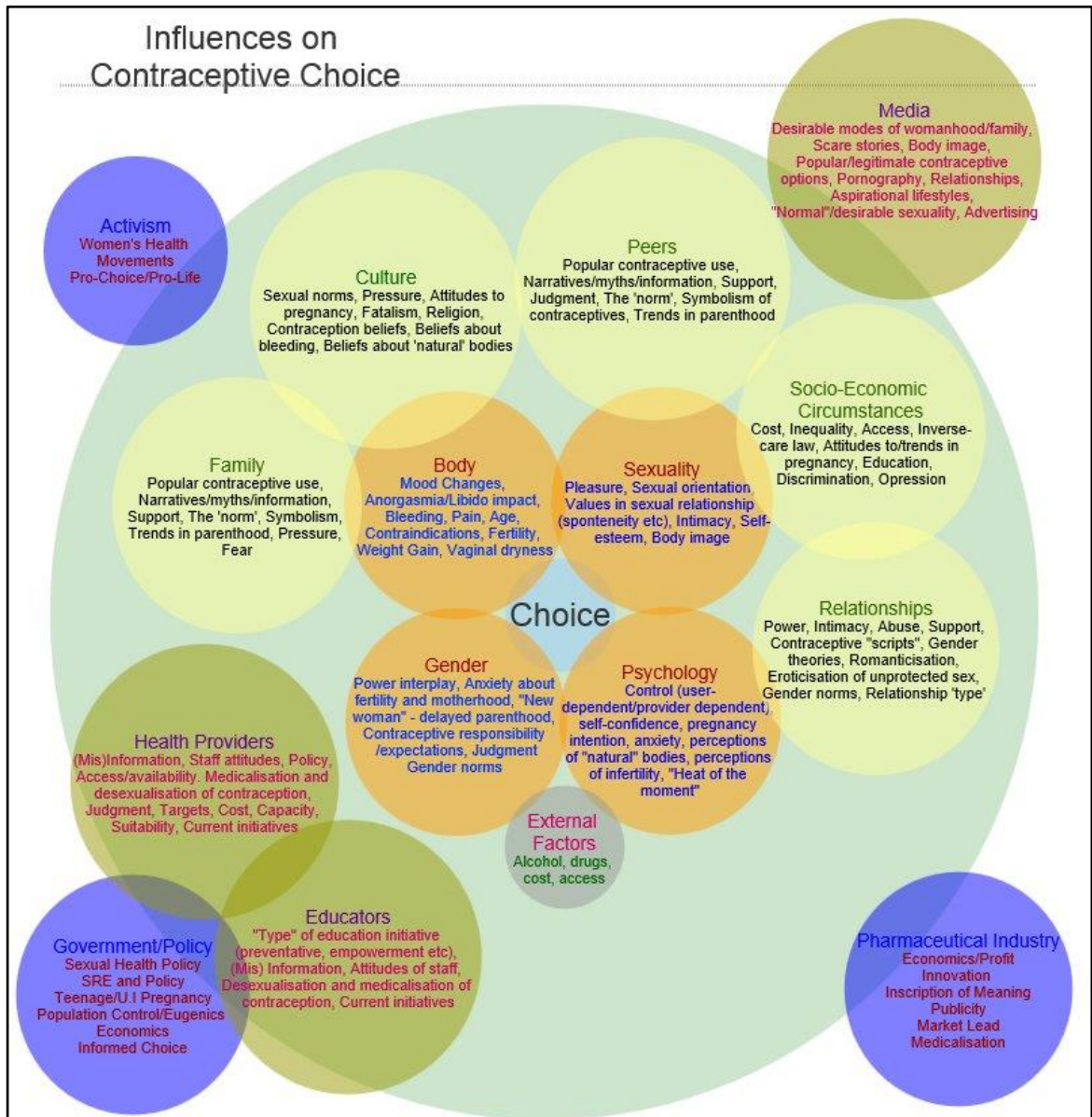


FIGURE 4.4: PROVISIONAL MAPPING OF INFLUENCES ON CONTRACEPTIVE CHOICE

Figure 4.4 was also simplified and translated to act as the prompt for the life map and included in the resource kit to encourage reflexivity and stimulate recall - Figure 4.5.

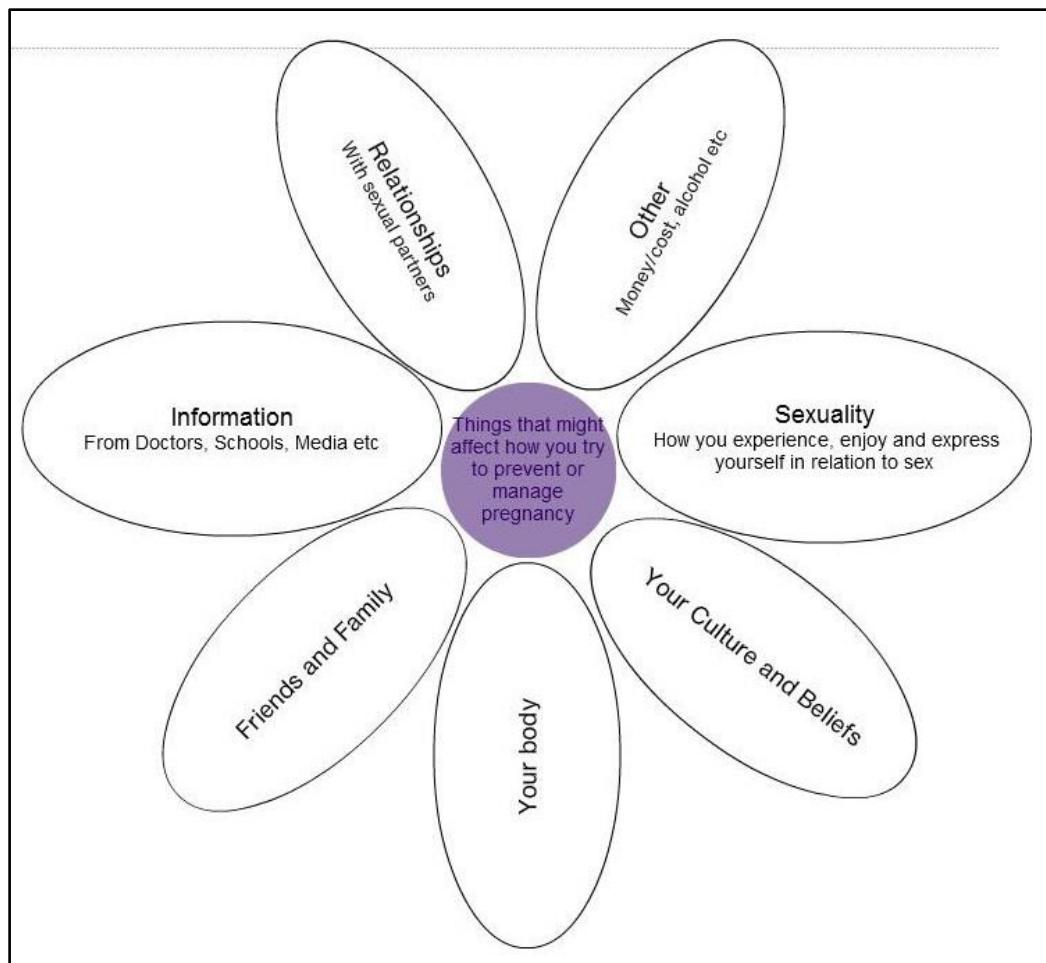


FIGURE 4.5: PROMPT FOR PARTICIPANT'S MAP MAKING KIT

To avoid any inhibitory effects that could have been associated with map-making during the interview setting, I asked for the life map to be developed in private as 'homework.' I suggest that private space offered a less pressurised, less self-conscious environment for the participants to create a map of these intimate life experiences whilst affording adequate time for reflection and re-call. The scale of visually representing a *life* compared to a discrete experience or feeling means that the life map as 'homework' offered time and space for the map to be synthesised on the participant's terms.

Following pilot work and the completion of the life map by the first participant, it became clear that the maps could also be a source of very rich and complementary data rather than just an 'aide memoire' as originally conceived. Although the map *did* function as a prompt and shape the content of the interviews to some extent, it also contributed a wealth of information that in many cases was not verbally articulated. The final maps thus indicated how such techniques can offer a broad holistic perspective on phenomena and how these women's experiences are not only lived out, but represented in very different ways. It was important to me to encourage women to create the life map in whatever way was meaningful to them. For example, insisting on the production of a timeline would have assumed that the participants conceptualised their experiences in a temporally linear fashion. Although many did structure their map in this way, the diversity of the representations was of crucial importance in accessing different dimensions of the women and their lives.

Congruent with the importance of the researcher/participant relationship in life history research (Plummer 2001), this first meeting functioned as an ice-breaker, offering the participant an opportunity to determine if they would be comfortable to commit to meet me twice again and share the details of their (life's) experience. Feminist methodologists have noted how early discussions like these can prove beneficial in enhancing participants understanding and sense of ownership of the project (Donnelley et al, 2001). All participants who attended the first meeting continued the process to completion.

This meeting was audio recorded, not for full transcription and analysis, but to act as field notes. These meetings also proved very valuable for me to gauge the needs and preferences of the participants and make relevant arrangements for future meetings. For example, one participant communicated at this first stage that she had experienced some traumatic periods in her sexual history, likely to upset her when discussing them. This disclosure prepared me; allowing me to reiterate that there was no pressure to participate, that she could withdraw or stop at any time, and that there were support services that she could be signposted to if necessary. Another participant brought her 9-month old daughter to the meeting and therefore allowed

me to plan for the needs of a young child and offer to travel to her home for greater convenience and comfort. If, like in this situation, the sites selected for further meetings were at participants' homes, I could also make personal safety plans and operationalise the University lone working policy in advance.

4.4.3 Meeting two

At the second meeting with each participant, the first interview took place. This was as naturalistic as possible using open-ended questions to prompt where necessary but was semi-structured in the sense that the discussion was led by their life map. After reconfirming consent, participants were asked to share their life map. From my perspective as researcher, this method was invaluable, facilitating a flow in the narration, especially when women had difficulty expressing themselves orally. It also acted as a focal point in the meetings and minimised discomfort by placing the women out of the spotlight; they did not feel under scrutiny as, when necessary, the focus of the interview could comfortably shift to the life map. This is a recognised advantage in that visual data can act as an ice-breaker and help to establish rapport and a shared understanding (Harper 2002; Bagnoli 2009).

The life maps were solicited and facilitated through my delivery of a set of instructions, resource kits and prompts. Although it was stressed that it was not imperative to use the materials I provided, 13 of the 15 women chose to do so. Drawing on the guidance and resources given, the women then constructed their map. Therefore, the final product devised and developed by the participant and facilitated by me (in an echo of the 'inter-subjectivity' of life history methods -see section 4.5), functioned as a bridge between us, building rapport and shared understanding(s). Harper (2002) describes how photographs can function to bridge worlds and in this instance, I suggest the life map bridged my world as a researcher with (theoretical) aims and objectives, with that of the woman and her lived experience.

I am including these reflections to enhance the methodological rigour of the research process. Also, after using this approach and being overwhelmed by the richness that these methods can contribute, these reflections are intended to challenge concerns frequently raised regarding 'graphic elicitation' where "*Images are still regarded by the academic orthodoxy as a subjective, inferior, or even eccentric form of data compared to words and numbers*" (Stiles in Copeland and Agosto 2012; p515).

The participant was then encouraged to tell their story using the map as a guide, in as much detail as they could recall and were comfortable with. As such, the discussion was very specific to their personal experience. The nature of this meeting varied significantly depending on the participant as characteristics such as confidence, openness, meant some women gave much longer narratives than others. Where 'story telling' seemed to be more challenging, I intervened more frequently prompting and probing with open questions. In these cases, the life maps often captured other dimensions of experience that were not spoken.

In all the meetings, I adopted the approach of an 'active listener;' (Mauthner and Doucet 2006; Leavy 2007) - engaged and attentive towards the detail and nuances of verbal and non-verbal communication. I made concerted efforts not just to listen to, but also to *hear* the story (including the emotional register), whilst at the same time, respecting the silences. These second meetings were at least an hour in length, and in some cases, much longer. Finally, I asked whether the participant would like a copy of their life map and discussed the expectations of the final meeting.

4.4.4 Meeting Three

This final meeting was, most importantly, an opportunity for the women to validate their stories. I provided each participant with a full anonymised transcript from their second meeting and a copy of the life map. I used an annotated copy of the meeting two transcripts and the life map in the fashion of an interview schedule, i.e. to request further details and ask questions where relevant. Hence this meeting more closely resembled a semi-structured interview than the last. This integration of interview

styles within one project is argued to be complementary and helps to minimise the insinuation of the researcher's agenda into the research process (Hesse-Biber 2007).

It was important for me to stress that some of the questions I was asking during this meeting may seem repetitive as the topic had been discussed at the last meeting. I also acknowledged how my probing may be (in) sensitive, or that the details I was requesting may be difficult to recall; therefore, that nothing *had* to be answered or added if this was the case. In the main, questions were specific to the individual and their experiences, but there were also some 'general' questions asked at the end of the meeting (if they had not been covered by that time) derived from both a priori and emergent themes. I also asked the participants to describe how they had made their maps.

At the end of the final meeting the women were thanked for their involvement, given their voucher gift and encouraged to ask questions. They were also reminded that they could contact me to make changes to their story if they so wished. The nature of the study made it possible, in theory, to witness any changes that may occur in the attitudes or experiences of the participants, over time. For most of the women involved, the time interval for completion of the research was within 6 weeks (Figure 4.6). Joanne, was an outlier whose family and work commitments meant that our meetings took longer to arrange. Similarly, Cara's second meeting was delayed as she spent the summer holidays abroad with family.

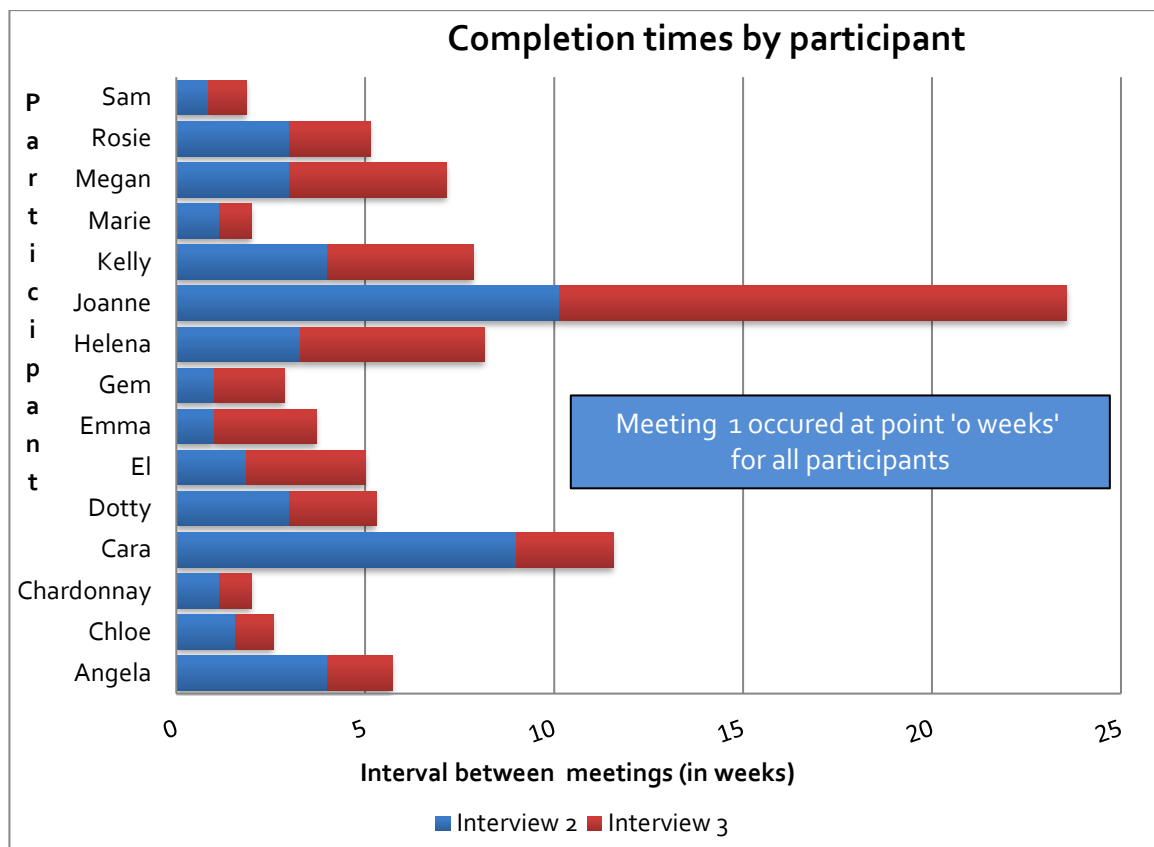


FIGURE 4.6: TIME INTERVAL BETWEEN MEETINGS

However, when the interval was longer or shorter than this average the insights offered and/or richness of the data was not notably altered. All women completed each of the three stages of the research process and all women appeared and/or communicated directly that they were happy with their involvement.

4.5 Validation

To confer validity and collaboration, congruent with both feminist approaches and the methodological rigour of life history methods (Musson 2004; Stanley and Wise 1993), participant validation was undertaken. This took place largely in meeting three, based on provisional analysis of material from previous meetings. This allowed the women to confirm that I understood the meanings that *they* ascribed to their experiences and the ways they understood their realities. This was important to foreground the voices of the participants and to reflect their perspective as much as possible. For example, one participant not only confirmed my interpretation of her

mother as a strong influence on her attitudes to contraception, but also expressed her surprise that the research acted as a point of realisation, i.e. that she had not realised *until* taking part how her mother had exerted such a strong influence on her, we had found this out together. Others stressed the importance of certain experiences that they wanted to make sure were included - in *addition* to my interpretations and summary. During meeting three I advised the participants to take time to determine if there was anything from their transcripts they would like to change, contest or omit. It was originally suggested that this would take place together during meeting three; however, the time needed to read the transcript meant that this was not feasible, so they were encouraged to do this in their own time and respond within 2 weeks (as stated to be the period within which they could retract their contributions on the consent form).

A more theoretical consideration is the nature of the story/voice that is finally presented. Life history methods use processes of 'inter-subjectivity' (Hatch and Wisniewski 1995; Leavy 2007) as the life history is narrated by the participant, but interpreted and presented by the researcher; this inter-subjectivity is also a key element of feminist research more generally (Hesse-Biber and Leavy 2007) but can also bring into question whose voice dominates the final product. Clear communication and openness, participant validation and researcher reflexivity are all strategies to try to ensure that the data is interpreted and presented in a way that best represents the authentic voice of the participant (Hatch and Wisniewski 1995; Ribbens and Edward 1998; Musson 2004). That is not to say that the narratives are perceived as 'objective truth,' and that they can accurately represent the 'whole life' (Musson 2004; Bagnoli 2004).

The mediation of the stories by the social circumstances in which the narration takes place cannot be denied, but the emphasis on, and the beauty of life histories *are* the interpreted, subjective experiences of the storyteller. Although I have made as much effort as possible to communicate the voice of the narrator, life history methods also recognise the 'collusion' of the researcher in the research process (Musson 2004). It is

accepted that the researcher will bring their own implicit and explicit theory and experience to the research situation. This is managed and validity is ensured, by the explication of the researcher's assumptions, theoretical framework and position and how this shapes analysis and interpretation - described fully in chapter 5.

Many of the resulting narratives also featured elements of contradiction. However rather than this being necessarily problematic, Miller (1999) notes how the 'multi-layered' voice of one individual can offer important clues to wider discourse; specifically, that some participants may experience an 'epistemological struggle' in which they try to mediate dominant/public discourses and/or moral insinuation or ideology with their own personal and private knowledge and experience. Hence, competing knowledges and influences can be helpfully identified through these apparent contradictions. Congruent with the constructionist and feminist epistemological position of this project (Stanley and Wise 1993) *all* versions are valid and no one is 'true'. These multiple versions are particularly beneficial in the context of this thesis which seeks to address the myriad influences and factors that shape these women's experiences.

4.6 Ethics

Full ethical approval was sought and received from Lancaster University Ethics Committee (Appendix 3). Although there was no risk of physical harm from involvement within this research project or any deception or covert practice, the key ethical concern related to the risk of discomfort from discussion of a 'sensitive' and private topic – sex and sexual behaviour broadly speaking. Further to written informed consent, verbal staged consent was sought at each subsequent meeting and all efforts were made to ensure that the participant was comfortable throughout the process. Efforts to build rapport and trust with participants, awareness of any distress and an open and non-judgemental attitude towards the women and their experiences in this project were crucial. My personal prior experience as mentioned in the introduction, chapter one, proved useful in this way. For example, through my previous employment I had experiences working with women who had experience of

sex working, drug addiction, prison and so on. Hence, participant's narratives of 'controversial' experiences were not new to me, and I hope that my inclusive, understanding and non-judgmental approach made sharing these experiences more comfortable.

Central to these concerns of participant's (dis)comfort, were issues of confidentiality. It was very important that the women who participated felt assured about the confidentiality of the project. Musson (2004) comments on the need to balance the richness of life history data with anonymity and certainly the detail afforded in the life histories collected could potentially identify some of the women involved. This risk in turn needs to be considered against notions that it is unethical to conduct a life history and "*write the storytellers out of their own lives*" (Pamphilon 1999; p393). Therefore, throughout the process I offered various assurances and demonstrations of the anonymity of the project and proactively accommodated the women's requests to ensure their privacy. For example, although some were satisfied with anonymisation of their 'life map,' one participant was concerned about the possibility that she would be identified by her handwriting and the specific time/job/education details that she had included. As such I developed an alternative version that, built upon the framework she had produced, but omitted the details she was concerned about. I replaced her handwriting with typed comments for instance. In addition to assurances that I would alter any identifying details in the final work, the opportunity to change and omit whatever details or anecdotes that the woman found too identifying, was stressed.

I was encouraged by the fact that some participants *did* contact me further to completion of the process to request specific changes in their stories, which I accommodated. All the women were offered the opportunity to select their own pseudonym to enhance their feeling of ownership of the project. Some embraced this offer whilst others were happy for me to make the selection. One woman wanted to use her own name and after explicitly (re)confirming this request it was upheld. This is congruent with ethical guidance that recognises that the notion that participants

(always) *prefer* anonymity is an assumption and such requests should be upheld to respectfully maintain the participant's ownership of their narrative in this way (Grinyer 2002; Moore 2012b).

Power relations are key considerations in feminist research (Mauthner 2006; Oakley 1981; Maynard and Purvis 1994) and are also important for ethical and non-exploitative research practice. I was originally intending to postpone any questions the participants had *during* the meetings to the end of the process in a misguided attempt to preserve the narrative flow. However, I quickly realised that to allow for the most equitable relationship possible it was important for me to avoid traditional and inherently masculine interview formats that value 'objectivity', 'detachment' and avoid engagement (such as answering questions), which in turn render the participant a passive subject; and to engage instead with the 'active participant' (Oakley 1981).

However, I was conscious of avoiding any extensive discussion that may lead or bias the participant. The *nature* of some of the questions posed by participants also required ethical consideration. For example, one participant took the opportunity to ask questions about health problems. In this instance to avoid any potential harm for her, I explained how medical advice needed to be sought and instead signposted her to relevant clinical services.

Life histories have been suggested as potentially 'riskier' than other methods because of the detail and disclosure of many, very personal, experiences and feelings. This is closely linked to the contentious perception of 'researcher as therapist' (Dickson-Swift et al, 2006). As recognised by Bagnoli (2004) the multi-stage process used to facilitate trust building and comfort, along with a comprehensive life story, may also position participants in a circumstance where they are at risk of 'over disclosure;' sharing information that later leads to feelings of embarrassment, regret etc. I tried to minimise this possibility by checking that each woman was satisfied with the process, and emphasising the ownership of the story that I wanted them to have. 'Over disclosure' did not manifest in any way that I identified regarding the narratives in this research.

However, interestingly, it did occur in one instance with the life map. One participant, who had included original pictures of her daughter, including her ante-natal scan, insisted that I should keep this copy. Concerned that she would later regret this gesture, I had a high-quality copy of the map produced and returned the original. Scanlon (1995) recommends a 'take and give' approach to life history work which resonates with what I attempted to offer my participants - as life (oral) histories are liable to 'take' a great deal from the participants (personal information, time, commitment) whilst offering little in return for their personal benefit. As such, she advises that researchers attempt to compensate the participants in a measurable way in recognition of their contribution; with money, time or resources for example. In this way, reciprocity is part of collaboration and assumptions that the 'scholarship' associated with participation in research is sufficiently empowering and/or rewarding to compensate for all that is contributed, is avoided. Congruent with these notions, I thanked my participants with a voucher gift, they were provided with resources for making their 'life map,' they were refunded for their travel to/from our meetings if relevant and I made the interview environment as comfortable as possible with refreshments, tissues etc. I also provided the participants with information, signposting if necessary; hoping these gestures went some way to ensuring the 'take and give' was as balanced as possible and that, at the very least, no participant was compromised by their involvement in my research.

Ethical risks are also inherent in the resulting data, specifically that participants could feel misrepresented by the analysis and final work. Respondent validation was carried out as described in section 4.5, so the women had a chance to confirm my understandings of their experiences. I hoped this strategy would minimise any crises of representation in the resulting work, i.e. questions about the dominant voice as efforts to maximise the authenticity of the resulting 'voice' are important (Ribbens and Edwards 1998; Hatch and Wisniewski 1995). Care was taken to ensure that in capturing a multidimensional picture of the woman's experiences assertions of disempowerment and 'silence' were negotiated sensitively or ideally, avoided entirely. As highlighted by Tierney (1999) lives are not hidden or invisible to the people who live them.

Also, and as anticipated, some of the experiences associated with the women's sexual lives have proved traumatic and/or challenging. As such, as I intended at the outset, whilst avoiding any position as 'therapist' via advice/guidance, participants were signposted to relevant sexual health and/or counselling services when necessary.

Further to developing this research protocol and carrying out the fieldwork with the women participants, I was tasked with selecting a method of analysis that would also best meet the methodological and political demands of this project. The Listening Guide method of analysis offered me this possibility. As a relatively peculiar method in health research the next chapter will critically describe the analytical process.

Chapter 5 –Listening Guide analysis: Process and positionality

Building on the commitment to methodological rigour as described in the previous chapter and due to the relative paucity of literature about the method I selected for my analysis, it seemed fitting to include a brief discussion of the process I adopted in more detail. I echo the sentiments of many researchers before me, who have written about the practice of qualitative analysis noting that there is limited practical guidance about the *doing* of research within this paradigm (Mauthner and Doucet 1998). In this way, I also intend to fill a methodological gap in qualitative research around contraception namely, an explanation of the process of analysis. As with the method described in chapter 4, my analytical approach was driven by the aims and objectives of the study. The Listening Guide (LG) technique enabled an approach to the analysis of these women's contraceptive lives in a way that captured the detailed meanings of their practices as situated within the wider British context, over the course of their lives.

5.1 Choosing the Listening Guide

In deciding how to analyse my life history material I was originally inspired by Barbara Pamphilon's (1999) 'Zoom Model,' characterised by a layered – macro; meso; micro; and interactional - analysis of life histories. I then discovered the Listening Guide (LG) after following references linked to the work of Ken Plummer (2001) and noted the similarities between the two; specifically, the multidimensional focus of both, their emphasis on the situated experience of participants and researcher reflexivity. Developed by women for research with women specifically, LG spoke directly to the women-centred nature of my project. Based on the Voice Centred Relational Analysis method conceived from a psychological perspective by Brown and Gilligan (1992), the method is derived from a feminist perspective that acknowledges the relationality of women's lives – an observation from work with women and girls in education settings.

Mauthner and Doucet (1998) subsequently adapted this method to include a sociological element whilst maintaining the relational ontology, creating LG, since

defined as a “*systematic psychodynamic method for interpreting narrative data*” (Tolman 2002; p38). Drawing on the theory in chapter 3, I also argue that this method is transgressive in that through its emphasis on *relationality*, it opposes the dominant (neo)liberal ideologies that embrace the inherently masculine *individual* – another of its appeals from my perspective. Instead LG offered a way to take “*a view of human beings as embedded in a complex web of intimate and larger social relations*” (Ibid; p125) and to understand women’s subjective experiences ‘in their own terms’ (Mauthner and Doucet 1998). For these reasons LG was ideal to meet my research objectives, but also my personal and political agenda. The multiple readings characteristic of the LG also offered a framework for analysis congruent with my research aim of situating the contraceptive individual within their wider context. In contrast to other approaches such as thematic analysis that may ‘chop up’ the narrative and emergent themes, these temporal, contextual and experiential layers were drawn out and then together in the analysis as described in the next section.

5.2 How I Listened

LG is flexible in its practice and for that reason I stress that the version of the method described here is specific to *my* research. First, by way of preparation I transcribed verbatim both meeting 2 and 3 for each participant. All identifying details in the transcripts and on the maps, were anonymised, altered, or removed if requested. Practically, LG analysis involves a *minimum* of 4 readings of each transcript involving: reading for relational and reflexively constituted narratives; tracing narrated subjects; reading for relational narrated subjects; and reading for structured subjects (Mauthner and Doucet 2008). The ‘listening’ refers to the iterative process of re-reading the transcripts and engaging with the narratives to fully immerse oneself in the material and “*hear the intricacies and various voices in this conversation*” (Woodcock 2010). This ‘conversation’ within the context of contraceptive lives may be complex and infrequently shared - thus ideal for analysis with LG.

The first reading involved getting to know and responding to the story in a combination of grounded theory’s ‘what’s happening here?’; with narrative analysis

elements, such as plot, themes, events, challenges, chronology, recurring words, and metaphors (Mauthner and Doucet 2008). A 'worksheet technique,' where the participant's words are arranged in one column and the researcher's reactions adjacent – emotions, interpretations etc., is suggested as one way to organise this part of the analysis (Mauthner and Doucet 2008; Brown and Gilligan 1992). The version I undertook was structured as follows:

Story Component	Part A – the material	Part B - Reflexivity/Response
Main events		
Difficulties/challenges		
Resistance/success		
Key relationships		
Recurring devices – words, themes		
Story variations		
Plot progression		
Interesting quotes/descriptions		

FIGURE 5.1: EXAMPLE OF THE WORKSHEET TECHNIQUE USED FOR ANALYSIS

The second reading allowed me to pay attention to the women's subjectivities - how the person spoke about herself within her social world through tracing the voices of 'I' 'you' and 'we.' I used different colours on the relevant parts of the transcripts to highlight these voices as suggested by Woodcock (2010). I noted in this way, that the experiential 'voice of I,' the first-person voice (Woodcock 2010; Gilligan et al, 2003) tended to dominate in the women's accounts of their contraceptive lives; although some spoke more in this way than others. The voices of 'you' and 'we' by contrast, can represent tensions or dissonance between the experiential and what is socially normative (Woodcock 2010), although admittedly in this thesis the 'voice of we' often related to a shared experience, used for example, when arranging contraceptive methods with a partner.

In reading three, I highlighted sections of the narratives that represented social networks and intimate relationships; using different colours to correspond to different relationships or, in some cases institutions. This was a good way to visualise to what extent some of the women's contraceptive lives seemed more independent

than others, and how much 'medicine' dominated their accounts – a relationship I highlighted across all the transcripts. In reading 3 I also used a worksheet, as in reading 1, to analyse the nature of these connections – for example, whether they were supportive, negative and so on and my responses to the relationships described.

In the fourth reading, the aim was to link the "*micro level narratives with macro processes and structures*" (Mauthner and Doucet 2008; p406). Once again, I arranged narrative material in a worksheet like that in Figure 5.1, albeit one which reflected the broader social, cultural, political and structural contexts, noting my personal responses in the same way as with previous readings. The material, isolated from the full transcripts in this case, reflected not only age, gender, ethnicity etc. but also normative discourses such as: planned pregnancy; contraceptive choice; safe sex; teenage pregnancy. Structural institutions such as school and social services were also captured.

In addition to the recommendations, and in keeping with my interest in temporality within this research, I also undertook a fifth reading for change over time. In this part of the analysis I attended to the ways that the women spoke about *their* perceptions of what had changed since the past; and any expectations they had for the future. I aimed to 'listen' in the same way to the visual material within the life maps, but noted specifically any responses and interpretations I had to the artefact itself, and any disparity between what was communicated (or not) compared to the verbal narrative.

When undertaking these readings, it was important to consider the fundamentals of LG – a method that seeks to deeply immerse the researcher in an emotionally engaged way with knowing the individual stories. Drawing together the multiple (polyphonic) dimensions rather than 'coding the contents,' such as in thematic analysis, is a specific characteristic of LG. Looking at the framework for analysis and the worksheet techniques, it could be perceived that this process *does* simply chop up and code the contents like other approaches. However, the process of immersion within the narratives, structured by the different readings, allows the researcher to trace the voices *through* the interviews rather than linking discrete themes between

them. 'Thinking through' rather than 'chopping up' the material demands a different epistemological approach, albeit subtle. This means that where in thematic analysis a code is assigned, a theme determined that remains (relatively) fixed; with each reading in LG analysis, the 'themes' that emerge are storied and dynamic, evolving throughout the process to offer a *multi-layered* understanding of the *story* rather than to identify theme/s with a transcript. For example, in one life story, a woman's relationship with her mother was identified as very influential. This evolved to represent more about discourses of teenage pregnancy and then further, to ultimately reflect classism. By contrast thematic analysis would have fixed the code as the relationship with her mother and potentially missed the different layers, the fuller narrative illuminated through using the LG approach.

To help with the process of thinking through, I drew on guidance specific to narrative analysis too to shift my mind-set into a storied frame. Brett Smith (in Brown and Clarke 2013; p197) offers some general tips for analysis within this paradigm, including posing questions to yourself to facilitate the narrative analysis process. In this way, I listened to the voice of the 'narrated subject' whilst also considering the overall narratives that were being told through the voices of all the women participating. In noting a story's 'theme' I considered where it began, the challenges, the plot, where it was going and so on.

The multiple sources of material, i.e. both transcripts (from meeting 2 and 3) and the life map required consolidation for analysis. Typically, the final meeting for each woman, prompted by my questions specific to their life history experiences as told to me in meeting 2, contributed extra details to the main story and/or more material that reflected their attitudes and feelings on specific issues. Both transcripts for each woman were drawn together in the same analysis table – with the material colour coded to identify which meeting it came from. Overall the analysis involved 150 transcripts being read in detail, as a minimum i.e. 5 readings x 15 women x 2 transcripts each. This was, at some points, overwhelming and I worked on one woman's material at a time, getting to know their story, and listening to their voice as intimately as possible. The visual data in the life maps was noted into the worksheets accordingly

and the drawings were annotated directly. Attention was paid to inconsistencies between information offered in the maps and through the interviews; and to ways in which information in the maps was specifically highlighted through use of colour, drawings etc. Synchronistically, I began to interpret and theorise their accounts; a process that was carefully documented and considered as described in section 5.3.

5.3 Theorising their stories and my place within them

Congruent with the atypical nature of this chapter, I have also chosen to include my reflections on my positionality and considerations of reflexivity here – more conventionally included with discussion of the method. I deemed this to be appropriate due to the specific emphasis that LG analysis places on reflexivity and suggest that the forthcoming factors are understood as to have been considered in tandem with the process of analysis as described in section 5.2.

In fieldwork notebooks and in every reading of the analysis I captured my responses to the material and the research experience. As with other qualitative work at the early stages “*identifying what are the key issues feel more intuitive than anything else*” (Mauthner and Doucet 1998; p121) and quickly some of the overarching story ‘themes’ that form the basis of the next chapters started to become clear. I frequently felt that these stories were ‘speaking out’ to me, and in this way, I tried to be little more than an active listener to absorb them without manipulating them. Although I knew not all the individual stories would be represented in the final thesis, I analysed the accounts with LG to trace the voices through and across the women to get to know the collective stories in detail.

I was also concerned that my original ‘intuition’, especially because my reflexive practice, may reflect more of me, than of the women involved. As explored in Chapter 4 the problem of representation of narrative material and inter-subjectivity has been frequently highlighted (Hatch and Wisniewski 1995; Ribbens and Edwards 1998). Reflexivity is one way to address this and can offer transparency to the research and

analysis process that helps the reader to observe any possible crises in this representation. The impact of researcher's positionality and the profound importance of reflexive practice was captured by Denzin and Lincoln (2005) who observed how *"Any gaze is always filtered through the lenses of language, gender, social class, race and ethnicity. There are no objective observations only observations socially situated in the worlds of- and between-the observer and observed."* (p21) In considering this for myself, I start at the beginning of my own contraceptive career – as mentioned in the introduction of this thesis. I shared this story in the first chapter, of my challenging first engagement with contraception services as a young woman, to explain in part what stimulated my interest in this topic. However, the experience also contributes to my individual presuppositions and experiences as a researcher and may impact the way I have worked with the women in this research and how I have analysed and interpreted the data.

This consideration is an example of the reflexivity that is key for validity in qualitative research. It is also characteristic of the methodological rigour associated with life history methods (Musson 2004), feminist approaches (Roberts 1981; Ribbens and Edwards 2006; Mauthner 2002), and LG (Mauthner and Doucet 2008). This reflexivity and an interrogation of my assumptions and position were considered critically throughout the process to better understand the nature of the knowledge being produced. Qualitative research generally recognises that the researcher is not a detached observer and that researcher interaction and influence mediates and shapes the process and product of the research (Bryman 2008; Legard et al, 2003). I suggest that life history methods with the emphasis on 'inter-subjectivity,' and the potential for power imbalances based on detailed sharing of experience, make the need for, and benefits of reflexivity, more obvious. I did this very actively during the research by: keeping a diary throughout; by producing my own 'life map' at the outset of the research; and by mapping out potential biases, i.e. my a priori interests and concerns about contraception.

Aside from my own young experience with contraception, I have various other 'identities' and biographical details that need to be reflected upon. Given that the

research was women-centred, I was conscious that the key facet of my identity, positioning me to an extent as an 'insider' and salient in establishing rapport between myself and the participants, was being a woman. Indeed, some participants observed that they would not have volunteered if the researcher was a man, or at the very least that the story they shared would have been significantly different. Underpinning this and suggested our discussions was that I 'got it.' I was perceived to be familiar with, amongst other things: use of contraception; women's health matters; menstruation; and sex with men. In many cases, there was a definite sense of alliance and understanding as the women shared their stories and as a heterosexual woman of reproductive age, to an extent I did 'get it.' However, I also recognise that although unifying in some ways, our shared womanhood does not mean that we are the same and/or that I was perceived by them as such. It is well documented in feminist literature that care must be taken to attend to the multiplicity of women's experiences and standpoints and avoid essentialising women and reducing all to one homogenous group (Stanley and Wise 1993; Hesse-Biber and Leavy 2007).

Various other specific characteristics may have also influenced my standpoint. As a White British woman, I was broadly in the same ('White') ethnic category as the women involved which may have been beneficial with regards to perceptions of shared experience. It was discussed in chapter 4 how this status was also potentially exclusionary, and how it may have been inappropriate for me to work with women from non-White backgrounds. Conversely, this similarity with the women who did participate may have been helpful.

I was 30 years old at the time of the research, in the middle of the age range of the sample. I found this position, or the perception of my age to be helpful, in that to some of the young women I still appeared 'youthful,' I was a similar age to the middle cohort of women and, to the 'older' women, I was perhaps deemed mature enough to understand more 'adult' experiences such as childbearing.

I identify as a feminist; my feminism having been developed through lived experience rather than theory; for example, via working in women specific settings with other

feminist women. A key facet of my feminism has been to maintain a critical standpoint, paying attention to oppression and expectations that may shape women's experience but also, more broadly, to collaborate with and respect others. Thus, my specific politics, will undoubtedly have contributed to how I undertook the research and what was produced. However, I did not identify this as my (political) position in the field and I was not asked.

I made no knowing changes to my dress and speech and would describe my appearance and approach as relatively informal and casual. Generally, I was 'local' in that being from Lancashire I was close to most of the participants involved. My accent and familiarity with the region may have minimised some perceptions of me as an 'outsider.' However, I currently live and work in Lancaster as a mature research student undertaking a PhD. This circumstance will have positioned me in a certain space to many of the women involved; as an 'expert,' with a certain social status. Although I cannot speak on behalf of the women involved in this project, I accept that being a PhD researcher has certain classed associations. However, I approach my *own* class status with as much trepidation as the hesitancy I expressed in Chapter 4. I grew up in what I perceive to be a working-class household with little economic stability. However, over time changes have occurred in my personal and my family's educational attainments, income, profession etc. – 'social mobility' for want of a more suitable term. The reductionism of class categorisation means that shifts like these over time (a crucial consideration in this research) are also not captured. This meant I felt unable to meaningfully articulate my own status congruent with any current or past pre-defined framework; another reason I did not wish to ask my participants to comment on their own class identity.

In addition to my positionality, the emotional labour involved in the research is also important to reflect on. LG analysis demands an engagement with both intellectual and emotional responses to the material but regardless it would have been impossible for me to claim I could occupy an unemotional, 'objective' position. I liked and admired all the women who participated for myriad reasons; because they were interesting; intelligent; amusing; courageous etc. Many stories detailed experiences

of abuse, trauma, sadness, regret and loss that were harrowing to hear. However, at the same time, these disclosures put me in a very privileged position and offered me wonderful data. These conflicting feelings were important to reflect on and deal with for my own wellbeing– not being accustomed to dealing with a sense of achievement and satisfaction (for the project) to be borne out of the difficulties of other women; and for methodological rigour. The pace of the fieldwork in the early stages, in conjunction with my own feelings proved to be very stressful, draining and demanding. As such I began to stagger the interviews to adopt a more manageable schedule where possible. All my reactions and emotions were recorded in the research diary and drawn on in LG analysis as described. I also noted that some of their stories and experiences resonated closely with my own experiences so in these circumstances it was even more important to avoid the imposition their voice with my own.

Being reflexive does not necessarily mean focussing on the facets of identity that may prejudice the research process and findings. Many factors may also be generative for the research relationship, for data collecting and meaning making. Indeed, Haraway (1991) regards the positionality of the researcher as a 'focussing device,' via which phenomena can be seen in new and valuable ways. My experience working with women offenders in a women's centre and with young people in a sexual health clinic and supported accommodation settings meant that I was not surprised or intimidated by the women or their disclosures.

I have, for example, supported women experiencing sexual and physical abuse, drug dependency, engaged in sex working; all experiences that I feel made it easier for me to listen to and discuss the women's stories comfortably and without judgement. More specifically, I have supported women terrified of asking for contraception or embarrassed and humiliated when discussing sex and therefore I felt comfortable and confident negotiating these situations sensitively. My experience talking openly about sex and using sexual language in 'everyday' settings and, as identified as problematic by Parr (2006), avoiding presumptive language adopted from academic literature such as 'barriers' facilitated good communication with the women. I am also

familiar with a multiplicity of sexual and gender identities and am committed to equalities therefore aim to carefully avoid the use of proscriptive and assumptive language such as heteronorms that may be discriminatory and alienating.

Although I view frank discussion of contraception, sex and sexual health as important for increasing the legitimacy of these issues, more broadly, I also understand many people may not have the same confidence in this way. Hence my approach was flexible to ensure that participants were comfortable and unintimidated during the research process. Indeed, Chloe expressed her amusement about how I must be 'bonkers,' for asking women (strangers) about such private and intimate issues.

Finally, as evidenced at the beginning of this section, I think that my position reflects Hesse-Biber and Leavy's (2007) comment that '*The researcher's personal experience and worldview may serve as an impetus for creation of the research project and topic*' (p14); for that reason, to my own experiences and identities, I am very grateful.

5.4 Representing life history narratives in the PhD thesis

I dedicated a lot of time from the very beginning of the research to actively reflecting on my "*personal, political and intellectual autobiography*" (Mauthner and Doucet 1998; p121) to understand how this may shape my theorising. Although important in qualitative research more generally the emphasis on reflexivity in LG is very strong and must be made clear in the presentation of the findings. In available LG examples, I saw how the material was presented in a very storied way that also captured the researcher's reflections; see for example the work of Natasha Mauthner (2002) and Lyn Mikel Brown and Carol Gilligan (1993). This accounts, in part, for the format of the chapters that follow, where I include some of my reflections on the women, their stories and descriptions of the circumstances.

From the outset of the project, I was also aware that some difficult decisions would have to be made as the narratives would be too large to include in their entirety. I consulted myriad sources and examples in advance of doing my analysis to get a good

feel for how to undertake and present LG analysis. In addition to published material this included other PhD theses and liaison with a LG group based at Huddersfield University. Unfortunately, this collective was in the process of disbanding as they approached the end of their PhDs and research projects, but I gained access to some material by being part of their email network. These other sources inspired me to opt for a combination of individual and collective voice stories as the best way to make the most of the material for the purposes of this PhD.

My own concerns echo those of Mauthner and Doucet (1998) who reflected on the problem of 'breaking down' their material - anxious to make it manageable, but frustrated about not devoting the same time to everyone's story. I too was conscious of how best to present the life history material so drew once again on Plummer (2001). He suggested that life history material, could be presented typically in one of three ways: 1) without any interpretation; 2) 'framed' by interpretation; and 3) with interpretation in a commentary at the end of documents (Plummer 2001).

I thus decided to structure my substantive chapters as two 'collective voice' narratives and one individual story chapter. The individual stories presented in chapter 6, illustrate the life history experiences of 4 women in more detail. The stories were selected to represent a spectrum of life and contracepting experiences and address the original research aims of:

- Exploring the impact of individual women's life experiences on their decisions about and practices regarding contraception;
- Identifying any transitional life events that have influenced individual women's decisions and practices regarding contraception;
- Exploring the interplay between determinants of contraceptive choice/use; and
- Capturing the dynamism of the influences on contraceptive choice/use over the individual life course.

The 'collective voices' represented in Chapters 7 and 8 include a range of the participants and capture what I interpreted as *shared* accounts of contraception use. In consolidating the 'collective voice' I also considered its multiple layers as defined by the LG, approaching these in the same storied way as I did the individual accounts.

The material in these collective voice chapters addresses the original research aims namely:

- Draw together and characterise the historical contextual factors that may influence British women's contraceptive choice;
- Analyse and situate British women's contraceptive experiences in relation to these broader cultural, historical, political and economic factors;
- Explore the impact of women's knowledge and if/ how the sources of information and nature of their understanding may have changed over their life courses;

In these chapters, the original material is 'framed by the interpretation'. I have aimed to present as much of the material as is feasible to give a good feel for the voices of the women who participated. Next, in the first of these substantive chapters, I will turn my attention to an exploration and illustration of the contraceptive lives of 4 diverse British women.

Chapter 6 - Exploring contraception use through individual life histories

6.1 The contraceptive lives of four British women

"A half dozen individuals with such knowledge constitute a far better 'representative sample' than a thousand individuals who may be involved in the action that is being formed but who are not knowledgeable about that formation." (Blumer [1939] 1979: xxxiii in Plummer 2001)

In this excerpt, Ken Plummer (2001) challenges critiques of life history research by re-thinking representativeness. Where critics assert the 'eccentric world of the atypical' may offer little of merit than a good story, Plummer argues that this perspective completely neglects the meaning of this type of research. That being where *"insights, understandings, appreciation, intimate familiarity are the goals and not 'facts', explanations or generalisations"* (p153). My material was extremely rich in these ways and I have chosen to use four life histories to illustrate the detail and diversity of contraceptive experience. In making the selection I drew on Plummer (2001) again to capture what he refers to as a 'continuum of representativeness' and therefore selected the stories that represent a range of characteristics theorised to impact contraceptive practices and a spectrum of experience - from adversity to unproblematic use. First, El's story highlights a version of ideal and unproblematic contraception use as lived out by a woman with a clear commitment to avoiding pregnancy and the resource and support to achieve it. Next, Chloe's narrative depicts arguably the opposite – the difficult experiences of a young woman with significant social and economic challenges. Following on, Angela's story reflects a scenario in which contraception is desirable but its use has been frequently disruptive to her body and ultimately her life. Finally, Helena's account illustrates the ways in which contraception is linked to the pursuit of an enjoyable sexual life and the ups and downs associated with finding a method to best suit the needs of her sexual self. These accounts are then drawn together in the second part of this chapter and

theorised. The quotes included are the verbatim words of the respective women, unless specified otherwise.

6.1.1 El: 'I think lives are only as good as the opportunities you have in them.'

"I guess I'm always pretty scathing of people who get pregnant by accident because all of the situations I've heard of, it could have been totally fixed by having the morning after pill. So, there are ways to do it, you just have to take control of, y'know their own lives and stuff. And they're like 'Oh we thought it'd be okay' and I'm like 'Well I wouldn't risk it, well I wouldn't risk it.'" (Meeting 2)

The scorn El describes here is intelligible in the context of her own life; one which is epitomised by responsible contraceptive practice. This quote linked to a story about a provider judging El's request for emergency contraception as unnecessary. The provider's response fell short of El's commitment to avoiding unintended pregnancy and she asserted herself accordingly - a determination and confidence that characterised El's entire contraceptive history. It was also present in her manner and when we met. I was struck by the way that she radiated a healthy energy - something I quickly came to attribute to her capability and prosperity as a young woman enjoying her life to the full. El was 27 years old, working in clinical sales and waiting to start a career break when she would leave the UK to travel. We met in the northern English city where she lived at that time but she was originally from the south and had benefitted from London's extensive network of sexual health services in her youth. On each occasion we met she shared her story with well-practiced hospitality, across a neat table, over freshly brewed coffee in her stylish flat. El started her narrative with the introduction of contraception into her consciousness:

"I was trying to work it out cos it was making me think about it loads, about where my attitudes were from and stuff...Cos we had like *okay* Sex Ed at school I think; although we had the school nurse who was just awful cos she'd sit there and be like 'Oh my *friend*' and

you knew half the stories were about *her*...So that was really quite awkward but she was really quite approachable for stuff. And then my first like serious-ish boyfriend; we went out for like 5 months, and a week into that my mum like was driving me round to my friend's house and he was going to be there and she started talking to me about sex and stuff and I was obviously being like 'Shut up! I don't want to talk about this and also we've been going out for like a week and I'm 14, shut up! We're not having this discussion.'" (Meeting 2)

This typical response of a young person confronted about sex was tempered in EI's case because these sources acted as such supportive influences. EI was always encouraged to delay pregnancy and pursue an experience rich life. It was evident she had had the resources to do that in terms of parental support:

"My next boyfriend who I went out with, we went out for 2 years... And I got together with him when I was 16, and we went out for like 3 months and my mum had always been 'Wait 6 months to have sex with any boys,' ...But I slept with him after 3 months but I thought 'I'll just *tell* my mum after 6 months, it'll be fine.' So yeh, when we first started having sex we were just using condoms and in like a week, the condom had broke." (Meeting2)

She also had resource in the way of friends, her partner and the service providers along with the facilities of her private school setting:

"I went with my friend Joanie and she...the school nurse is actually a family friend of hers so it was all a bit awkward and so she was like 'Have you considered the pill, that might be a good idea if you are doing this kind of thing?' but she basically just said, she had no way to give it but she basically just said 'Where do you live?' and worked out the best place for me to go for the morning after pill...we had

to just go and sit in A&E for ages and ages. And then there's like a clinic near there so they referred me to there to go and speak about to them about contraception afterwards...And my boyfriend offered to come with me but because I was trying to keep it secret from my parents I was like, 'I think it's just best to go with my friend'" (Meeting 2)

El's aspirations, inspired by her parent's advice, conferred a very strong commitment to preventing any unintended pregnancy:

"My mum had me when she was 35 so she'd had like quite a long life, like she'd always been like 'Don't settle down early, wait to have kids, do all the exciting stuff, get the holidays out of the way first'.... I think that's like part of the attitude. My family have never been of the attitude of like 'You can't have sex with people' but it's always been like a 'Don't get pregnant.'" (Meeting 2)

El noted how the attitude of her family informed her approach to pregnancy and motivated her to use contraception meticulously. Her commitment to avoiding pregnancy/delaying parenthood was stressed repeatedly – one of the few women with clear (non)pregnancy intentions. She unfailingly compensated for any perceived risks taken with emergency contraception and prevented STI's by using condoms until after screening with a new partner. This commitment inspired her to seek a method more effective than the pill; although her discomfort with hormone use was influential too. Her friend's experience triggered a very successful method swap and El became a 'massive advocate of the coil':

"4 times I had forgotten to take it or I'd been sick or whatever and I was like 'I'm not comfortable, I'm going to take the morning after pill.' Cos I've always joked like 'I'm still at an age where pregnancy is the worst of the sexually transmitted diseases.' So I'd been on the pill for ages and I was a bit uncomfortable about how many

hormones I was taking, how long I'd been taking them for, the fact that I would occasionally forget and have to take the morning after pill as well, and it was just like, a bit stressful. And my friend had just got a coil, she got the Mirena coil and she'd raved about it and I was like 'That seems like a good idea,' so I went and got that and they last 5 years so I've just had a second one in. So I'm pretty dedicated to this form of protection now and then condoms for diseases." (Meeting 2)

El represented her experience of hospitalization following a broken back on her gap year travels as formative of an 'un-embarrassable' version of herself. I understood this to be a factor that increased the acceptability of IUC for her; a method which is often avoided due to invasive embarrassing perceptions of having it fitted. In this way, this adverse event translated successfully into El's contraceptive life.

El was also an active (contraception) decision maker and the experiential voice in her accounts indicates how agential her contraceptive practices were. In contrast to comments other women in the study made that insinuate that power was situated in the realm of the provider such as 'they put me on the pill;' El's position was frequently more dominant, remarking instead how 'I went on the pill' and 'I went on the coil.' Her confidence was also implied in how she rarely reflected wider socio-cultural norms in her speech, being comfortable to communicate her experiences as she lived them through the 'voice of I.' Other voices reflected the equitable nature of her relationships, for example in sharing contraceptive responsibility – 'we used condoms.'

In El's story adversity was relatively absent and most challenges came from her anxiety about pregnancy. Indeed, much of the stress she characterised was perversely a consequence of her privilege - such as irritation caused by the support (interference) of her mum although she clearly acknowledged her good fortune in both life and in contraception. She occupied a position where she felt in control and that was unlikely to change:

"I am very positive about contraception as an option and the ones that I've used and, and particularly the coil at the moment. I've, the more I talk to my friends about it, the more I realize how lucky I am that I haven't had any adverse effects and I've kind of got on with all of the contraceptions I have tried, whereas I have got lots of friends who have had issues or whatever and I've just been very lucky I think, not to." (Meeting 3)

Other than her fortuity and aspirations, El perceived her 'personality' to have a masculine quality, congruent with the conceptualisation of rational neoliberal subjects; an attribute that both dictated her need for and ability to control her reproductive body:

"I think my personality is quite, I'm quite practical about things. You know they always say that thing about girls explain a problem and they just want you to listen and guys try and solve the problem. I try and solve the problem. If I have got some kind of massive emotional thing I will write it all out in my diary and think about what is a course of action that will make *me* feel better about things and then I will follow that and then, I like plans and I'm quite practical about what I am planning to do so I think that comes through in my birth control choices." (Meeting 3)

Possibly the best way to conceptualise El and her experience was through her map. Her planning, meticulousness and competencies are evident in this visual representation of her contraceptive life. Factors such as her educational background/professional training were illustrated in a computerised format. The 'stats' and exact dates communicate something about her epistemological perspective – something I interpreted as involving an appreciation of measurable 'factual' information. This is interestingly congruent with the approach of the biomedical framework governing contraceptive service delivery which values the

measured 'facts' of evidenced based medicine. However, this map also illustrates the importance and influence of her education/career, like her spoken narrative; whilst reflecting the orderliness of her (contraceptive) life.

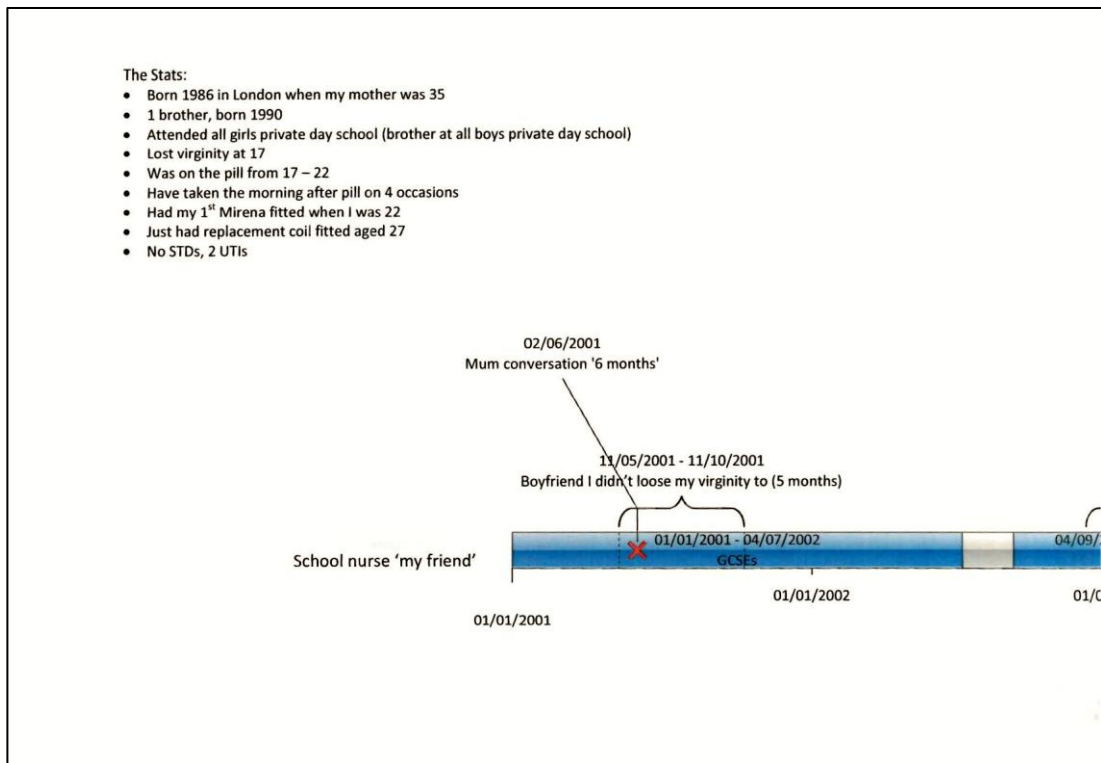


FIGURE 6.1 – EL LIFE MAP PAGE 1

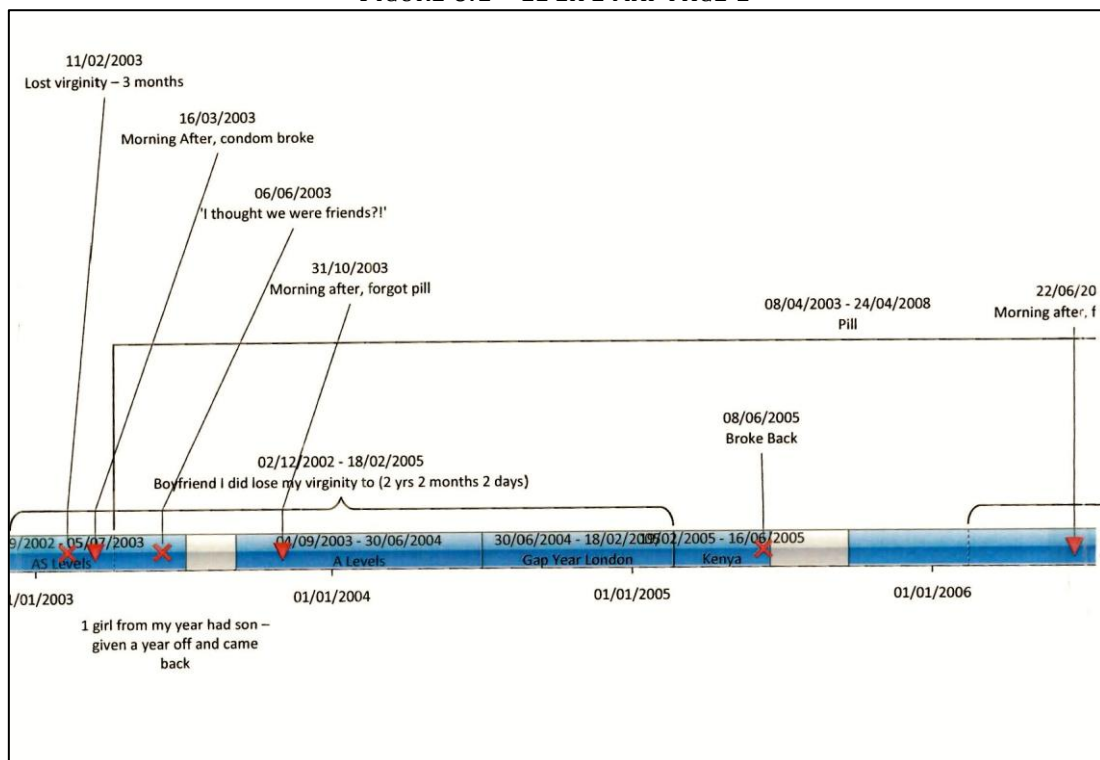


FIGURE 6.2 – EL LIFE MAP PAGE 2

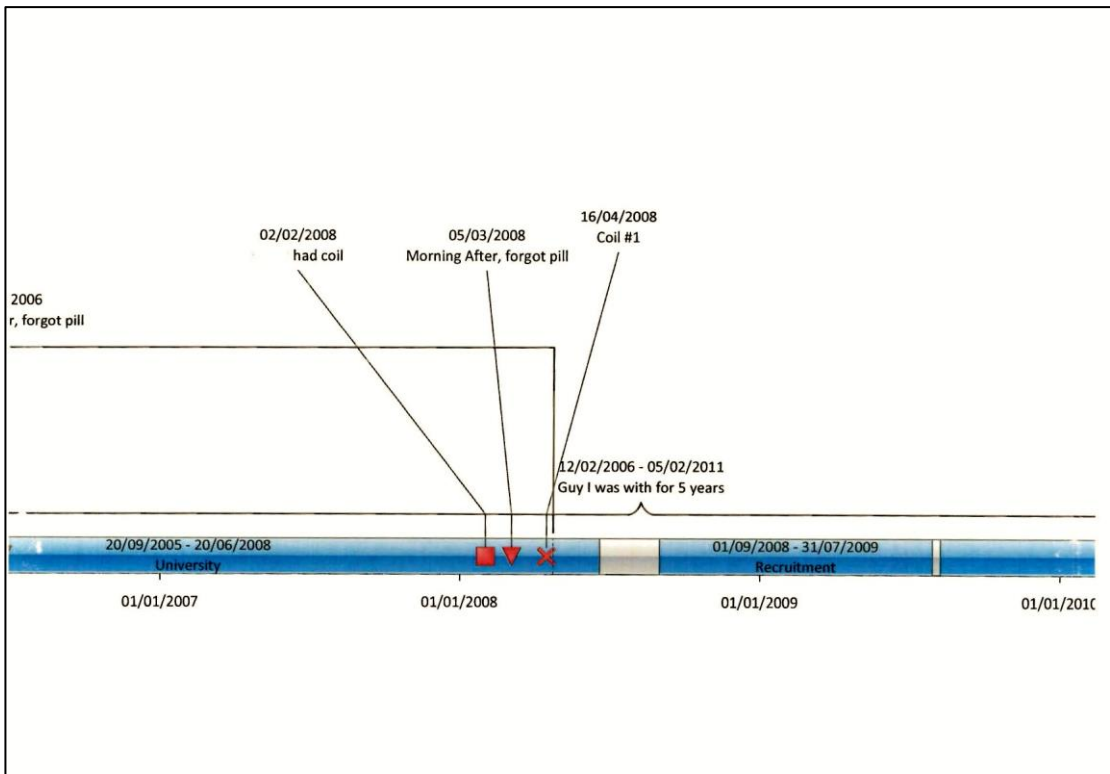


FIGURE 6.3 – EL LIFE MAP PAGE 3

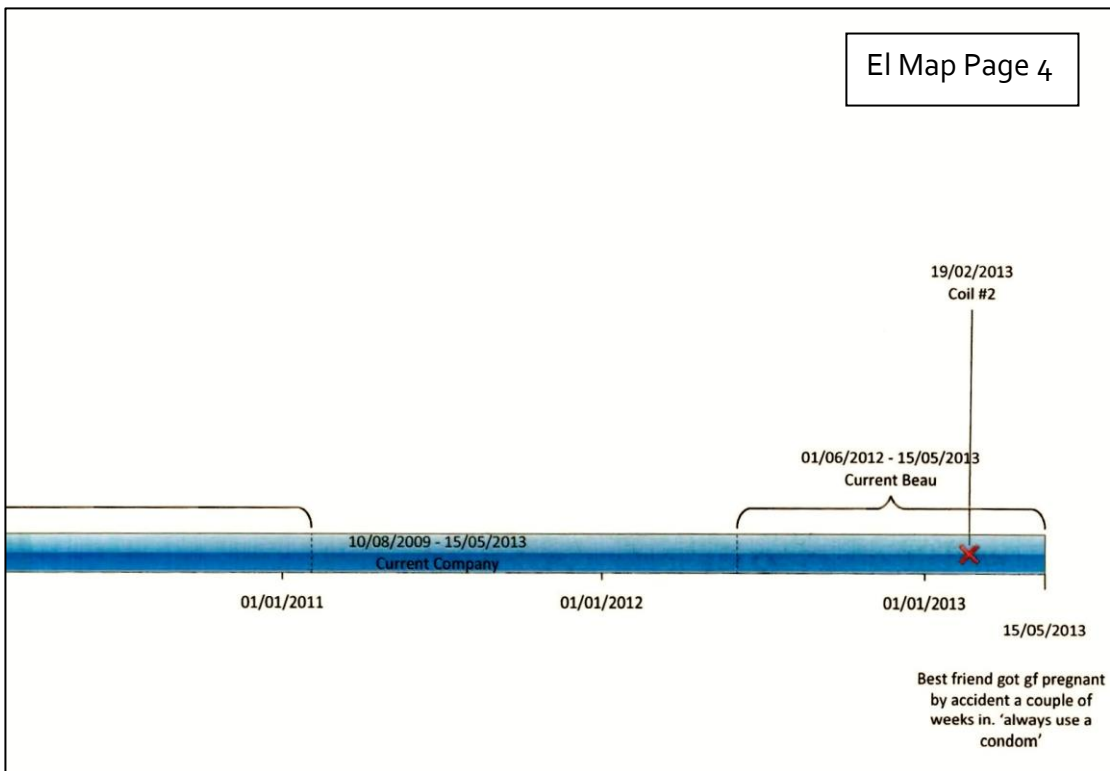


FIGURE 6.4 –EL LIFE MAP PAGE 4

The limited impact of partners on EI is evident in the map when considering how her influential friend is named (Joanie) and her mother is quoted, but by contrast her long-term partner is referred to as 'guy I was with for 5 years.' Her own comments about

the masculine nature of her perspectives resonate with the functional scientific format and the aesthetic of her map – both consistent with dominant, socially desirable versions of rational neoliberal subjects and with the approach of the biomedical framework that governs contraceptive service delivery. Her map and oral history are congruent in the same way that her fertility intentions align with her contraceptive practices and her body has accorded with the methods – an overall harmony between EI, contraceptive methods and the service delivery environment i.e. the three 'spheres of influence'.

6.1.2 Chloe – “Listen to the silly contraception shit”

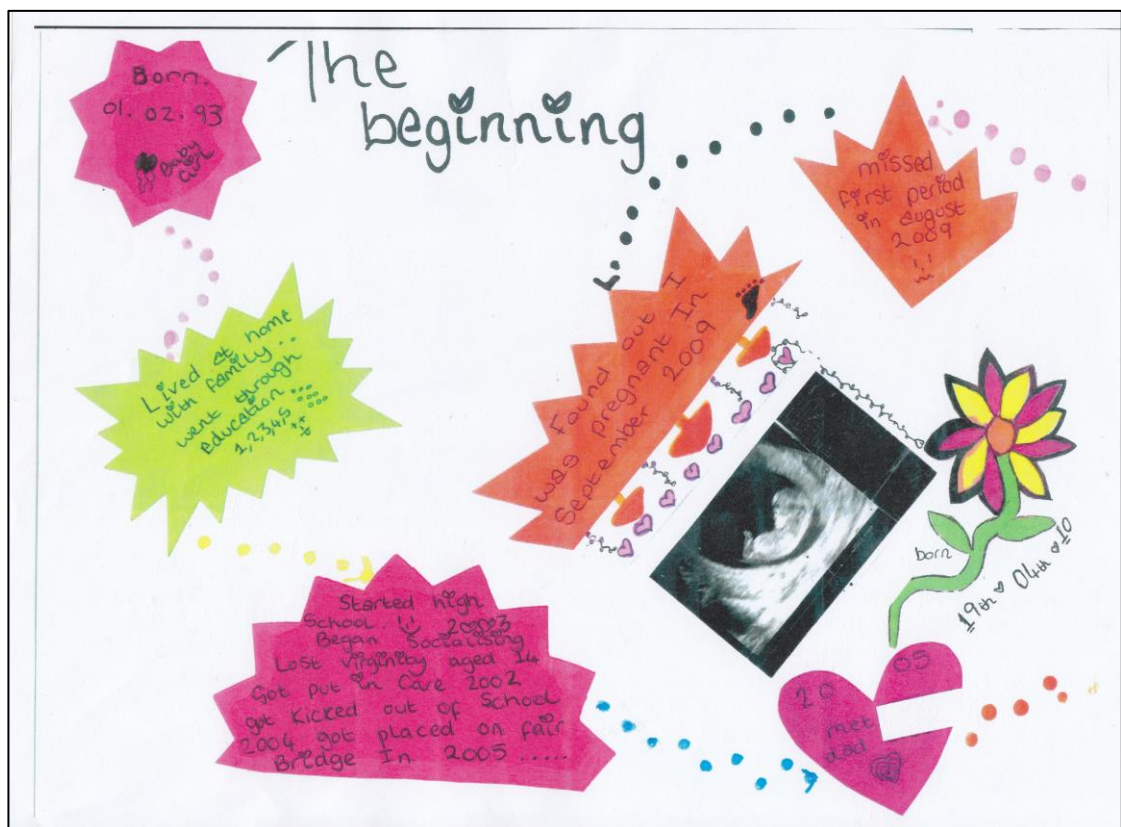


FIGURE 6.5 – CHLOE LIFE MAP PAGE 1



FIGURE 6.6 –CHLOE LIFE MAP PAGE 2

This beautiful map sat in stark contrast to Chloe’s mood at the beginning of our second meeting. Chloe arrived like a storm, wrestling with rage and frustration; different altogether to the gentle woman I met the week before. She practically threw the map at me as I sat in the meeting room but before the interview started, Chloe’s drawings spoke volumes about the young woman that sat in front of me and what mattered most to her – her daughter, Leonie. Chloe, aged 19 when we met had lived a challenging young life in the care system, had experienced unintended pregnancy and had subsequently had her daughter removed from her custody.

The colour, vibrancy and creativity of the map clashed with the tired, communal living space we met in at the supported accommodation hostel where Chloe lived. I had been warned that her benefits payment had been delayed and she had nothing – no money, no home; but her feelings of dejection related to more than her material

circumstances. I agonised over whether it was appropriate to conduct the meeting. I was not at risk but worried about her wellbeing firstly and the material I might (not) get secondly. However, she made it clear that she wanted to continue with the interview.

To begin, I used the map as a device to try and defuse some of her tension. I hadn't expected anything like the piece of work that Chloe had produced and hadn't anything else to compare it to, as she was the first participant. I thought that it was beautiful and perhaps my excitement alleviated some of the tension as Chloe became more relaxed. She started her narrative at birth; a poignant moment considering the emphasis on mothering throughout her story:

“When I was born; I was at home with my mum. Primary school; and then things went a bit rubbish. Like I started high school and mixed with dodgy people. So then I ended up in a care home. Like, when the school year started.”

R: “Okay secondary school?”

“Yeh. But then I refused to go to school...so they sent me on some course which was really where I started everything. Like, I dunno. That's when I started being sexually active and that” (Meeting 2)

Chloe's speech was often clipped and hesitant as evidenced by the above quote, compared for example to that of El. The story was also told in a non-chronological way and she bounced from past to present whilst I made efforts to focus her attention on particular events. This sits in contrast to the chronological presentation of her life map, perhaps indicative of her preoccupied mind at the time we met. Thus, the central narrative needed considerable patching together:

“I saw very little of me mum like me Nanna brought me up from being 6 months old. Then I went to live with me mum and that's

when everything went downhill. Like, I've not wrote it on that [MAP] but it says there, 'Lost virginity,' when I went to school it weren't, I was assaulted in me mum's house. That's why I went to care. But I weren't writing it on that [MAP]. But that was when things went downhill with me and me mum." (Meeting 2)

Thus, Chloe's first experience of what she conceptualised as sexual activity was 'assault'. I am unsure if she did not write this on the map because she felt that it would spoil the aesthetic or because she did not usually disclose it. This event, alongside the relationship she described with her mother, instigated her assimilation into the care system. At this time, and without any particular need, Chloe used contraception in a way she described as 'daft' – 'tagging along' with friends who were seeking the pill. She first sought contraception 'proper' in 2007. The legitimacy of these practices to her mind was linked to the relationship she started with someone attending her alternative education programme:

"I met me daughter's Dad at the same place in 2005. So then I left me care home, moved in with him. Like went on a little mad one. That was 2007. We went to the same thing and we was still going and then when I moved in with 'im I had the injection"

R: "So can you explain what made you decide to use contraception?"

"Cos I lived in the care 'ome. And I saw like, all like, the way that kids 'ad come in and gone out and like their life and I was thinking, I don't want to bring a kid into that." (Meeting 2)

Despite her aversion to care home life she valued it grudgingly, including in regards to her sexual and reproductive health, as her life became increasingly 'mad.' Embarrassed about sex, distrustful of strangers and self-identified as 'bone idle,' Chloe benefitted from the intervention of the care home:

"To be honest the care 'ome was the best days of me life like they saved me there. Or I would either have been dead or in jail if it weren't for them." (Meeting 2)

And the opportunity to accompany friends to sexual health services:

"Probably everything I've used is just what other people were using and they told me about it. Otherwise I would probably would have never have had anything. If it was left to me meself cos I'm so bone idle. I probably would never have got up and gone. I wouldn't go on me own." (Meeting 3)

Chloe's used the injection method for a relatively short-term but this still conferred some challenges. She didn't get on with the injection – "it gave me loads of spots and made me get fat" (Meeting 2), but its emphasis on her map suggests that she conceptualised it as her 'main' form of contraception. She shifted to the implant but this was also unacceptable so had a removal after 18 months:

"I think it was because I had a constant dead arm with it [IMPLANT]. Like, the local anesthetic, it was like that. But it never went... I 'ad to make an appointment to have it taken out and it took months and I can't remember why. I had to wait *ages*. I just couldn't wait to get it out. I couldn't wait to get it out and I can't remember why I had to wait." (Meeting 2)

Nonetheless, she made other efforts to avoid pregnancy:

"That's embarrassing, going for that [Emergency Contraception]. I'll never do that again."

R: "Okay can you tell me more about that?"

"It's just like a chemist. I thought there was a waiting room for you to go in at the side but there wasn't he just give it me, with a cup of water, over the counter, in a chemist full of people. I couldn't even look at me mum, I wanted to be sick. I just looked at 'im like 'Are you for real?' If I was a bit braver like I am now, I would have been like 'I'm not taking this here'... I was so ashamed. I bet that is one of the reasons why so many people have got kids now, cos that's just embarrassing." (Meeting 3)

Feeling humiliated through the pharmacy consultation she experienced during her efforts to use EC and overall alienated by the bodily and social experiences of contraception, she did not use any method, with profound results:

"I was mortified when I found out I was pregnant, I was *mortified*. And I was like 5 months gone. It was horrible. I remember going for me scan and I was expecting to see like a little ball and it weren't like, I saw all her legs and that and I was like 'What?!' So that was me first scan. She weren't like a bean. She was a baby. She had arms and legs it was 'orrible." (Meeting 2)

This pregnancy brought a 17-year-old Chloe much hope and potential:

"You're gonna be a *mum*, you can't be that horrible gobby little shit you used to be, you can't. I stopped loads, I stopped loads. And I had this completely grown up head I was like a different person. Completely different and all, everything I focused on was my baby. All I talked about was baby talk. That's all that would be in me head. I'd love to go shopping, I'd love to do all sorts of things with me Nanna, I've never had such a better relationship with me Nanna in me life. Ever. Never got on with her so much. And me mum if I'm honest. Never got on with them better. And I loved it..." (Meeting 3)

R: "So your actual, like, experience of having Leonie changed how people"-

"-Yeh cos I was a mum. I had my dependent so it weren't my life it was hers. It didn't matter about anyone else. If she come first and as long as she was happy then I was happy. And I weren't interested in anyone else. And that's what they say, that seems a good thing."
(Meeting 3)

Then when Leonie was born, Chloe described being compelled to have the implant by clinicians in the maternity setting:

"I had a lot of trouble when she was born. So I think it was like done there and then to like stop *me* getting pregnant again at the time. Like forced on sort of thing."

R: Did you feel like that then? Pressure about it?

"I just weren't bothered at the time. Y'know what I mean I was tired and like 'If you're gonna do it, do it.' I just wanted them to go away. Like I'd just been in labour for 27 hours, I didn't need to listen to that" (Meeting 3)

However, the implant was quickly removed because of gynaecological complications and Chloe got pregnant again within a relationship that was extremely abusive. I had noted the deep visible scarring across her skin when we first met but was horrified when I learned that this had been inflicted on her by a partner. The details of this relationship were played out briefly in her descriptions of this second pregnancy and contrast starkly with the honest tenderness of her feelings about the termination she had:

"She [Leonie] was about 4 months old. And I ended up pregnant again. And I did then. [HAVE AN ABORTION] Cos her Dad was

violent as well. So it weren't worth me being stuck in that relationship with Leonie and another." (Meeting 2)

"I'd never, ever do that again. It was mad. When it come I wanted to keep it. I wanted to bury it somewhere I knew where it was. Like when you're there you don't care. You're just like 'Get it done' and then, I shouldn't have looked. But I did. And then I wanted to put it in like a butter box and bury it in the back garden. And that's disgusting. That's tapped [CRAZY/MAD]. I'd never want to do that again, ever. I looked at it and all I could think was 'That's my baby.' That's another Leonie that's all I could think... I did I cried me eyes out. And he [PARTNER] was 'orrible, he just took me knickers and put them in the wheely bin like 'You won't ever think of it now.'" (Meeting 3)

However, finally, what Chloe described as pressure on her as a mother, and her abusive relationship led to what she referred to as a 'blowout.' This event was not described either in her map or verbally but after this her daughter was removed from her care and has since been looked after elsewhere. This had devastated Chloe who was also displaced and living in supported hostel accommodation. Rather than any *fertility* intentions, Chloe's intentions were related to avoiding relationships with men altogether and she had not used contraception since her second implant- men, sex and contraception were totally peripheral for her at the time we met she had other more pressing priorities to contend with:

"I've been passed through places like this all me life now. Like I've had 2 houses and had to get rid of them cos of his [PARTNER] family. And now look at me, I've lost me daughter, I've lost me 'ome, I'm *stuck* in a place like this. I've not even got 2 pennies to rub together to go and get a bottle of milk, it's a joke." (Meeting 2)

Despite the adversity and chaos of her story, her narration and map also communicated a sense of optimism, resistance and strength. The map focussed on the most positive events further celebrated in the joyful and playful design. The mood that was captured in the map is what she embodied by the time we parted company after our last meeting. She was beaming, pleased to have taken part and she literally skipped off with my flyers to inspire interest amongst other women she knew. This energy was inherent in Chloe's entire story - from how she spoke of 'fighting' the system for her benefits, access to her daughter etc.; to how she unapologetically described her attitudes to issues like abortion and other women's sexual behaviour. Her independence and boldness was demonstrated frequently during our meetings - as illustrated through this comment on other people's judgment of the physical scars she had:

"If you don't like it, don't look. That's your opinion and you don't have to speak to me. They don't phase me in the slightest. They're laughable. It will make my day brighter knowing that they actually speak about me." (Meeting 3)

Chloe's story was dominated by her challenging circumstances and the structures and individuals who have exerted power over her throughout her life. Whilst Chloe's map presented a particular (positive) view on key moments in her life, potentially a view of herself that she wanted to present to the world, the narratives enabled an unpacking of the other experiences that she did not want to represent visually – a good example of the multiple dimensions accessed through the combination of visual and narrative methods. Either way her strength and tenacity meant to me that, like her map, she could make some of the darkest sides of life look bright and beautiful.

6.1.3 Angela- 'I just want someone to listen to me. Not judge and have decided what I am going on before I even enter the room.'

In Chloe's story, contraception use was peripheral, subjugated by other pressures, but in Angela's life her contraceptive practices were much more conspicuous. From the first expression of interest to participate in the study, Angela clearly had a lot that she

wanted to share. She couched her experiences in the context of her 'medical needs' and the challenges she had encountered as a result. When we first met, Angela, aged 29, was accompanied by her smiling 2-year-old daughter Katy and pregnant with her third child. Her efforts in juggling the demands of our meetings, the comfort of her pregnant body and a small toddler mirrored the efforts she described in negotiating the needs of her fertile body with her experiences of contraception and service providers.

In meetings 2 and 3, her current partner, Mickey, was present; quietly working in the background and offering support with Katy when necessary. I worried that company would be inhibitory but I was struck by the open-ness of Angela's communication throughout and her focus amidst of myriad possible distractions. In her lounge amongst children's toys and biscuits, Angela talked fluently from the beginning of her story – when she first started to have sex at age 13. After successfully using the pill from age 14, supported by her mum, lifestyle transitions demanded a method shift:

"I got older, obviously started drinking and going out and obviously other things in your life are, I stopped taking them, forgot to take them, was too hung-over or whatever so I went back to speak to the doctor cos my periods were still really heavy as well on the break that I was having with my pill and the doctor suggested that I went on the Depo injection... but University for some reason wouldn't do my Depo injections under a temporary residency ... so I went back to her [HOME GP] and said 'Is there anything else we can look at?' and that's when she suggested the implant... So I decided to go for that" (Meeting 2)

After switching back to the injection Angela began to experience physical problems:

I started having really bad pains during sex, really bad bleeding, just generally pains that were out of sync with when I should be getting periods and such what. So I went for a scan and they found I had an

ovarian cyst. So I was referred to gynecology and had a laparoscopy, which is -just keyhole surgery where they insert a camera and then they have a look round and they literally popped my cyst and drained it so it was in and out, easy done, but it was just a pain cos I had to take time out. He [Gynecologist] suggested that I just go back on the pill for the time being.” (Meeting 2)

To Angela’s surprise she got pregnant whilst using contraception, attributed to simultaneous use of some antibiotics that compromised the efficacy of her pill. After the birth of this child, Angela was refused oral contraception again due to contraindications (BMI and smoking) and began to use the injection once more. Further to the experience of more ovarian cysts Angela switched to condoms to avoid hormonal methods until a new relationship inspired her to try the injection again:

“I’d met Mickey and we were quite sexually active at that point and obviously condoms weren’t working for us, so I went to family planning, told them *everything*, and she rang up the Doctor there and they just refused to give me the pill again and actually quite, made me feel that if I did take the pill that I would be risking my life so made me feel that Depo was my only option and saying ‘Oh y’know the risks of a cyst are only slight’ but I don’t think now, looking back, they had the right to say that to me cos they had no idea of my history at all but I felt kind of pressured at that point and I had to make a decision there and then to have my first injection so I just agreed. But things were okay for quite a while for a year but then again, I started with the pains again, went for another scan and there it was again [CYST]” (Meeting 2)

The risks from possible future laparotomy intervention (impaired fertility) meant that Angela and Micky planned a pregnancy whilst it was possible:

"Katy was born in February. Then I was breastfeeding which my health visitor said was a mild contraceptive and that I probably won't get caught cos I wasn't expressing, all I was doing was breast feeding her she wasn't on formula at all, but yeh, I, I got caught so here we are, in November and I'm looking at having another baby quite soon" (Meeting 2)

Angela seamlessly described the events in her contraceptive life in detail; perhaps indicative of the time already spent recounting these events to others. Indeed, it was very difficult to break up the first few pages of this narrative to accommodate it within this chapter. Angela's map captures all her method use and the associated challenges. Like the way she spoke, Angela's paper representation was clear and chronological. Her 'medical needs,' the occurrence of cysts, punctuate the efforts she has made to use contraception through her life.

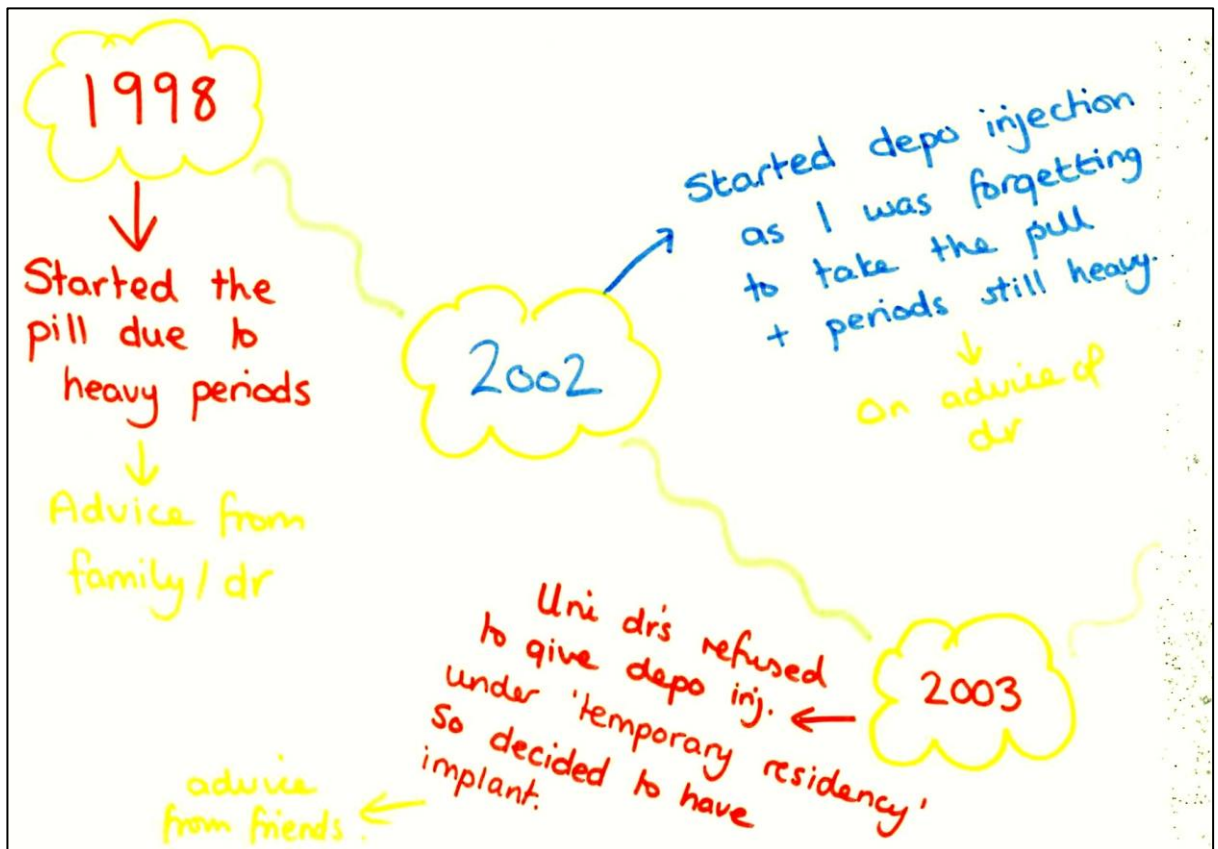


FIGURE 6.7 – ANGELA LIFE MAP PAGE 1

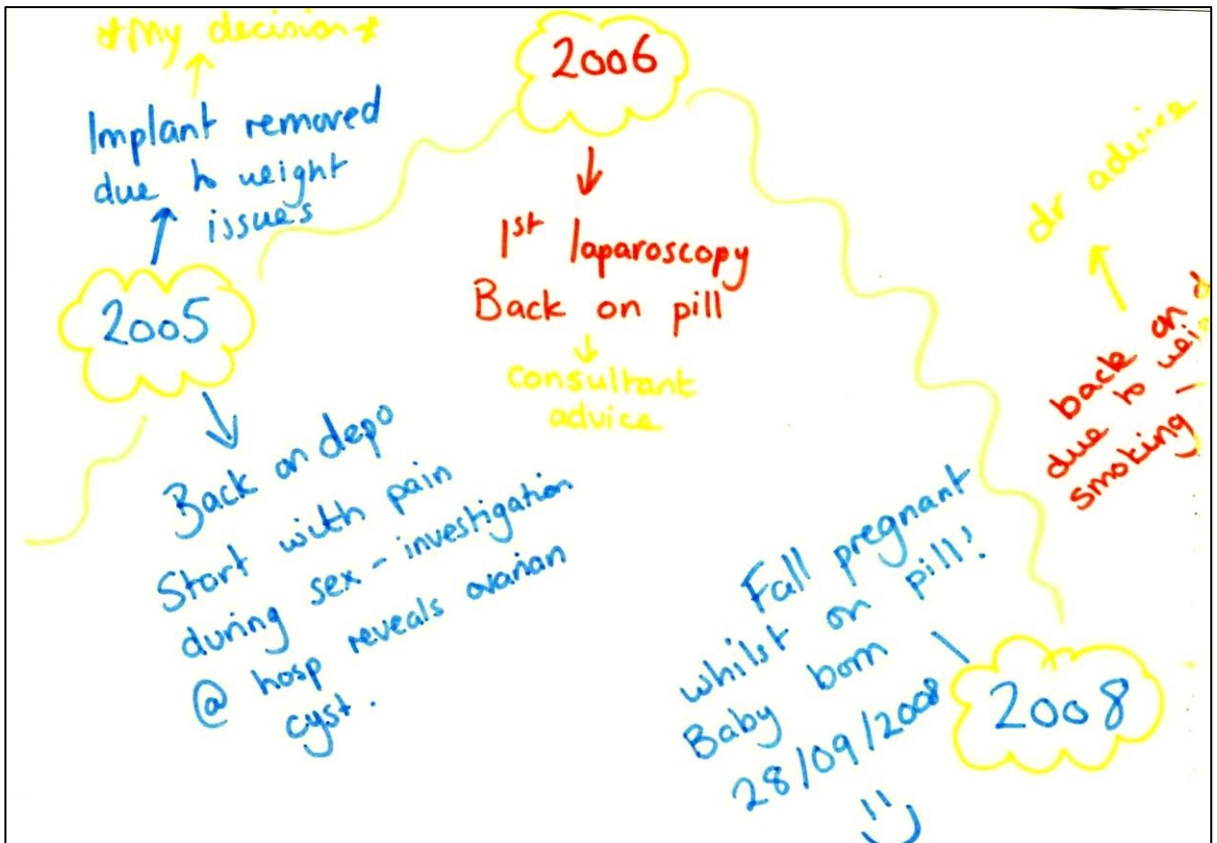


FIGURE 6.8 – ANGELA LIFE MAP PAGE 2



FIGURE 6.9 – ANGELA LIFE MAP PAGE 3

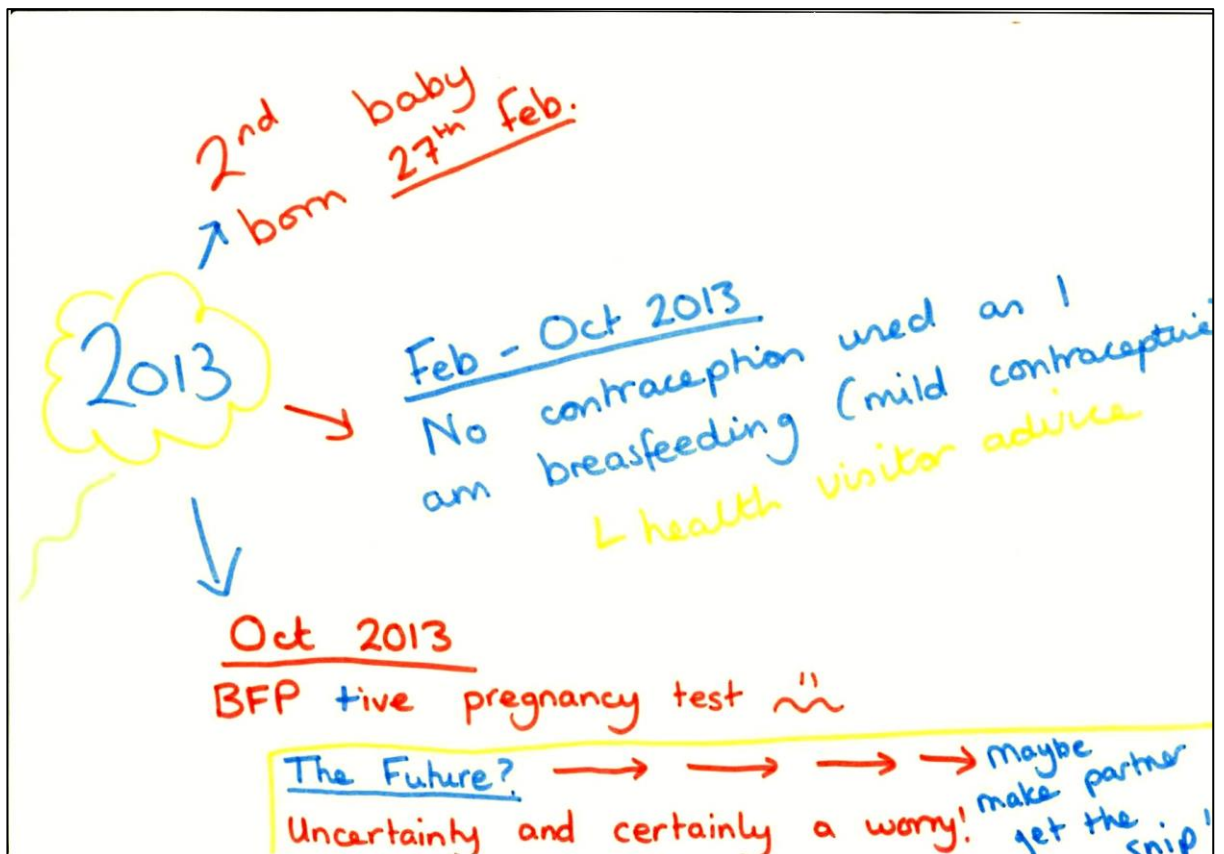


FIGURE 6.10 – ANGELA LIFE MAP PAGE 4

This storytelling and the map were consistent and subsequently Angela gave even further detail of her feelings and the encounters in the final meeting. Her needs confounded efforts to arrange contraception but her relationship with providers added complexity to the narrative. Aside from feeling pressured towards LARC she noted how the tension manifested as a battle between expert and embodied knowledge when Angela 'dared' to question:

"I said 'I'm here about contraception,' and she suggested the long term straight away and I said 'No I cannot do that,' and she said the pill was just a no-go and I said 'Well we've got an issue then cos I need something,' and she said, 'Well I'll call the Doctor and speak to the Doctor,' and the Doctor said no, so they wouldn't prescribe it to me....To be honest -I know this is quite sad, but I've actually got used to it because there was a time when, y'know like I'd gone back to the Doctors in 2005 and she put me back on the Depo and

I'd said 'I've had ovarian cysts' and she looked in her book and said 'Oh no its fine.' Just because a book said so obviously she wasn't willing, I had some huge concerns then and yeh, I just feel that throughout my history it's always been other factors that have come first and I hate to say it but I think it's mostly cost-over my actual needs. And the ironic thing about it is, I know, I understand, family planning putting me on Depo again, but it's actually costing the NHS more putting me on long term contraception because I have to keep going and having an operation to have my cysts removed" (Meeting 2)

Angela's stress was exacerbated as other clinicians *had* confirmed this link and illuminated the risks of these cysts. Her relationship with providers was the dominant influence in this narrative. These relationships are represented on her map in yellow and the majority (6/9) 'decision makers' that she identified in this way are providers. Tellingly she also highlights 'my decision' to use the injection with asterisks (See Map p2).

A long-standing aversion to what Angela referred to as 'family planning services,' rooted in her perceptions of 'scabby people' and the stigma of using them, was a noticeably incongruent attitude to her otherwise non-judgmental approaches. However, she'd had unfavorable encounters with other specialisms within sexual and reproductive health too. As such, by the time we met, the culmination of these experiences had compelled Angela to activism and she was instrumental in her local maternity/birth support groups, lobbying and campaigning for policy change. I encouraged Angela to share all the experiences if she perceived that they related to her contraceptive life history. I interpreted her concerns about whether to discuss certain issues as representative of the piecemeal approach often taken to (women's) health, highlighted in the chapter 2. Angela identified this in relation to the management of her contraception:

“The people that you are referred to about contraception-mostly for example after you’ve had a baby your midwife or health visitor will talk about it; but however brilliant the health visitor and midwives are, they are not qualified enough to speak about my gynecological issues. But then if you try and talk to the gynecologist consultant he doesn’t care about contraception cos that’s not his field. As far as he’s concerned he deals with the cysts - so I’m in a bit of a limbo.” (Meeting 2)

The lack of coherence in service delivery related to reproductive health was striking in Angela’s narratives. As was the clinical assumptions that each specialism ‘knows best’:

I think there is an attitude of, just going off on a tangent here but I do think there is an attitude within the health profession that if you are asking for something that isn’t straight down the line, they don’t like it. - I do feel at the moment that a lot of people have that attitude that ‘I am in my medical opinion, giving you this and you don’t have the right to really question it cos I’m the medical profession, you’re not..’ -I just feel that everything at the moment is, is a battle if you are outside the norm; or if you dare question.” (Meeting 2)

This failure to adopt a holistic approach to Angela’s needs, and to listen to her input, is what she perceived to be responsible for her challenges – being unwell and unsuitable contraception. The results of these experiences, namely having children and ovarian cysts had disrupted a professional career that she had been trying to forge after leaving University and she was not employed when we met. The financial strain of this was mentioned more than once. Her future remained uncertain, as there were few acceptable contraceptive methods on the horizon. After becoming pregnant whilst using contraceptive methods previously, her perception of her own hyper-fertility contributed to her anxiety. She was prepared to explore alternatives but her past encounters meant she felt that options for acceptable contraception were

limited. Her tension with the 'expertise' of the providers suggested this relationship would continue to be challenging and unproductive:

"So in all honesty, I do think I'm gonna be looking at natural, natural contraception and just hoping to god."

R: "Have you been informed or guided about that?"

"No that's my own research, reading, having friends who have done it and I think I'm gonna ask more. And I know, I know they're gonna be prejudiced about that and I know, one place that I won't go is family planning clinic cos I know they'll just 'Pfff,' at me."

R: "So you don't feel that family planning would be"-

"-supportive, no I don't. I don't even think a GP would be supportive. I think the only person I might talk to is the midwife or the health visitor because they're more supportive in terms of understanding the, the needs of a woman in terms of post baby I mean our health visitor - she was all holistic and she was the kind of woman I could speak to about things like that. I just want someone to listen to me. Not judge and have decided what I am going on before I even enter the room. Cos that's what I feel like happens. 'You need contraception, certain age, certain BMI, yep she's gonna have this.' And what I say doesn't make any difference and I either agree with them or I go somewhere else. So I just want someone to listen to me and see how and be *honest* with me about the natural not, 'oh well it's not very'" (Meeting 2)

It seemed very possible that Angela's future would be shaped by the complexity of her circumstances rather than her irresponsibility or failure to choose, a situation that her good humour helped her to cope with:

"It shouldn't be such a complex thing- I don't know it just feels like so much effort, it's easier just to get pregnant and have children. We just need to win the lottery and we'll be fine. Or we can move to America and then give them all away." (Meeting 2)

Angela's humorous remark belies the stress and challenges that she had encountered for most of her adult life in her attempts to use a method and avoid pregnancy. Angela illustrated how despite her desire to contracept, the reality was not straightforward and that clinical considerations undermined these efforts. In addition to the corporeal experience, Angela also encountered social challenges in regards to her relationships with 'expert' service providers

6.1.4 Helena – "Dodging the zeitgeist" – (re)sexualising contraception

Helena's story communicated a fantastically sex positive experience of contraception-use encompassing sexual practices, pornography and pleasure. This contrasted with most of the participant's accounts that, in a mirror of broader socio-cultural tendencies towards desexualisation of contraception, did not emphasise their sexual lives if they mentioned them at all. Helena's emphasis on the sexual (contracepting) self was exciting; an almost 'best practice' example of how contraception, in the right circumstances, can enhance a woman's sexual life. That said her experiences of contraception use were not without their challenges. From our first meeting Helena was entertaining; eager to regale me in her Lancashire accent with one of her amusing stories about sex/contraception. At 35 years old she offered colourful descriptions of her life and had a sense of humour that made her company fun to share. When we met, Helena was a mature student at University. Although her first introduction to contraception was for non-sexual reasons, her contraceptive practices evolved over time to meet the demands of her sex life:

"The first time I encountered contraception was *largely* to stop the side effects of Rocitane which is an acne medication. And if you get pregnant at that time, I mean it leads to disfigurements

etcetera...so I was simultaneously put on my first contraceptive, which was Microgynon, which fortunately *seemed* to suit me and I was not actually sexually active by the time this all happened... So anyway being on Microgynon was okay. As I say I wasn't in a relationship at the time *but* two weeks before my 18th birthday I'd started, seeing a lad for a couple of months and I was like 'Right okay, let's do this now, let's go.' He was a little bit older than me, he was 21, and I didn't really have any inclination to sort of go and demand that he go and get tested or anything like that and we didn't use any contraception other than me being on Microgynon."
(Meeting 2)

After this relationship Helena embarked on a sexual career of what she described as 'promiscuity' and, exposed to media reports about HIV, her experiences of contraception became conflated with concerns about protection from STIs:

"So our relationship lasted about a year and half and *then* I sort of became *quite* promiscuous. I would say that the turning point in that, when I had a real wake up call, was when I was 18. And I had sex with a foreign man and the condom split. So, although I was still on Microgynon, obviously you know you're told if people are coming from exotic countries, and I perceived it was an exotic country. I shit me pants. And I went to the GUM clinic and I had to have the pre-counseling for the HIV and everything. I had all that then. And I was very upset cos at the time if you are listening to so much sensationalist media regarding HIV then you know it was very, very difficult. But it *did* come back negative and everything was fine." (Meeting 2)

Although accepted as an inevitable 'danger' of her sexual practices and mediated by her efforts to assess how 'clean' or 'high risk' her partners were; a concern about STIs

enjoyed the experiences that this environment offered and reflected on this era very fondly. Newly single, she had stopped using the pill (and she feared adverse effects on her skin) but despite the fun she identified 'low points' with regards to her sexual health, often linked to alcohol. Instead of condoms or contraception she had drawn on embodied knowledge and took many steps to avoid pregnancy and manage STIs in the aftermath:

"After I had split with my boyfriend I moved for a job and that's when I came off contraception because I no longer had a regular boyfriend. But by the same token I also had my most promiscuous times cos I was very sociable, I was drinking quite a lot and I was meeting a lot of people. And I put down here, this is a total approximation but I went from about 8 partners to about 22 in the space of a year. Now as much I can look back on this and laugh about my naivety and how *cocky* I was I went for the morning after pill 5 times. The clinic was round the corner so it wasn't really, well it wasn't really out of my way or anything but I remember going with such frequency that it had to be addressed. In that entire time, I didn't use contraception but I went regularly to the GUM clinic to make sure everything was alright...*Fortunately*, I never had any STDs. Which is absolutely *astonishing* in retrospect." (Meeting 2)

"I mean, there's a certain amount of logic, as you get older obviously you look at when the dominant times that you could become pregnant are going to be. And then you will go to the clinic and they'll say 'When was your last period?' and you say and they say 'Oh, we don't need to give it you then you'll be fine.' And so you start to think about that and then I then think the incidences that I did use it I thought 'That's an iffy time that, that's a bit iffy.'.... I know that but I wasn't ever willing to take that chance so that was when I would use it with the morning after pill but using it with that frequency and in such close succession to each other I just thought

'Something's got to give here, this is ridiculous, you can't just keep going to the clinic.'" (Meeting 2)

Helena's sexual partners have been influential due to their passivity. Their lack of action around condom use combined with Helena's desire to have sex (regardless) meant that she took steps to be certain that she would at least prevent pregnancy. This was a key sub-plot in Helena's story:

"What I've commented about overall, what I've found is that men are *so* unwilling to use condoms; with the exception genuinely, of one, *one* individual. And he was in a younger age group....and it's almost as if that particular generation are more up for it. And, y'know I could have asserted myself and said 'Tough, it's happening,' but it was such a repeated experience that I'd had with men that I thought 'Okay, the ball's in my court here. I have to take a big risk and I have to make sure *I'm* using protection against pregnancy.' Cos that was obviously aside from obviously an array of STDs that you can pick up, with the exception of HIV, pregnancy for me was *terrifying*." (Meeting 2)

Her preoccupation with her experiences of men and their (lack of) condom use was captured in her 'bonus' map (as she referred to it), overleaf:

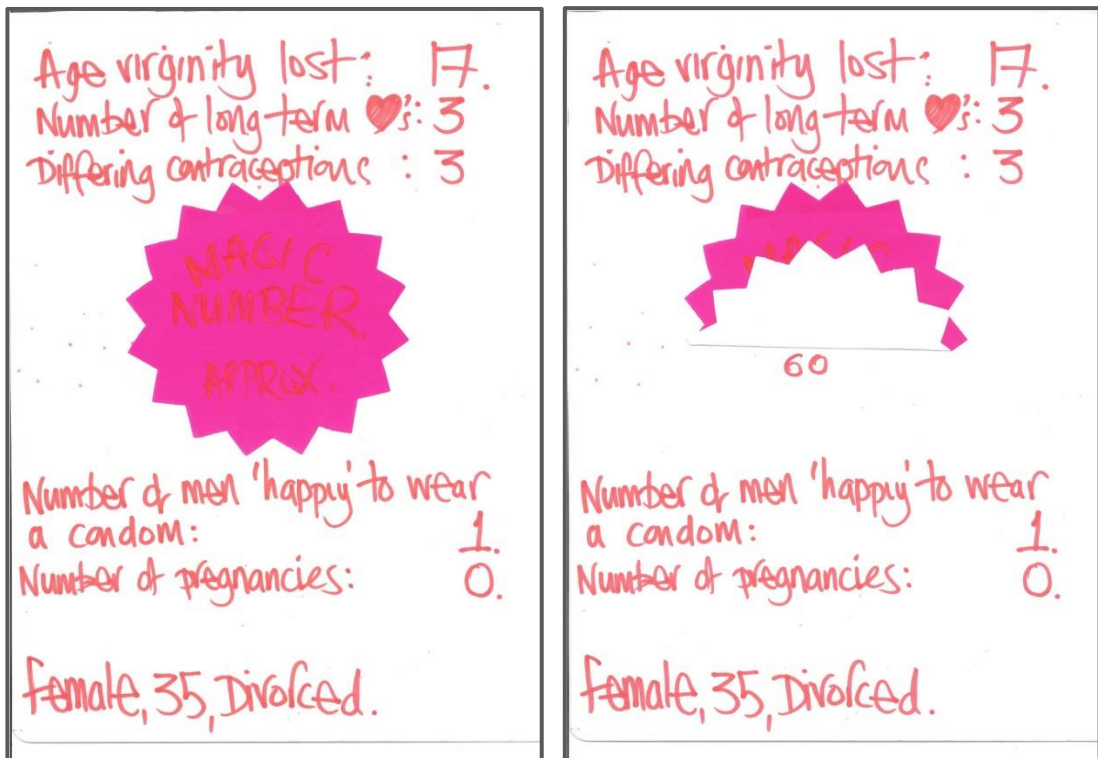


FIGURE 6.13 – HELENA LIFE MAP – ‘BONUS MAP’

Both contributions demonstrated Helena’s playfulness and sense of (‘highly sexed’) enjoyment – sex is plastered across the drawings, literally in the first map. The bold emphasis on her ‘magic number’ is almost a protest against the shame associated with (active) female sexuality – reflecting its existence but rejecting it from her lived experience like her verbal account. Helena explained her maps and the perspective that informed them clearly:

“I think that my promiscuity, in relation to my contraceptive choices are strongly interlinked and that’s why I wanted to show that side of it. I wanted to make it fun at the same time, for me. So although it does kind of err away from the whole matter in hand I didn’t want to do it very clinically. I just wanted to play around with it a little bit. But yeh, the magic number business and all that jazz, that’s important cos I think I need to be demonstrating the kind of person that I am and the choices that I’ve made and the bad choices I have made cos I won’t be the first, I won’t be the last.” (Meeting 3)

In this way, the methodological approach has clearly enriched the material, allowing for Helena to represent something specifically through her map making. Helena's first map also centralises her experiences of the contraceptive injection, 'Depro povan' that she encountered during her time in Australia. She used this relatively happily for 5 years and her practices did not change when she married for a brief time in 2005:

"I think we got talking about it one night round a camp fire and I'd had a couple of instances where we'd got talking with girls my age saying 'Yeh that's what I'm on, it's great.'...I just thought 'Once every 3 months, brilliant.' And it stopped my periods. Yeh, bloody hell, it stopped my periods which was quite good. And I stopped taking it they came back quite quickly as well. But I did still think there was a slight element of the crazies about it as well.... but certainly not to the extent of the pill" (Meeting 3).

In keeping with her carefree approach Helena didn't dwell in her story on adverse effects of her (hormonal) methods. However, their overall acceptability *was* undermined by their impacts and between mood changes (the 'crazies') and impacts on her skin Helena sought an entirely hormone free method. This switch came when she embarked on a new relationship after her divorce; the long-term nature of the method reflected her predications about the longevity of the relationship at that time:

"I'd just got back from Australia after I'd split up with my husband...And I got in touch with my first boyfriend and we embarked on a fling. That at the time I thought might have some longevity to it. And I thought 'Right okay it's time to get the armor out,' and I thought 'I don't want hormones anymore I really don't.' So I did a little bit of research, online research, simple as that and I thought 'Is there something that I can get that is hormone free,' and I think I spoke to me mum as well cos she had it. And it came up with the two types of IUD the one that has it and the one that is

hormone free. And I thought it's as simple as that, I'm gonna get that. Just, y'know, I don't want anything being put inside me that's alien really. I went to the Dr and they said it's painful. And I dismissed that really cos I think I'm dead 'ard. It *was*. It was put in and it was just so painful. The first three cycles that I had were just hideous. So heavy. But then it just, it just y'know, now it's fine it's just normal it doesn't feel like it's there." (Meeting 2)

This relationship did not last but her IUD did. The efficacy and forgettability of the method meant Helena continued to enjoy her sex life confidently protected from pregnancy. Helena demonstrated significant ambivalence about future motherhood and this was reflected by conflict in her narrative, for example, she both rejected notions of motherhood and worried about compromise to her fertility. Nonetheless, pregnancy wasn't planned soon and she predicted continued IUD use. Her sexual self rather than her fertile self was the focus in her story despite acknowledging her age (35) and circumstances as typical times to make plans about having children. Helena reflected the stigmatisation of the sexual woman frequently with her language - 'promiscuity,' 'slag' etc. and her observations on the atmosphere of sexual health services ('an air of dirt'). She also hesitantly remarked on the links she had observed in the news media between sexual women and contraception:

"It's just a bit weird. Y'know it's like some sort of tag. But that's how I remember it in a context of.... an individual who would sleep and around and become repeatedly pregnant until you are a bit like 'Come on now love.'" (Meeting 3)

Having finally found a very acceptable method, Helena noted the challenges she had experienced in her contraceptive life but she approached them pragmatically and opted instead to gloriously embrace her sexual life and celebrate contraception for the freedom it gave her:

"I think contraception in itself allows you to assert yourself more because you're not dealing with an anxiety that would come from becoming pregnant. Because obviously - if you bring that into the bedroom in any sort of intimate play, then it's gonna hold you back so it aids you in asserting your sexuality; that's what it does for me."
(Meeting 2)

6.2 – Theorising contracepting lives

Drawing on the individual narratives of El, Chloe, Angela and Helena as examples, but interpreted through the analysis of all 15 women's narratives overall, this section further theorises the experience of contracepting across the life course.

6.2.1 - Thinking across contraceptive lives

In the context of individual women's lives considering amongst other things: transitional life events; challenges; knowledge; temporality; and relationships, the main interpretation of the very diverse material is that there were few, if any 'norms' that conferred shifts in contraceptive practice over time or in relation to specific life stages. Instead what was consistent through the narratives were the subjectivities that were being re/constituted through the process of negotiating their fertile bodies; through contraception use but also through pregnancy, infertility, menstruation etc. These subject positions were regulated and shaped by the normative, dominant discourses, which were reflected with relative constancy across the individual stories and over historical time. This finding was elucidated particularly through reading four of the Listening Guide analysis, 'reading for the wider context'; analysis that drew my attention to the discursive facets of the wider context which included: planned pregnancy; 'safe sex'; the deviance of female sexuality; the problem of the teenage mother; romantic love; individual choice and contraceptive responsibility.

All the woman's narratives from the 1980s onwards reflected these discourses; albeit some more than others. The older women, Dotty and Kelly, highlighted the lack of *open* discussion around sex and contraception compared to now, but still reflected the

same norms regarding the deviance of female sexuality, teenage mothers and so on. Even when women personally rejected these regulatory discourses, they were still acknowledged through their use of language or behaviour; for example, Helena resisted the stigma of female sexuality in relation to herself, but used pejorative language ('slag' etc.) and hid the number of her sexual partners from immediate view on her life map.

I suggest this consistency is coherent with the fact that all the narratives are located in the British neoliberal context, more specifically, in the post-pill era where contraception is medicalised. I purport that there may have been other discourses illuminated if the cultural context differed, or the narratives had included *pre*-pill era contracepting women. Furthermore, I suggest that the capability and/or inclination of a woman to re/constitute these desirable subject positions then shapes their contraceptive practices. Drawing on Helena's narrative again, her deliberate, almost provocative disregard for the regulatory discourses around female sexuality meant that she had been happy to repeatedly use EC and risk perceptions of 'irresponsibility' or 'deviant sexuality.' EI, an arguably 'gold standard' contraceptive throughout her life was both willing and able to use methods in the most desirable way. Reflecting near perfectly the willed pregnancy procreative ideology, EI's narrative indicated how she shifted her meticulous pill practices to an IUS to confer a better chance of realising this (and other) ambitions.

The analysis of the life histories also supported, for the most part, research that suggests that attitudes towards contraception are more important in conferring its use than fertility intentions (Bruckner et al, 2004; Borrero et al, 2014). In only a minority of instances such as that described by EI, were fertility intentions linked to contraceptive practices. Rather ambiguity about pregnancy intention was reflected in the fact that eight of the women had experienced one or more unintended pregnancies, with most these having one or more abortions as a result. However, *all* women in the research expressed myriad clear positive or negative attitude to individual methods. With the notion of attitudes to contraception as stronger predictors of its use in mind, I started to take note of the general feeling of each

woman towards methods they discussed, a flavour of which is represented in Figure 6.1.

. = negative perceptions articulated
 + = positive perceptions articulated
 A = ambivalent
 N/A = not mentioned

Name	Condoms	Implant	Injection	Pill	Withdrawal	Fertile Days	EC	IUD/IUS	Sterilised	Abortion
Angela	.	+	.	A	N/A	N/A	+/-	.	A	.
Cara	A	+/-	.	A	.	N/A	+/-	.	N/A	+/-
Chardonnay	.	.	+/-	+	N/A	N/A	.	.	N/A	.
Chloe	.	A	A	+	N/A	A	.	.	N/A	.
Dotty	-/+	+	+	A	.	N/A	A	.	A	.
EI	.	.	.	+/-	N/A	.	+	++	N/A	+
Emma	.	.	N/A	+/-	N/A	N/A	+/-	N/A	N/A	+/-
Gem	-/+	.	.	+/-	N/A	N/A	+/-	.	N/A	+/-
Helena	A	.	+	A	A	A	+	+	A	A
Joanne	+/-	.	.	.	N/A	+	+/-	+/-	+	+/-
Kelly	+/-	.	A	.	.	A	.	.	N/A	.
Marie	.	.	A	A	N/A	N/A	.	.	+	-/+
Megan	+	.	N/A	+/-	N/A	+	+/-	.	N/A	+
Rosie	A	.	N/A	+/-	N/A	N/A	+	-/+	N/A	.
Sam	+/-	N/A	+	++	+	+

FIGURE 6.14 – OVERVIEW OF GENERAL PERSPECTIVES TOWARDS DIFFERENT METHODS/PRACTICES

As expected, methods that are more peripheral were little mentioned (such as withdrawal) and were typically mentioned negatively, if at all, in reflection of the social (public health) desirability of these practices. Although negative comments were made frequently regarding IUC, consistent with the legacy of the IUD - harm to health and bad press, two women were *overwhelmingly* positive about them and spoke with more enthusiasm than was directed by any other participants towards any other methods. The implant was also regarded generally negatively – a circumstance which, in conjunction with perspectives regarding IUC, reflected a lack of support for the methods which are the most provider dependent. These negative comments were often linked to discussions about provider's efforts to encourage LARC use – another trend across the life histories that suggested a resistance to being 'out of control' of their contraceptive method. Most usually however options were regarded ambivalently or as having a variety of pros and cons with some being more acceptable at different points in women's individual lives than at other times. For example, in Angela's case where the pill had met her needs as a young woman, lifestyle changes meant it was less desirable as she got older, then post-pregnancy, it was a desirable option to her again. In contrast to pregnancy ambivalence over the life course, as reflected in Helena's account, women communicated their attitudes to contraception much more clearly based on previous experience of a method or perceptions of the method gleaned through their social networks- contraceptive inclination therefore was more influential than fertility intention.

It is also important to reflect on the variation in the relative importance of contraception over women's lives. Angela's narrative illustrates how (problematic) contraception can be *very* influential over time. In addition to the smaller obstacles, like accessing preferred methods and the irritation of directive contraceptive counselling for example, Angela experienced profoundly disruptive adverse effects in the form of ovarian cysts which compromised her employment and professional training, amongst other things. By the same token, however, so did accounts of pregnancy/motherhood. Drawing on Chloe's account for example - her shifting life, future hopes, and the associated expectations experiences of pregnancy/motherhood was central in her narrative and by contrast her accounts specific to contraception

were peripheral. Although their stories haven't been included in this chapter, this was the same for Chardonnay's circumstances and parts of Marie's life where factors such as drug and alcohol addiction, displacement, abuse and prison sentences, meant that contraception was simply not a priority compared to the basic resources that these women had been frequently deprived of. For other women, for different reasons, contraception was also relatively unimportant in the broader context of their life. Helena's narrative illustrated an attitude in general that was not conducive to getting 'hung up' on the details of her contraceptive practices, nor had she had a more pressing reason like Angela, to do so. Thus, the relative importance of contraception between women and throughout their lives varies. This observation challenges assumptions that free accessibility of contraception in Britain, and women's desire to use it, will confer its uptake as for some, at some points of their lives, contracepting does not occupy any space within their consciousness.

This material reveals consistency in women's cultural context – the British neoliberal post-pill era – and its associated normative discourses rather than the individual 'life stages' such as those suggested recently by the Department of Health (2013). A finding that suggests the effectiveness of such approaches could be limited. Within this context broader expectations around *who* is a capable choice maker and associated characteristics that confer inequalities mean that women like Chloe, despite being knowledgeable about the value of listening to the 'silly contraception shit,' have limited capability to mobilise 'good choices'; circumstances that will be discussed next.

6.2.2 Contraceptor characteristics

Contraceptive choice and being a suitable 'choice-maker' is a raced, aged and classed experience (Ruhl 2002; Granzow 2010). This links to both intersectionality (Crenshaw 1989) and the concept of stratified reproduction (Colen 1995 in Ginsburg and Rapp 1995) which I will also draw on in this sub-section.

Notions of the 'capable chooser' as described in chapter 3 are well represented in El's profile – a white, private school and university educated, 27-year-old, professional

woman with a close and supportive network of family and friends. Her privilege, which she gratefully acknowledged, has facilitated choosing *well* through conformity to Ruhl's (2002) '*middle class, educated and scientifically orientated worldview*' (p656). Indeed, as illustrated previously, El's '*scientific worldview*' is captured in her meticulous and chronological approach to her life history, especially in her life map where exact dates of starting methods and other events have been included.

Considering the theoretical orientation of this thesis, most interestingly from El's narrative, is how she described so few challenges in this realm. Other than the absence of any adverse effects from contraception, El proffered that she was able to plan and control her fertility using contraception because of what *she* conceptualised as masculine characteristics – "*You know they always say that thing about girls, explain a problem and they just want you to listen and guys try and solve the problem. I try to solve the problem.*" Drawing on the discussion in chapter 3, I suggest that El's account illustrates how choosing *well* demands a perspective that is typically understood as '*masculine*' – in that it is rational, controlled etc. This position is in turn congruent with desirable neoliberal subjectivities and furthermore sits in contrast to typical versions of female subjectivities that position women as inherently irrational and '*hysterical*' (Lowe 2005a; Johnston-Robledo and Chrisler 2013; Longhurst 2010). Thus as contraception use is desirable (intelligible) from *both* female and neoliberal (masculine) subject positions, women are *simultaneously* being compelled to occupy both despite their inherently oppositional nature. Although El highlighted how her masculine perspective facilitated her success at contracepting, by default she also became intelligible as female through this practice.

The intersection of El's characteristics (at the time we met) therefore placed her in a strong position; characteristics that also map onto notions of stratified reproduction. In her life, so far El's choices were socially '*right and responsible*' and harmonized with wider normative discourses. Drawing on Beynon-Jones' (2013b) findings however I argue that El's place in this hierarchy may shift if she leaves (inevitable) decisions to have children '*too late*' in an act of wilful '*risky older pregnancy*' or '*selfishly*'(p516) remains voluntarily childless.

Chloe's narrative occupied the other end of the spectrum. Her inconsistent contraception use, teenage pregnancy and abortion arguably represent the assumptions about women 'like Chloe' – a young woman who had been in the care system since age 14. To re-cap at the time we met, Chloe was living in supported accommodation, had no job, claimed welfare benefit as her main source of income, described abusive and difficult relationships with family and partners throughout her life and had been educated to GCSE level in an 'alternative educational' setting. She had her first (and only) child at age 17. Her map ended here at the birth of her daughter, a poignant 'full stop' to any meaningful life (as she spoke of it) at that time when her daughter was removed from her care. Chloe's life history was almost the opposite of El's and far removed from any conformity with the template of the ideal contraceptive choice maker. Where El met the criteria - '*middle class, educated and scientifically orientated worldview*'; Chloe inhabited a place characterised instead by social abjection, limited (formal) education and adversity. Despite her circumstances being symptomatic of broader social and health inequalities (NCB 2013; LHO 2016), the rhetoric of individual choice facilitates the responsabilisation and stigmatisation of Chloe as an individual. Drawing on the prevailing neoliberal discourse, Chloe, as any other woman, is positioned to have a free choice to use the contraception that is available to her and must assume responsibility for any 'failure' to do so. This framework for judgment is co-opted by those around her, including contraceptive service providers which, through the lens of stratified reproduction, may arguably account for her (immediate) post-partum 'forced on' implant, humiliating experience of seeking EC or even the long delay in getting her first implant removed after her request. Despite a clear acknowledgment of the value of contraception, Chloe was often not powerful or inclined enough to mobilise any intentions she may have had to use contraception successfully, if at all.

Of all 15 narratives, El and Chloe's examples occupy the most polar opposite ends of the 'continuum of representativeness'; most others fell somewhere in-between. I was struck by the myriad instances where choice was circumscribed during participant's lives. Regardless of the intersection of user characteristics or their position within the hierarchy represented by stratified reproduction, all women in the research had been

subjugated by the power of the service delivery environment (medicine) or the demands of normative female and/or neoliberal positions at *least* once, if not regularly in their contraceptive lives- explored further in the next chapter. Even independent Helena's account indicated how she had been refused EC when she was 'going with such frequency it had to be addressed' by the pharmacy staff.

6.2.3 Reflections on the 'individual'

Relations with institution/s responsible for contraceptive service delivery were of central importance. This differs from the preoccupation of much of the research literature that explores the influence of other individuals - partners, friends, family etc. on contraceptive practices (Charmaraman and McKarney 2011; Bolton et al, 2010; Baxter et al, 2011; Asker et al, 2006). Indeed, the profound *lack* of influence of partners (sexual, romantic etc.) on contraception was noted. Admittedly in situations where the women had been in relationships that they identified as abusive, contraceptive practices were often, but not always, influenced by the control of their partner. However, I was struck by how under 'normal' i.e. non-abusive circumstances partners were absent from the narratives. Some of the women explicitly identified that their partners did not, and *should* not have any influence over their decisions around contraception through a 'my body, my choice' rationale; although negotiation with partners was often reflected in comments regarding condom use.

Referring to the examples earlier in this chapter, El's account reflected support from family and friends and her relationships with medicine, education and 'others' (whom she judged 'scathingly' against her own standards) in equal measure. El's (contraceptive) life had been very unproblematic and in this way, it may come as no surprise then that her relationships were overwhelmingly positive and supportive, described by El in ways that implied relative egalitarianism. The confidence and capability translated to her relationship with providers, a relationship within which El could assert herself and get what she wanted.

In stark contrast Chloe's narrative reflected one overwhelming relationship, that with 'the system' by which she was dominated. Her language was combative as she spoke

of her subjugation to this institution; her outlook was bleak. Her experiences with contraceptive services were no different and - it was Chloe who used the term 'forced on' for example in relation to seeking LARC.

Angela's relationship with medicine, because her 'medical needs,' was the focus of her narrative. Within these encounters over time, she oscillated between relative powerlessness (being dismissed, denied and pushed by service providers) and resistance, making her position more powerful through activism, research and determination; including participation in my research. Angela's account most clearly highlighted the impact of service providers on the individual's choices, behaviours and fundamentally, health.

Finally, Helena made very limited references to relationships of *any* type in her contraceptive history, offering up one of the most autonomous narratives of all the women, consistent with her self-definition as independent. Her priority was herself and her needs, particularly her sexual self. On numerous occasions, she rejected the influence or value of dominant norms, refusing to be regulated; a factor that I interpreted as instrumental in the fearless 'alternative' approach to her contraceptive life history. I would argue that this non-conformity and commitment to her instincts about what was best and most desirable to her personally situated Helena in a very powerful position.

Education was also an influential institution in addition to medicine (contraception providers) with many of the women starting their accounts with knowledge making in education settings. Where the women drew on the values and norms of 'others' these comments typically reflected the prevailing norms/dominant discourses of the British cultural context as discussed in section 6.2.1, or in some cases, sub-culture such as the normality of teenage pregnancy. Thus, overall the narratives communicated a more profound impact from 'relationships' with the wider context, i.e. institutions and discourses rather than any other individuals. Once again, the relative importance of these relationships varies dramatically between the women participants and across the life course of each woman.

As described in chapter 5, the relational nature of women's lives is the focus of LG analysis, a contrast to typical perspectives that draw on a free and autonomous individual (Mauthner 2002; Brown and Gilligan 1993). Considering the relationships in women's lives in this way allowed me to identify the importance of relationships with these bigger institutions – a somewhat unexpected finding considering the typical focus on the influence of relationships with peers, partners and so on. However crucially, the main relationship that women described was that which they had with themselves. As introduced briefly in this chapter, drawn on particularly from EI's account, there is a tension between female and neoliberal subjectivities. The implications of these desirable subject positions led me to consider the meaningfulness of contraception use on women's identities and their relationship with themselves; and subsequently, to reconceptualise women's experiences of contraception- this will be explored in chapter seven, next.

Chapter 7 - “I feel like there is a pill me and a real me”: Re-thinking the impacts of hormonal contraception

Drawing on the concepts of idealised versions of femininity noted in chapter 3, the collective narrative presented in this chapter represents what I understood to be the meaningful-ness of hormonal contraception’s ‘side effects’; specifically, the profound impact that contraception can have on women’s sense of identity. I use the concept of identity to represent the way that women in the research spoke of feeling unlike ‘themselves’ and how this troubled the relationship that they had with their own concepts of self. However, I acknowledge there are many critiques of this term, including its assumed fixity (Butler 1990; Weir 1996). Of course, all the women who participated had their own idiographic reasons for (not)using contraception and their narrative extracts drawn upon in this chapter speak for themselves regarding some of their lived experiences. Nevertheless, I assert that overall the material demands a reconsideration of the concept of ‘side effects.’

Unless stated otherwise in this chapter the term ‘contraception’ refers to hormonal methods. I have focussed on the women participant’s negative experiences of hormonal contraception, despite also hearing many accounts of the benefits of hormonal contraception use. This decision was made because the concept of ‘side effects,’ also understood as the negative impacts of contraception use, is a typical focus of much research about contraception. This chapter therefore offers a way to contribute to and further existing literature. Although this approach could arguably limit understandings of in the sense that it feeds into ‘typical’ preoccupations with contraception use in research, this orientation also reflects the way that the women participants spoke much more about their negative experiences of hormonal contraception than the advantages. Thus, I assert that this focus honours an important part of what the women in this research wanted to reflect about their contraceptive lives.

The parts of the narratives formatted in bold script are intended to highlight how I have interpreted that these women experienced a sense of subverted identity through their use of contraception.

7.1 Reconsidering contraceptive 'side effects'

When I met Rosie early in the fieldwork she made her eagerness to participate in the research very clear. She told me how her mother had encouraged her to take part in this study, especially to share her experiences of implant use. I was instantly curious about what Rosie was going to tell me and at the same time nervous about how to handle what she alluded to as being traumatic for her. This is important in terms of the overall study, as I now identify my time with Rosie as key in becoming attuned to the bigger picture of contraceptive impact. Although an arguably extreme example, her use of language and expressivity focussed my attention on the meanings of what is usually categorised as a mood related 'side effect.' There was certainly nothing peripheral about the effect the implant had on her. Rosie was a young woman of 20 when I met her and the implant was not her first experience of hormonal contraception. She started using it at 17. Selected parts of her account clearly illustrate the impact of hormonal contraception on Rosie's sense of self:

"I got the implant in the January. The implant was fine. But I slowly started developing like a psychosis. I slowly started becoming completely irrational, really aggressive. I'd have the most vivid nightmares I'd ever had in my life, like there was about 3 months where I wasn't actually sure what was real and what, what wasn't cos I was having this continual, continual nightmare, that was so vivid...And my mum was like 'I don't understand what's wrong with you, what's happened?'...I sat down one day and I'd just had like a massive rage fit and just got really, really angry for no reason; at all. I'd just walked into the kitchen absolutely fine and then all of a sudden started slamming cupboards and smashing plates. And I just sat down in the middle of all these broken plates and my mum

was like 'Rosie what the fuck's wrong?' and I was like 'I don't know. I feel like I'm going insane.' I said 'I feel like there's like a million insects in my brain and I just can't get them out and I just, I feel like I'm going mental'... So my mum got me straight to the doctors and got it straight removed. Within a week I was absolutely fine. **Completely back to normal, completely, cos I'm a very calm person, I don't get angry at all. So I was completely calm, absolutely fine.** I was sleeping properly. Within a week. Within like 3 or 4 days I was absolutely fine and my mum was like, my mum just couldn't believe it. She said 'As soon as it clicked in my head that you'd only changed since you'd had the implant'... I'd already turned 17 at this point that I had it removed and it was just amazing the effects. I suddenly, was able to sleep and I was able to breathe y'know it felt like, without going mental" (Meeting 2).

I explored the experience with Rosie in more detail later in the meeting:

"Yeh it was very gradual. It, it wasn't like, I was fine for a couple of months and then all of a sudden and then I was getting really angry. I just slowly started getting more and more agitated about things. I slowly started getting irritated and annoyed. **I'm like a really really calm and positive person. I'm always like, look on the bright side of life and y'know everything has a good in some situation I think...** it was just, that, from having the implant in the January, I slowly became very negative, very aggressive, I self-harmed a lot. I really like, I quite, disturbingly. It wasn't just slitting with a razor, it was like scrubbing with sandpaper and stuff like really aggressively self-harming and it was like I hated myself. Like I hated everyone else. **And I've never felt hate before. I don't hate anybody...** And it progressively got worse over about 6 months and it was after 6 months that it was like really bad."

R: "Okay, so 6 months in, and then before you realized?"

“Yeh cos my mum thought y’know, we didn’t have the best home life **but she knew I wasn’t her little girl. She was like ‘I don’t know who this is but you’re not Rosie.’”**

R: “Was there anything that you thought, any explanations that you had that you could tell me?”

“I, I just couldn’t think. I genuinely, genuinely couldn’t think about anything... Oh it was horrible. It was just awful. And I would have like an hour when I’d be fine but then it would start again and I’d be like, ‘Oh my god,’ and I’d just feel, I’d feel so angry cos I was so frustrated that I couldn’t shake this thing out of my head.... **Cos I’d started college like this really nice girl and slowly become like a complete weirdo”** (Meeting 2).

What Rosie referred to in the same meeting as otherworldly; *‘it’s like having an alien inside you.... it’s, it’s like something out of some sci-fi film’* (Meeting 2) - had very real impacts on her life:

“It was just like a downward spiral of psychosis it was horrible. It was *absolutely* awful it was the one of the worst things I’ve been through... **Cos to feel like you were losing yourself.** Especially at such a young age it was horrendous. It was absolutely horrible” (Meeting 2).

Subsequently Rosie chose not to use any form of hormonal contraception and was happily using condoms only at the time we met. Her GP, with whom she also had a personal relationship, supported her decision to discontinue. The severity of Rosie’s experience amplified the disparity between the ‘normal’ and the implant-using version of herself. None of the other narratives revealed anything as extreme as Rosie’s experience but, as mentioned earlier, her account alerted me to the meaningfulness of the impact contraception can have on women’s lives, theorised further below.

7.1.1 Identity crisis and the 'pill me' - re-situating 'side effects' within the realm of identity

In addition to Rosie, other women in the research described crises of varying degrees induced by contraception – circumstances that frequently situated their understanding of their 'contracepting self' as antagonistic to their 'normal self' – reminiscent of perspectives regarding the antagonism caused by the reproductive body and subsequent women's oppression (Letherby 1994; Granzow 2010). Mood swings, mental illness, personality changes, 'going mental' and psychosis; were some of the ways that these lived experiences were understood by these women. Experiences varied but the more distressing accounts were typically associated with how much the impacts subverted a woman from her 'normal' self - 'normal' 'natural' and 'real' being just some of the words that were used by the women in this research. During their lives fourteen of the fifteen women in this study had used 'the pill' and *all* had experience of hormonal methods, although two no longer perceived any contraceptive need. However, at the time of my fieldwork only four of the women were still using hormonal methods.

Despite the heterogeneity of the women's experiences, the majority contributed some material included in the analysis which informed this chapter. It was as a result of using LG analysis that it became clear that the most important relationship represented in these life history narratives of contraception use was that which the women had with themselves. The collective account drawn upon is relatively ahistorical and did not occur at any 'typical' time in their lives; the data revealed no 'typical moment' that epitomised their first experience of an unstable sense of self. Instead, the events are more united by their insidiousness; a gradual realisation about the 'different person' that contraception use, specifically its side effects, may shift women into being. In some cases, only acknowledged retrospectively.

For women, such as Rosie, Sam and Gem the story of subverted self was one of, if not *the*, central plot in their life histories. Identifying these changes, as they relate to contraception, was often impeded by the women's perception that a plethora of other life factors (time of life, relationships, life events) could feasibly have been responsible

for their experiences of subverted self. In this way, the setting for these events was often characterised by uncertainty, although I do not infer that these women are necessarily disadvantaged by this. Instead I use this term 'uncertainty' as a contrast to a state of knowing or understanding that they may prefer.

The pursuit to 'find', 'know' or even 'love oneself' is culturally familiar in a British context (Barker 2013) but is rarely conceptualised in the context of contraception use. Nonetheless a version of this narrative is what came through the accounts of the women's experiences. My interpretations have emerged from my own, and my participants', immersion within this cultural context. As illustrated in chapter 3, neoliberal approaches draw heavily on the concept of individually bounded selves replete with rational choice-making potential and an onus to behave responsibly. Control of the (reproductive) self is frequently interpreted as being available to women through contraceptive technologies (Granzow 2010). Furthermore, from a gender perspective, contraceptive practices can contribute to a culturally intelligible version of 'doing gender' (Cream 1995). Gender is also an important part of selfhood, frequently mobilised in the politics, discourses and activism of identity. Some of the ways these identities were compromised are captured and theorised in the following sections.

7.1.2 'To feel like you were losing yourself' - Artificial and aberrant selves
I drew on Rosie's experience to introduce this chapter, but the data revealed more than one account of 'losing oneself' in this way. Sam (28) told of her prior experiences with the pill:

"So I took Cilest for about 18 months and eventually I came to realize, because during that time I had sort of, *horrendously* bad PMT type stuff so for about a week and a half every month I would just be either very sad and sort of quite emotional and insecure and all of that. Or I would be sort of fuming with rage. And I, I didn't have *any* explanation for it. Erm, and I think because my partner at the time was the only person around, I kind of just went 'Well it

must, it must be him! It must be his fault somehow; I don't know why but it is!' Cos I really did feel like, really angry and **I'm not naturally an angry person, so, that was really weird.** And I *couldn't* work out what it was that was behind it erm, and then I eventually sort of came to realize that like, this hadn't been a problem until I'd started taking the pill. So, I then decided to come off the pill cos I didn't want to be furiously angry every month for the rest of my life.... **And everything is kind of, back to normal now.**" (Meeting 2)

And later in the meeting:

"When I was a teenager, I would quite often feel anxious, but not sort of angry. But this was like a sort of similar feeling in terms of feeling anxious, sort of really kind of frustrated and sort of stressed for kind of no reason but I was just really sort of angry with it as well. So I kind of thought, after a while I thought **'This is quite odd, I'm sure I didn't used to be like this.'**" (Meeting 2)

However, Sam's GP was not as supportive as Rosie's in responding to these disruptions:

"Well, when, sort of when I first wanted to come off the pill, he asked if I'd had any side effects and I said I hadn't had any *physical* side effects but it was affecting my mood. And he, he said, 'Well are you under any other kind of stress?' as if to say y'know, there must be another cause even though it's a, it's a quite a well-known side effect of a *hormone* based pill, that it messes with your hormones and that can affect your mood... I think that, I think that if you GPs priority was your overall health including your *mental* health it would seem sensible, if somebody is having a reaction to something that is harming their mental health, for them to have some time after it **to go back to normal...** But obviously, in that

instance, the GPs priority was more about managing pregnancy **than being concerned for me going back to normal**" (Meeting 2)

After having some adverse reactions to the implant too, Sam started using the IUS which was very satisfactory because it allowed her to be 'normal':

"So on balance it's been, it's been absolutely fantastic because I've just had *no* adverse effects from it whatsoever. Like none at all. **And everything is kind of, back to normal now**" (Meeting 2).

Sam's account is just one example of an attempt at doing the 'right thing' and using the pill – an experience that was far from 'right' for her. Through their contraceptive practices and the hegemony of pill use, most of the women in this research, fulfil/led the intelligible role of Cream's (1995) 'woman on the pill' at some point during their lives. In an extension of Cream's (1995) female intelligibility and building on preliminary theorisation from the last chapter, I suggest that contraception use can re/constitute more than the *female* subject. The concept of intelligibility can be understood as the re/constitution of *neoliberal* subjectivity too; where responsible behaviour and the 'willed pregnancy' (Ruhl 2002) are also realised through contraception use. Sam acknowledged this through the recognition of her GP's agenda ('managing pregnancy') despite difficulties with her contraceptive method. I differentiate this neoliberal intelligibility from the female intelligibility because as mentioned in chapter 3 and illustrated through El's account in chapter 6, the neoliberal subject and its characteristics are typically masculine (Roberts 1995) and thus oppose many characteristics understood to be inherently female. In this way, I argue that contraception is a technology for doing *both* of these subjectivities intelligibly i.e. using (hormonal) contraception re/constitutes neoliberal (masculine) and female subjectivities simultaneously—a paradoxical circumstance that creates significant challenges.

The social imperatives to be intelligible in both neoliberal and female ways may contribute to women's 'compliance' with a contraceptive regime, despite discomfort

with it. I suggest that in addition to their own personal reasons for continuing with a contraceptive method, the pressure of this intelligibility may come into play for women whose experiences don't, or haven't yet, caused *enough* upset to shift their practices despite the fact they would *ideally* stop or switch. Emma (aged 22) had used the pill for three years. A self-confessed worrier about the health risks associated with her method, Emma gave a fascinating account of her experiences. Rather than a *loss* of herself due to pill use, she explained it instead as though her body was a host for the contracepting versus the real version of herself, which were switched between:

"I used to be able to tell before I was on anything when I was due to start my period because I'd start feeling a certain way, and now those kind of feelings, it's almost like they're on a kind of schedule now so I know when I'm going to start feeling a little bit moody and I know when I'm going to probably cry on a particular day. So it's a bit weird cos obviously I know it's the hormones that are causing that but obviously **they're coming from a pill they're not coming from me**...if I showed you my packet I can say 'Okay so around the 16th pill I'm probably going to get really angry.'...You feel a bit robotic to be honest cos you can pin it down. It's really strange. It's almost like, sort of like there is a little switchboard and when you are taking the pill you're kind of dictating that you're going to feel a certain way on certain days and things like that and that does feel really weird. Cos **it's kind of like it's not just me anymore, it's me and some hormones that are a bit separate from me** but they are affecting me, and that's really weird. Really strange.... it's got a bit thrown off whilst I've been on my exams which was a bit disconcerting but at the same time it was bit kind of 'Oh hang on a minute, they're not in *complete* control, maybe I still have the mains' if you like; if I'm going with the robot thing still...It is weird cos it kind of takes away the naturalness of feelings and emotions."
(Meeting 2)

Although when we met, Emma was feeling able to cope with this artificial version of self she was also making plans about when/how to stop her pill. Her aim was to do this soon to reclaim her natural state, whilst at the same time, safeguarding her future as a mother (the main worry she had about hormonal contraception use). Concerns about compromised fertility also represent an aspect of identity that was specifically linked to being female. This can also be disrupted through contraception use as many of the other women, in the same way as Emma did, worry contraception will compromise future fertility. Emma indicated how even just a veneer of normality may be preferable to that which feels disconnected from normality:

“I wanted to have just kind of a regular monthly one cos that *felt* more natural rather than having kind of sporadic ones.... I was used to having that kind of regular cycle before until the stress and everything else kicked in when I started my exams and stuff, because I was used to having that kind of cycle for *me* it felt more kind of right to try and repeat that and sort of emulate that really, despite the fact that I was taking a pill to sort of, do it.” (Meeting 2)

Rosie's, Sam's and Emma's experiences reflect how women's sense of an individual self, so strongly emphasised in neoliberal and cultural discourses, was disrupted through contraception use. Therefore, I suggest that hormonal contraception may confer a tension between being intelligible (in female *and* neoliberal senses) whilst feeling disconnected from their respective individual selves. I assert that this 'disconnection from self' rationale for dissatisfaction with a contraceptive method may not be as relevant in cultural contexts where the discursive construction of individual self/identity is not as significant – for example in cultures such as Japan where collectivism is favoured instead (Imada 2012; Kawabata 2013). The neoliberal (masculine) emphasis on rationality and control (Ruhl 2002; Nadesan 2008; Granzow 2010) is further compromised as the women describe experiences of an almost hyper-feminine nature, akin to hysteria, including erratic behaviour, moodiness, oversensitivity and so on. In addition, the imperative to be *simultaneously* intelligible in

female and neoliberal senses, due to their inherently oppositional characteristics, is an impossible demand.

7.1.3 The Woman problem: contraception, female bodies and madness

Other conceptualisations of the feminine also shape contraceptive acceptability. The *visible* impacts of contraception, such as irregular bleeding and weight gain can subvert women's notions of self through compromising confidence and self-esteem (Higgins et al, 2011). In this way, these impacts created a twofold challenge – a threat to the woman's 'real self' and a challenge to how she is able relates to herself as feminine or as a woman.

When I met Chardonay, she was 37 years old and living in hostel accommodation. She was not using any contraception. Her story was one of chaos, including rape and abuse, alcohol dependency and multiple unintended pregnancies; most of which (she estimated 6 or 7) had resulted in abortion. She regretted these events and expressed shame about what she identified as socially abject behaviour. She described how she 'lost her virginity' through rape; an event that the police blamed her for, citing her 'provocative dress.' This seemed to set off a chain of disastrous events in her sexual and contraceptive life. Overall Chardonay's life history revealed myriad experiences of powerlessness and dejection. Despite having to deal with numerous unintended pregnancies /abortions, she did not identify a method of contraception that could have helped her avoid them. What *was* clear was that one of the realms in which she seemed to feel she had power, and could understand and value herself, was through her womanhood - specifically her position as a fertile 'producer'.

"I think I am naturally, just meant to progress and give birth to, give birth to babies and my body's just made to produce. But then without these substances, I think I'd have about 100. But, oh, it sounds bad doesn't it? But I know in my head, in my heart and in my head, that yeh, I could.... I feel like if I sleep with one man, I'll be pregnant the week after." (Meeting 2)

Although Chardonnay wasn't very voluble generally, the enthusiasm she expressed regarding her capacity for reproduction was obvious. Knowing this, the *meaning* of the impact of hormonal contraception to Chardonnay became clearer:

"I don't really want to start on the depo cos I know...I'll pile the weight on, feel like shit, I won't have my periods and **I won't feel like a woman. I just didn't feel human.** But I still have the effects the headaches, the stress, like I wanna' kill someone and the stomach cramps but I want bleeding but it's like it's not normal and then it took me 18 months before I gave birth." (Meeting 3)

This unwomanly-ness was realised when it took her time to conceive after discontinuing the injection – an experience that has deterred her from further use. Chardonnay linked her experiences explicitly to womanhood and other women in the study also described bleeding irregularities as problematic at some point in their contraceptive histories. Again, such 'side effects' have been widely characterised as factors that influence the acceptability of a method (Hoggart et al, 2013a; 2013b; Hoggart and Newton 2013; Kane et al, 2007). Certainly, they present practical challenges - need for sanitary wear, ruined knickers etc. But I also suggest that some of the accounts represented how bleeding irregularities may subvert the self as they disrupt a woman that is otherwise (more) confident and calm. This was described by Rosie in a way that made her anxiety clear:

"It sounds silly; it was quite stressful. Cos you can't, like y'know you worry about what you're going to wear. If you, say for example it's a really hot day and you're sat on a plastic chair for like 2 hours in a lecture and you, you're like 'Okay, does that feel a bit damp because it's hot and I'm sweating? Or does it feel a bit damp because I've just started bleeding? And I'm wearing jeans and my jacket's not long enough to cover my bum and I don't want to stand up.' And it'd get to the end of the lesson and I'd be like 'Oh it's okay, I'll catch you guys up.' And it's like, people are like 'Why, why don't you just come now?' and I'm like 'What if I stand up and there's

blood everywhere and you are kind of trying to check without being really obvious' and it's like, it's just. Cos I get really panicked about stuff like that and I'd just really panic." (Meeting 3)

A self-conscious version of 33-year-old Megan was manifest in relation to issues around her weight and skin, both of which had been altered (for worse and better) through pill use. A highly educated woman and self-defined feminist, Megan identified how these aesthetic issues are also intrinsically linked to women's identities:

"Well you always think that people, when they see you as a woman and there is this thing that there is this whole culture of being women being obsessed with being thin and that's not *me*, I'm not interested in that at all so I felt like I was going and I was being read in a certain way...I'm quite small anyway but I felt, I had observed the difference in that, my boobs had got bigger, which was bizarre. I had to buy new bras and new clothes because they weren't fitting me round the waist and it might not have been weight, it might have been water retention or bloating or something but something very, to me, **I didn't feel like me.**" (Meeting 3)

Cara, aged 21, characterised herself repeatedly in relation to her femininity; her interest and investment in the feminine being communicated through comments about her beauty regimens, fashion and embodied in her glamorous appearance. This pride she so obviously had in herself and her sense of femininity was being compromised by weight gain associated with implant use. She described an ongoing 'argument' with providers who responsabilised her for these experiences, whilst dictating the terms of her 'fat-ness':

"I've had the arguments with the doctors and they say there is no evidence whatsoever, whereas with the injection, there is evidence that you put on weight. She said, 'You putting on weight with the implant is basically, the food that you put in your mouth, that's your decision and there is no evidence to say it makes you want to

eat more and stuff like that.’ But I just look at it is, I’ve never, well, I’ve only been back to the weight I was when I was 17 when I’ve been y’know, working at it, hard, and obviously I know you can’t not go to the gym and eat everything and expect to not put weight on *but*, it’s always been harder. But she said to me, ‘Look you’re not fat and I wouldn’t say that you’re fat and you’re not massively overweight,’ she said ‘If you’d put on like 5 stone, since you were 17 and you could never get to that then I’d understand.’” (Meeting 2)

This account, and those of Chardonay and Megan represent a clash between living Cream’s (1995) female intelligibility whilst simultaneously feeling ‘unwomanly’ due to bodily changes; changes that reflect intrinsically female characteristics such as fertility in Chardonay’s case (bleeding) and body image (weight gain) for Megan and Cara. Thus, once again, practices that confer intelligibility can be seen to *simultaneously* challenge female and/or neoliberal subject positions. The resulting dissonance can contribute to an ‘identity crisis’ which may lead to discontinuation of, or anxiety about, a method. Where neoliberal and gender norms contribute to a woman’s sense of ‘doing the right thing’ when contracepting, the actual experience can challenge expectations of what it is to be a woman in neoliberal Britain.

Gem referred to the ‘pill me’ as cited in the title of this chapter and her account clearly illustrated the struggle to differentiate between this contracepting version and what she understood as her normal self in the non-contracepting state. At age 19 (now 22), Gem got unintendedly pregnant and had an abortion – the experience of which was degrading and distressing for her. This pregnancy resulted from inconsistent pill use, something that Gem linked to her anxiety about her ‘mood swings.’ Contraceptive providers did not offer any supportive response to Gem’s issues so she ‘just stopped’:

“I went on to Microgynon and it, and I was on that for about 2 years I’d say...I personally don’t think it agreed with me and I don’t know, when I went to the doctors anyway and said ‘Look I’m having really bad mood swings’ and stuff like that she said

'Well I don't think it'll be your pill but we'll change it anyway' and she put me on Cilest. And that was, that made me feel worse, if not the same...I've come off it now...so I feel a lot better but I don't know whether that is because I've come off the pill or because I've got things to look forward to...I still get like moods obviously like you do but I feel completely different inside. It's strange cos like, I felt like I couldn't control it and I'd be dead teary all the time and now I don't feel like that."
(Meeting 2)

Gem stressed explicitly that this fear of, and confusion about her 'pill me' was the main issue in her contraceptive life history:

"I think the main thing would be the pill and my fear that it was causing me mood swings and I think that's the main thing I wanted to get across cos it's like I've never had a chance to see if it caused that because obviously it feels like ever since I've had a period I've been on it or I've been taking it. But it seems to have got a lot worse since I have been in a long term relationship and that's when I've been using it more frequent but I'm not sure if it's all in my head which is why I kind of need this break to see if it is or not." (Meeting 3)

Although Cara volunteered accounts of the visible impacts the implant had on her weight and bleeding patterns, she also gave a detailed account of what she described as a 'Jekyll and Hyde' identity:

"I was so much more confident and like, I'd say mouthy in a way and bubbly and like not care, whereas now I'm a constant worrier and I think that, that's the big difference. I think it's more to do with, before I had the implant I was just like in and out of relationships, didn't really think into things

that much, that serious, whereas now, it's a bit like 'I wish I could go back to being so'...I don't know whether I can say 'Yeh, my mood's changed because of the implant' but I do think it will have something to do obviously with the hormones. But in a way, another thing that's, I wouldn't say scaring me but stopping me from having the implant out... I think because I've had it for 4 years, what if I take it out and I end up running round the streets, I just completely, not that extreme but that something changes and then it's like, if I don't like that then having it out, that up and down y'know...I mean I'm not saying it will be completely like I am a Jekyll and Hyde or anything, completely drastic but in a way I could be much more relaxed and less of a worrier so that makes me curious to, y'know, see." (Meeting 3)

This uncertainty contributed to Cara's reluctance to discontinue her method. Many of the other women were similarly unsure if they could attribute their experiences to contraception with any certainty and therefore delayed taking action. In the case of bodily effects that influenced the sense of self, Megan's account clearly indicated how certain concerns (weight gain etc.) were dismissed as 'typical' female hang-ups. As such, I suggest that female stereotypes mean that women's anxiety about method impacts are considered as an extension of this inherent irrationality/hysteria and thus similarly 'intelligible' - by wider society, providers and users alike. Hence responses to these (typically female) impacts are delayed or entirely absent.

7.1.4 More than a 'corporeal dilemma': holistic impacts of contraception
Contrary to other literature that has identified a disconnection between a woman and her body - a '*corporeal* dilemma' (Williams and Bendelow 1998; Petchetsky 1995) - the accounts of the women in my research were dominated by the subversion of what they described as a much more holistic version of self, encompassing amongst other things; the female, the sexual, the 'normal' individual self, the body, emotions/mood. Where the impacts were understood in *non*-physical terms by the individual, such as

in Rosie's account of her 'psychosis', the effects were also acted out on the body through self-harm. In others, such as Gem's, there were angry tears; while Sam 'fumed with rage' – all speaking through embodied descriptions of experiences that were otherwise a product of the (irrational) 'mind'. Conversely, Chardonnay's bleeding irregularities were explicitly seen by her as a threat to her female identity; while Megan and Cara's weight gain caused distress. Thus the 'mind/body' experiences were frequently indivisible but more often than not described by these women in *non-corporeal* terms through their use of the language of madness (mood swings, psychosis etc.).

The sexual self was also compromised for some of the women in this research through hormonal contraception use. Admittedly, condom use was the method attributed by most of the women as detrimental to their experiences of sex, but some accounts also showed how sexual subjectivities were part of their conceptualisation of 'normal' selfhood. As with other effects described in this chapter these were characterised by an (often tentative) realisation over time. One third of the women participants mentioned sexual impacts through use of hormonal contraception in ways such as this:

"Also, it [IMPLANT] had removed my sex drive completely (which I suppose makes it rather effective as a contraceptive) and left me feeling generally numb. I can only describe it as a kind of low level depression. I had little energy and no real interest in doing anything (Sam, Excerpt from Map)"

Linking the previous sections together, I suggest then that instead of the 'separative self' in a binary mind/body sense as characterised by de Beauvoir (1977), contraception may induce a separation between multiple subjectivities. Earlier I described the 'identity crisis' caused by the competing interests of neoliberal and female subjectivities but there are other selves, other subjectivities that could manifest through contraception use and compete in this way. As with other impacts, these were realised slowly over time with the women steadily beginning to question their contracepting self against what they perceived to be their prior 'norms.'

Although part of the wider self, and overlapping with the demands of the normative female, I suggest the sexual subject is another subjectivity that may compete when either 'liberated' through contraception use as Helena illustrated through her narrative in chapter 5, or 'removed' through contraception use as illustrated by Sam's excerpt above. Of course, the separation/s or competition between these subjectivities does not manifest in every instance of contraception use; and even if it does, not necessarily in a problematic way. However, any experience of dissonance and subsequent distress, is problematic. So, whereas de Beauvoir (1977) suggested the 'separative self' would benefit women, some of the experiences induced by contraception in this study instead created a version of a woman which she was unhappy with; a contracepting chimera of sorts that comprises the 'normal' and contracepting selves. This experience could make an individual woman feel very disconnected from her sense of 'real' self. Therefore, I suggest harmony between these selves ('normal' and contracepting) when using any method may confer greatest acceptability and hence the best outcomes for sustained use in practice. Thus, the desired balance, although inherently personal, is shaped by the female (sexual) and neoliberal norms of the wider context.

For this reason, an important factor in the formation and experience of the contracepting self is the way in which it is constructed through social and political influences; this will be discussed in the next section which introduces another type of disconnection – that between the self as a contraception user, and the provider of contraceptive services.

7.1.5 Contraception as natural state

Contrary to the value a *woman* may place on her natural self, in clinical practice settings contraception use *is* conceptualised as the norm and provider's determination to maintain it was not overlooked. Sam, who conceptualised the lack of opportunity to know your natural self as inherently risky, frequently reflected this tension in her story:

"I think that is sort of the problem that I had with some of the doctors when I wanted to come off the pill and when I wanted to come off Implanon. There was sort of this sense of 'Well if you're not gonna do that what *are* you gonna do to, y'know, to take care of it?' And I was like 'Well actually if it comes to it I just won't have sex.' If that's what it comes to, if I really can't rely on anything else and everything else is messing up my mental state then, then I have the option to manage pregnancy in a number of ways." (Meeting 2)

"(Then) when I had it removed it was quite straight forward having it removed and the, the doctor said, the doctor asked me what form of contraception I was going to be using. And I said 'Well I'm not going to be using any kind of contraception apart from barrier contraception, apart from condoms,' 'Well, you do realize that there is an increased chance of possibly falling pregnant if it splits and blahblahblahblah.' I said 'Yes, Thank you. Yes, I'm aware of that, thanks but **I'd like to go back to normal now thank you.**'

R: "And did you feel that he was happy with your feelings about that?"

"Well it was almost like, y'know when you sort of hear an advert on the radio and at the end of it is' like 'Terms and Conditions apply,' It was kind of like that as if he felt that he had to warn me, that if I didn't use condoms correctly, I might get pregnant. So like a bit of a stock response to condoms. And it was, it was almost like I kind of *had* to be using some form of contraception" (Meeting 2)

It was clear that the notion that (hormonal) contraception *should* be used was dominant and assimilated into the practices of women. Megan identified contraception use as 'background' to women's everyday lives:

"I guess there's objectives of, public health has objectives of reducing this, that and the other that we all think is a good thing. But what I guess what's lost in that is that people are, it becomes very early naturalised habit to take the pill and then you're 33 and you think 'Shit, I've been taking the pill for 17 years, what does that mean in terms of my body and my health?' And I think, I do think that it's interesting that they do, they always just offer you another kind of contraception not a discussion about y'know, other methods" (Meeting 2)

Cara's thought provoking comments about her Jekyll and Hyde earlier in this chapter indicated her concerns about implant use and she expressed the priority of contraception providers in the same captivating style:

"I've still got another 2 years- so maybe when I have it taken out I'll have a break rather than have another one put straight back in. So, the way of that is kind of strange like, I can't explain it like, they take it out and put it straight, y'know like you're a, I can't explain what I mean. Cos obviously I wasn't sure when I had to have it, when the 3 years had finished, if she would take it out and make me another appointment but she literally took it out and quickly, y'know like, like a battery really. That's what it kind of felt like, like 'You can't go for more than a bit, it has to go straight back in,' cos I'd said 'Do I need to make an?' 'Oh no, as soon as I take this one out another one is going straight back in.'"

R: "Okay, so, that was like right there on the spot so can you tell me about, so you are saying that found like a bit of a replacing of batteries or whatever?"

"Yeh in the sense that, like keeping you in something that you *need* it was kind of like the norm to them like 'Quickly, get another one

back in and off you go.' I can't explain it 'Otherwise you're not going to work if you don't have it put back in.'" (Meeting 3)

The provider perspective – contraception as a natural state- is present in broader discourses and represents the normative right and responsible. Joanne acknowledged this whilst musing on media coverage of contraception and sexual health:

"Everyone always assumes that you're on the pill. There seems to be an orientation towards this assumption that you are on the pill and that you would only use condoms cos you were in a non-long-term kind of setting. I feel like that's an orientation. Actually even when you just converse with friends, that's what people orient to I think.

R: So you're resting normal state is to be-

-on the pill. Which wasn't mine. So that always felt a bit like, all those articles were irrelevant to me cos that wasn't the route I'd chosen so that's the only thing I can think about. But that's not really a trend it's like an assumption. 'Here's this effective contraception I'm *presuming* you are on it.'" (Meeting 3)

The comments of Sam, Megan and Cara, and others like them identify disconnections between providers and contracepting women. First, where the women were seeking their version of 'normal' or 'natural,' providers were likely to conceptualise contraception use as that 'normal' and 'natural.' Although in this research the narratives represent women's perspectives of their providers, it supports work by Beynon-Jones (2012) with abortion service providers who identified contraception use as a 'naturalised' state. Of course, many women described very supportive experiences with providers on occasion, but overall the collective account reflected how they clearly perceived their own agendas for contraceptive health and wellbeing, to be disconnected from those of their providers. On multiple occasions women even

mentioned 'cost-effectiveness' as a driving factor behind being directed towards certain methods, which contributed further to feelings of distrust by the participants in the user-provider relationship.

Thus, the narratives highlighted how providers, embedded within a biomedical framework which is in turn located in a neoliberal context, also drew heavily on the intelligibility of contraception use and compelled women to occupy this position accordingly. Although this represents, on one hand issues of knowledge/power and is an example of medical disciplinary power meted out in contraceptive practice (Ruhl 2002; Nadesan 2008), I suggest it is also rooted in what I theorise to be *another* incongruence between feminine and masculine epistemologies broadly speaking. Not only is the neoliberal subject inherently masculine, but so too are biomedical frameworks that draw on (masculine) rationality through their preoccupation with measurement and evidence-based medicine. As a result, women seeking support for 'hyper-female' experiences such as contraception may frequently struggle to have their needs met. As such there is a disconnect between women and providers due to the inherent masculinity of provider approaches versus the intrinsically female contraception users. In addition, when experiences are unsubstantiated by the 'evidence base', as in the case of Cara's weight gain for example, this may confer a precarious position in which women, feeling unsupported by providers, may stop, or wish to stop, using their method. This is problematic for the provider, incongruent with the epistemological perspective dictated by evidence-based medicine and their practice training to confer a contracepting state; and thus lends itself to further tension with contraceptors.

A recent critical review of existing literature regarding contraceptive discontinuation acknowledged how 'rational' evidence based medicine may indeed be incompatible with the needs of contracepting women (Inoue 2015). Similarly, Glasier (2008) had already identified how women's attitudes don't necessarily change with 'accurate' i.e. clinical evidence based, information. These findings are supported through the narratives of the women in this research. Instead of critiquing what constitutes 'accurate information', I suggest instead that the biomedical model is too reductive to

harmonise with the multidimensional nature of contraception use and its meanings which, as I have illustrated so far in this thesis, represents a matrix of competing discursive and physical imperatives located at individual and structural levels.

7.2 (Re) making/taking contraceptive control

Although I have so far largely interpreted the women's accounts through a discursive lens, particularly with reference to female and neoliberal subjectivities, the data also indicates the possibilities for agentic practice. In ways suggested by Maxwell and Aggleton (2010; 2012) which draw together the discursive and the physical, the women in my research re/made a version of 'control' through feeling connected or making efforts to connect with their bodies; and seeking *their* most acceptable version of self.

7.2.1 Becoming knowing

There are various ways that the women participants made efforts to 'find' this acceptable self; experiences that I understood to link closely with notions of 'control' - another concept characterised in the literature but rarely interrogated. I understood that lack of control in this case meant that the real self had been subjugated by the contracepting self. Gem spoke about her efforts to (re)take control and after her abortion she had strong commitment to avoiding unintended pregnancy. Conscious of the effectiveness of hormonal contraception, Gem wanted to better understand the extent to which it impacted her 'normal', and then she could make a (knowing) decision to return to pill use if she decided it was unproblematic. She described this agentic practice - a pursuit for this knowledge:

"I feel a *lot* more in control of my mood. But I didn't know whether it's because that is in my head cos I came off that pill *hoping* that it would change my mind and *thinking* that it will because I, if you think about it when I was on the pill I used to think that it was that that was causing my moods so since I've *thought* that I've not been as bad on it or anything like that and I think since then, I've

been like, what the word, I have been able to control it, yeh. But I don't know whether that is me just *thinking* it has. I don't know and it's not, I don't know if it's got nothing to do with my pill or not, but even if it is in ma head, I'm happy with it just being in my head and it not actually being a thing cos it's *working*.... so even though I dislike having added hormones which I probably don't need, if I thought, if I was still going to be this moody with taking the pill, well with not taking the pill, I'd probably take it anyway. Cos I'm gonna be like it anyway. So that's probably a bit more convenient for me to take it. Maybe I probably, if I knew *now* that it wasn't the pill then maybe I would go back on it.....But I need to give it a longer time yet because obviously as I was coming up to the end of Uni and stuff I was *really* stressed anyway and I felt like I was going through so much stuff then and like now, I'm not... So I'm thinking of staying off it a bit and when I get back off holiday and I've not got stuff to look forward to, whether things will be different." (Meeting 2)

Although relatively unimportant to Helena herself in the context of her overall contraceptive life, she described how she sought an entirely hormone free option, the IUD after using other methods (injection and pill) that she perceived to be detrimental. She articulated concisely how it became time to locate her real self and how this conferred her choice of method:

R: "So can you tell me more about the experiences that you've had that you think are related to hormones?"

"Just emotionally. I just felt all over the place... I just thought, well its logic that if you do push hormones into someone then they're going to be affected in many ways. I mean, weight gain is obviously a big one for many people who don't want to deal with that. And I was affected in weight gain as well. I just, I didn't feel, I **wanted to**

be honest to myself. When I finally went for the IUD I just thought, 'Let's strip everything back, see who you actually are.'

Yeh, and I'm glad that's what I did. It's brilliant." (Meeting 2)

Similarly, Megan embarked on an experiment over a 4-month period to address her weight change (diet and exercise based) and also to understand her contracepting-self better before confidently taking control by arranging a pill change. Alternatively, for others, tentative plans were being made to start the process of knowing and to take control through stopping the method. In Cara's case for example, she had visited the GP on two occasions with the intention to have her implant removed although on both occasions she talked herself out of it, with the encouragement of the doctor. Thus some women's narratives revealed agentic practices in which, catalysed by method dissatisfaction, they took control back from providers through their own 'experiments' and method switching. Therefore, although 'stopping and switching' is inherently problematic from a provider and public health perspective, for women these actions may represent a positive and pro-active approach to their health and wellbeing – representing another tension amidst provider-user relations.

7.2.2 The known self is the (most) acceptable self?

Around the time that I first met Rosie, I also met Joanne; another encounter that was also instrumental in consolidating my thinking around the meanings of contraceptive impacts. However contrary to Rosie's 'out of control' narrative, Joanne's account revealed how the time spent *knowing* herself using a natural method of contraception which afforded her a confidence in differentiating between her normal and her contracepting self. Joanne's narrative was characterised by confidence and capability. She described herself as a 'born researcher' who had investigated the ways that she could manage her reproductive self from an early age. Thus, from Joanne's first experiences of sex, she was knowledgeable about available methods. It was after some challenging experiences of pill use as a younger woman that Joanne started to use Persona as a method of contraception. Persona is a brand of fertility monitor used for contraceptive purposes that measures hormones from urine samples to determine the safe windows in the menstrual cycle when there is no risk of pregnancy; and

conversely indicates the need for abstinence or barrier methods during fertile times (see <http://www.persona.info/uk/index.php>). Her experiences of this method also led to increased self-awareness, although she noted that this was not the original intention. Now aged 36, Joanne reflected on that experience of knowing:

"I actually think that everyone should have that self-awareness of their own cycles. I think that lots of people struggle to have children because they don't have that awareness of their own cycle so it's a practical thing in that. But I just think it gives you more choices if you know yourself better. It could be the case that actually you don't have a very regular cycle so; but that would change the choices that you make. It's also self-awareness about how your cycle influences your mood and things. I think if you know where you're at you can start to look for patterns of things and that can change how you look after yourself as well. Yeh, I really still value knowing where I am up to with it. Even though I don't use Persona, I just know the patterns quite well because they were established over time...I guess I am also more aware of when I am willing to take a risk or not. So there are certain points when it just wouldn't be an option to take a risk, whereas other times I just think 'Yeh, actually.' So it's got like a long term impact of having more choice as well. And I think in some ways that's why I didn't like going onto the pill. Cos it didn't feel like I was used to it feeling." (Meeting 3)

Joanne's account illustrates the control associated with the known self; allowing her to gauge contraceptive impacts and make method choices accordingly and when to avoid any risk-taking. This suggests that a meaningful version of control can be reclaimed and reconceptualised in a women-centred way. This contrasts with versions of masculine co-modified 'control' and/or that which subjugates the fertile body to the autonomous mind (Petchesky 1995; Ruhl 2002). Joanne understood her 'real self' and therefore was confident if/when a method had impacted her unfavourably. Subsequently this allowed her to '*change how she looks after herself*' (Meeting 3) which

gave her more options and better opportunities for sustained method use. She also noted how the nature of her 'normal' also changes over time, but still indicated that she was confident enough in what she understood as her normal self to be able to determine any deviation even as it evolved. She even mobilised methods for non-contraceptive purposes (mood) and to her (self) benefit. Thus, she used her knowingness to achieve the outcomes she wanted in what could be argued as an example of ultimate control:

"And I had another pregnancy but that was planned. But again, I'm really, really aware of my own cycle, so I just tried once and I was pregnant...I looked at my contract and looked into the policies and worked for them for a year and then I'd worked out my full cycle and due dates and months I would have fallen pregnant so it fitted in with the training cos it was quite an intensive training and then a month before that I had circled to try we were just like 'Oh fuck it,' it's only next month anyway we won't bother. And I was like 'There's a strong likelihood that I will fall pregnant' but I was just like 'What's one month earlier?' And so then I fell pregnant."
(Meeting 2)

In relation to the benefits/risks of knowing, Sam also conceptualised the (un)knowingness as a potential risk, especially to young women:

"Obviously for me it really kind of, it messed me up on while I was on them [PILL] and fortunately it didn't have any lasting effects that I'm aware of, I don't think! But I think sort of, young women who start on the pill at, particularly at, the idea of using the pill to control periods I think is really quite dangerous. Because you've got young women who are getting a sudden influx of hormones *anyway* because they have recently started puberty and their bodies are changing a lot and then you introduce another set of hormones and then for some of them that will be their state for

their whole life because **they will never, they will never know what they're like as an adult**, as somebody that has gone through puberty without having the pill. Cos a lot of women will stay on the pill for the rest of their life and I think that, that's really quite sad...if you've got a 14, 15-year-old girl, who feels that angry and confused and doesn't know why she feels so angry then you can kind of see why some teenagers go completely off the rails, you know. **It's a lot to deal with if you've got no idea that that's not normal"**

(Meeting 2)

Finding, knowing and/or accepting may be an end-point for women who experience impacts events such as those reflected in this chapter. Women like Joanne can feel comfortable and sure about their selves – contracepting or otherwise, and in this way, negotiate their contraceptive lives feeling in control and satisfied, responding to any impacts accordingly.

The importance of control for contracepting women has been identified in the research literature (Hoggart and Newton 2013) but the concept itself has been rarely interrogated. I noted that the women in my research drew upon the notion of control regarding contraception far less than I had expected. However, they also described many situations where they had resisted, challenged or experimented and how they sought to (re)take control. Whilst Joanne came to her knowingness unintentionally, after trying a natural method, Gem and Megan pursued this knowledge through experimentation despite provider protests and Helena drew on her embodied knowledge, going with her instinct of '*I don't want any hormones anymore*' and acting on that.

These events resonate with Maxwell and Aggleton (2010; 2012) who link connection to, and sensate experience of the sexual body, as integral to agency. For the women in my research, the praxeological aspects of embodied knowledge making/connection to their (fertile) bodies can be understood as agentic practices. Where often the women spoke in a passive voice regarding contraception e.g. 'I was put on the pill,'

efforts at self-knowing were described in a much more active voice 'I did' 'I decided'. As Joanne's account illustrates, this affords a (more) powerful position from which women can make decisions about methods, recognise adverse effects and be trusting of themselves. Hence, being critical of the intelligible female subject position by not unquestioningly occupying a 'woman on the pill' role can offer an opportunity to experience a subjectivity that is 'real,' in that it is not borrowed from a discursive construct such as the normative female or the neoliberal subject position.

One of the crucially important factors that is often overlooked in policy and practice culture, but which was evident in many of the life histories in this research, is that contraception is not a 'life saving drug.' Despite myriad benefits, it is not therapeutic and arguably even a 'lifestyle drug' (Watkins 2012). I suggest that this characteristic affords women the possibility for (more) agency through scope to 'experiment' and resist in any way they deem necessary without ill-health in the same way that cessation of other drug regimens may incur.

7.3 Counter narratives

For the purposes of rigour, it's important to be transparent and to mention the material that challenges the chapter's central argument i.e. that 'side effects' have deeply meaningful impacts on the intrinsic sense of self of a contracepting woman and need to be reconceptualised in a way that takes account of their importance. In the same way that a woman may experience her contracepting self as unacceptable, other material highlights how the best fit version of contraception can in fact act to: enhance a woman's selfhood; improve confidence; improve 'mood'; improve body image and facilitate a more expressive sexual self. While these experiences were shared less frequently by the women in this study, there were nevertheless some good examples of how the contraceptive self may be a (more) acceptable version of self. For example, for Helena, contraception has facilitated a more sexually assertive version of herself:

"I think contraception in itself allows you to assert yourself more because you're not dealing with an anxiety that would come from,

becoming pregnant. Because obviously, if you, if you bring that into the bedroom in any sort of intimate play, then it's gonna hold you back so it aids you in asserting your sexuality, that's what it does for me." (Meeting 2)

For Angela, who suffers from depression linked to hormonal imbalances, the implant conferred a more stable version of self:

"There have been times when I have taken the long term, like whilst I was on me implant my depression was better. Erm, but that was because I wasn't having surges in hormones that would cause my PMT." (Meeting 2)

I argue that these benefits, as additional imperatives to sustain use of contraception, would also be most appreciated when women have a good understanding of their so-called 'natural'/'normal' self. As such, the known self could offer opportunities to determine the full extent of the benefits of different methods and *encourage* use as much as it could facilitate the identification of unfavourable impacts and provoke a method switch – both situations ideally leading to best-fitting sustained method use.

What was also clear from the material, as highlighted previously is that very many factors may be influential in the subversion of self - including pregnancy. This consequence of *no* contraception use can also shift and change perceptions of the desirable feminine self as highlighted by Gem:

"I wouldn't want to get pregnant now is that I'm still young obviously and I wouldn't want it to change my body and I'm a bit, conscious of my body changing cos I know it will cos I know I'm prone to, I'm *bound* to get stretch marks and stuff like that. I'm just not ready yet. I've not spent enough summers in a bikini yet to have a ruined body. And I'm not yet ready to love ma stretch marks." (Meeting 2)

Whilst acknowledging as do users and providers, that myriad factors could be influential on contraceptive sustainability, I assert that the most important factor is that if a method *is* perceived as (one of) the factors subverting the self, this can result in very real shifts in contraceptive practices with very real results.

There are other shifts too at a wider contextual level that also shape women's experiences. These will be explored in the final substantive chapter, next, which will consider changes throughout the women participant's lives and over (historical) time respectively.

Chapter 8 – Collective voices: Interrogating ‘progress’ in contraceptive technologies and practice over time.

Dotty: like I said there was no other choice. Like maybe if there had been the implant or whatever else was around then, then I would have probably had that. But there was no other choice. There was a different pill or nowt (Meeting 3)

Dotty defined her young self as ‘clueless’ and conservative in matters related to sex and contraception due to her strict Catholic family home and schooling. Despite this, it appeared that the main restrictions on her contraceptive practices related to the limited options available to her as a younger woman. By the time we finished our meetings, Dotty was aged 45 and she looked back with wonder on the transitions in sexual health and cultures that she had observed since she was a young woman growing up in a small Northern town in the early 1980s. The chronology of her early experiences with contraception relate to a period when options for methods and access were much more restricted than they are currently (see the contraceptive historiography in chapter 2). Although of reproductive age, Dotty no longer perceived a need for contraception herself due to polycystic ovary syndrome (PCOS). However, in her job supporting young people including with their sexual health she was party to insights into contemporary contraception use which she found ‘frequently shocking’.

Starting from Dotty’s early experiences in the 1980s, this chapter presents a collaborative story that seeks to draw out the shifts, or lack thereof, in the contraceptive context that have taken place in the 30-year period captured within this study, as perceived by the women participants. This includes the proliferation in contraceptive technologies and the lived impact of policy changes. My LG analysis highlighted another key relationship that underpins this chapter - that between women and medicine; more specifically, with the contraceptive gatekeepers that mediate or limit the terms of use. Through these accounts assumptions of ‘progress’ can be troubled as the women’s experiences expose the fallacy of contraceptive choice. Their narratives revealed how the service delivery environment circumscribes

a woman's ability to freely choose despite 'surface level' markers of progress, such as increased method options and accessibility.

Due to its emphasis on temporality, dates are noted in this chapter where appropriate, to assist in situating time shifts. These are mentioned either in the excerpts themselves or in the brackets after the individual accounts. Where they were not specified, they are represented as 'circa' (eg.c.2008) based on my calculations drawn from the available information, or as no date (n.d.) if the comment is non-specific or there were no markers of reference. First, however, I discuss the shifts within individual life courses; a circumstance that was, relative to the wider contextual shifts, distinctly incoherent.

8.1 Contraceptive practices over time

As arguably expected the older women in the research noted most 'change over time'. These observations were typically related to macro-level factors such as socio-cultural approaches to sex (increased 'open-ness'), access to contraception and method options. However, despite the shared context of all the women in my research (post-pill era Britain) and similarities in the description of context made by women of similar ages (such as Dotty and Kelly who both noted the shifts in access and open-ness) the women's *individual* lives were very diverse and reflected few similar life stages, critical junctures or transitional events that I could identify as instrumental in shaping contraceptive practices. In contrast to the relative consistency of their experiences with the wider service delivery environment over time, the women's individual life events were as diverse as their relationships, feelings towards methods and so on. As noted in chapter 6 (section 6.2.2) the stories generally challenged the assumption that contraceptive practices are linked to fertility intention, rather they support recent literature that indicates the importance of attitudes to contraception itself (Bruckner et al, 2004; Borrero et al, 2014; Wellings et al, 2015).

Of the fifteen participants, only two women’s first efforts to seek contraception from a provider were linked to the time they started having sex. The most consistent method use, captured in Figure 8.1, was that no contraception or condoms only, were used at first sex.

Name	Age first sex	Contraception at first sex	First Contraception Age	Status at first contraception seeking	Reason	Method
Angela	13	None	14	Already having sex	Period regulation as ‘excuse.’	Pill
Cara	14	Condoms	17	Already having sex	Post-abortion	Implant
Chardonnay	13	None	13 (DENIED) and 15	Not having sex	Post-rape	Pill
Chloe	14/15	None	13/14	Not having sex	Peer group activity.	Pill
Dotty	16	None	16 (DENIED) and 17	Not having sex	First sex	Pill
El	16	Condoms	16	Already having sex	Condom break. More reliable method sought.	Pill
Emma	16	Condoms	18	Already having sex	Period regulation as ‘excuse.’	Pill
Gem	17	None	16	Not having sex	Sought for breast growth.	Pill
Helena	17	Pill	17	Not having sex	Prescribed as a precaution due to acne medication.	Pill
Joanne	16	Condoms	17	Already having sex	Move to UK facilitated better access to contraception. More reliable method sought.	Pill
Kelly	15	Condoms	16	Already having sex	Relationship.	Pill
Marie	16	Pill	16	Not having sex	First sex	Pill
Megan	14	Condoms	19	Already having sex	Relationship.	Pill
Rosie	14	Condoms	15	Already having sex	Partner violence	Pill
Sam	14	Condoms	21	Already having sex	Relationship.	Pill

FIGURE 8.1 – FIRST EXPERIENCES OF SEEKING CONTRACEPTION

As Figure 8.1 illustrates no ‘typical’ event precipitated first contraception use and the circumstances that instigated shifts in contraceptive practices further to first method use across the life course, were similarly diverse. At most, changes in ‘relationship type,’ i.e. whether the relationship was casual, long-term etc. inspired a method change, resonating with other evidence about ‘contraceptive scripts’ (Conley and Rabinowitz 2004). These relationship changes, however, did not correspond to any specific age or time of life which perhaps reflects the increasing shift away from more traditional patterns of sex, childbearing and relationships highlighted in chapter 2 (ONS 2013; Gillespie 1999; 2003; Everywoman 2013; Marteau 2013).

However, the narratives did highlight the influence of women’s individual histories, specifically in relation to previous methods used. For instance: Rosie, Sam and Helena’s method experiences with mood changes put them off *all* hormonal contraception; others such as Megan and Emma were unlikely to use hormones again if, and when, they stopped their current method due to a discomfort with the (unknown) impacts; Joanne vowed never to use the pill again after her experience of extreme sickness; Marie would never use IUC after her IUD was spontaneously expelled; Chloe wouldn’t use the implant again after irregular bleeding or seek EC

because she felt so humiliated by her pharmacist's practice. In none of these cases were these impacts responded to as 'valid' from a clinical perspective i.e. they were not reified in evidenced based medicine but nonetheless the circumstances made real impacts on their current and future decision making about methods. In this way, the majority of the women in my research had their options circumscribed by their own life/contraceptive experiences.

These events reflected the importance of knowledge made through the body; supporting other research regarding embodied experience in relation to contraceptive practices (Hester 2005). This suggests, therefore, that the use of life course models as suggested by the Department of Health (2013), could in fact act to narrow responses to women's experiences with contraception; especially as women increasingly adopt non-traditional approaches to sex and relationships and conform less to pre-defined life stages. The response of providers to women's historical experience with methods, however, does depend on myriad factors including the women's status and stratified reproduction (see chapter 6) but also the available methods and practice culture at the specific site and time. It is these situated experiences over time that will be discussed for the remainder of this chapter.

8.2 Methods and practices, past and present

The experiential and embodied knowledge mentioned above was valuable to the women in this research and was also liable to be re/made at any time of life. Historically, 'expert knowledge' has been valued over women's (embodied) knowledge and paternalism, framed as 'for her own good,' has characterised medical practice (chapter 3). Despite the neo-liberal rhetoric of responsabilisation and onus on the individual, the next section indicates how (state) paternalism is not obsolete, but has instead subtly evolved. I illustrate this, by describing the shifts in contraceptive technologies and provider practice as experienced by the women in this research over a period of 30 years

8.2.1 In the beginning there were condoms and the pill.

Kelly (aged 45) described similar circumstance to Dotty (aged 40) at the beginning of this chapter. Hailing from a small town in northern England where she was resident in the 1980s, Kelly also noted the limited method options available. For her, the proliferation in condom types, corresponding temporally with the campaigns post-HIV/AIDS, was a welcome addition to her sex life:

“He [DOCTOR] explained to me that there were two choices of tablets and I remember him saying there are two choices of tablets and that he was going to try me on this one cos it didn’t put as much weight on as the other one... cos the first time so it seemed alright and then after about 2 weeks or something like that, I kept ‘aving headaches as well with it and I kept feeling, not well. So I went back and the other alternative cos there was 2 choices, was the one that piled weight on.... I mean basically you didn’t have as many as you’ve got nowadays, I mean basically you’d go in and I mean you’d get excited if you found a packet of ribbed condoms, d’y’know what I mean? ...But then you ended up getting, then around, around this, this time in ‘93 they started getting a few more then. You could get fruity ones and all different kind of stuff so like it was, it was really good because you could like put them, put them on a bit earlier and like.” (Meeting 2)

Thus, for the older women such as Kelly and Dotty, the methods available to them in their early lives were limited. Technologies such as the contraceptive injection had not been added to the complement of methods available and ‘the coil’ was not deemed to be a feasible option for young, nulliparous women at that time. However, what transpired overall was that regardless of age and the proliferation of methods, condoms and the pill, either separately or used in tandem, dominated at the beginning of *all* women’s sexual lives. This is clear from Figure 8.1 and was also reflected in detail in the narratives, exemplified here in comments from 1995 and 2007 respectively:

I wasn't sexually active 'til I was 16. And I used contraception and I was good about that, I was on the pill when I was 16 (Marie, Meeting 2 – c.1995)

I was 16 and that was when I lost my virginity, and we used erm, condoms cos I was quite frightened about approaching anybody about going on the pill or anything like that (Emma, Meeting 2 – c. 2007)

This hegemony of condoms and/or the pill as 'starter contraception' for all participants in this study was linked to ease and access – both of which were perceived as valuable to young/er women who may find it more challenging to negotiate the service delivery environment. There was also something intrinsically *known* about the availability of these methods which was explained as a product of sex education albeit perceived as limited in scope and quality. Indeed, the comments made about using the pill to prevent pregnancy and condoms to avoid infection, were almost textbook - reflecting dominant and desirable versions of 'safe sex' inherent in sex education and wider social discourse. Thus, 'condoms and the pill' were referenced like a doctrine by the women in respect to their contraceptive lives regardless of age and place in time; inculcated and circumscribed, particularly by educational frameworks:

"They pretty much talked about condoms and pills at that point. I don't remember them mentioning anything else particularly but I guess they might have probably said 'You don't have to have sex and that would really help.' But no, I just remember her handing out condoms and like getting us all to watch her put them on and giving us a lecture about correct usage and stuff" (El, Meeting 2 – c. 1999)

Thus, despite a considerable growth in contraceptive technologies, the available methods appeared to be still limited both in the context of sex education and more broadly in the women's consciousness. The assumed challenges of using

contraception, for example remembering to take a pill every day, especially for young women, is one of the drivers behind recent emphasis on LARC. Thus despite the 'condoms and the pill' hegemony, LARC methods have become noticeably elevated in profile in practice settings in the last few years and efforts to insinuate these into women's lives were clearly represented by the women's narratives as follows next.

8.2.2 The LARC era

The earliest accounts of any LARC method was represented by Helena who reflected on the novelty of the contraceptive injection; a method she had learned about during her time living in Australia. This 'import' proved popular with her and her friends in 2002:

"I went on holiday to Australia and I became aware of the injection. And I thought 'D'y'know what this is probably the best thing for me.'..... and I went on Depo"

R: "Okay so it was in Australia when you were given your information about it?"

"Yeh I think I was chatting to someone and I think it, it certainly everyone at the time over there, that was what they were on. And I remember coming back here and speaking to my doctor about it and him being like 'Yeh, yeh, alright if you want to do it.'.... when I came back from Australia and nobody had heard about it then everyone was like 'Ooh, ooh, she's on new contraception, ooh' and they all went on it" (Meeting 2)

Reflecting on the same time period, 2002, Angela noted the newness of the contraceptive injection when she started to use it, followed swiftly by the implant:

"I went on the Depo injection, cos back then in 2002, it was quite a new thing as well.... I mean I don't know in terms of medically how

long they have been available but I know that when I was younger, looking at other girls and the contraception that they were on, the majority of people were still on the pill and long term contraception was still just a novelty to most people and it was really appealing 'Oh y'know, have no periods and I won't have to worry about getting pregnant for years.'" (Meeting 2)

At a similar time, 2004, Joanne tried the contraceptive implant. Helena, Angela and Joanne had all used various methods throughout their lives and all described themselves as relatively influential amongst their peers as a source of information about methods. Their roles as 'contraceptive trailblazers' meant that these women were first amongst their peers to move beyond the 'condoms and pill' dogma and explore the territory offered by, what they perceived to be, new methods. In fact, that the injection had been available for approximately 30 years by this time; albeit mired in dispute regarding safety and human rights abuses as discussed in chapter 2; and the first implant, Norplant, had also been released in the UK around a decade earlier (AHRP 2008).

Although LARC has been recommended in UK policy since 2005, the women in this research generally indicated that it had not been embedded in wider practice culture and use until much more recently. For those who have been using contraception and accessing services regularly over the last 10-15 years such as Megan and Angela, the recent emphasis on LARC methods was noted. As a grudging, but long-term, user of the contraceptive pill Megan was disinclined to change, but had observed efforts to encourage her to use LARC and described her resistance to these offers:

"They also tried for some time to get me to have the implant...Well you have to go every 6 months to go and get weighed and have your blood pressure taken and get your repeat prescription and then, 'Have you thought about the implant', have I thought about the IUD? Which again I wouldn't entertain the thought of cos again I know people that have had them and their periods have been very

painful, again it just sounds like 'you're trying to offer me something that sounds much worse than taking a pill every day.' So, yeh they they've stopped suggesting to me. So yeh, when have they, when? It's hard to think about these things cos when I think back around kind of like, in the last 5 years. I'm not sure I can be any more precise than that but I guess the older I've got they've kind of been more, the longer I've been on it they've tried to give me something" (Meeting 2 – c.2008-2013)

One of the unifying factors in accounts of LARC is that these methods are typically *offered* by the service providers as illustrated by Marie:

"There was once when he said to me when I had me two kids, 'Do you want to have the injection?' You can have one in your bum apparently. But I wouldn't accept that. So they did offer me injections and stuff but I didn't want 'em. I'm scared of needles so they'd have to chase me round the room" (Meeting 1 – c.2000)

The successful impact of these rebranded technologies could be inferred to some extent by the fact that many of the women who shared their stories had some experience of LARC use – the exceptions being two women with no contraceptive need and three who have sustained pill use since their contraceptive debut. However, mixed attitudes towards LARC and varied experiences of using it meant that many had discontinued.

A tension was noted regarding intra-uterine contraception (IUC) more commonly called 'the coil' although now encompassing the IUD (hormone-free) and the IUS. Listening to the narratives highlighted how notions of the 'coil' continue to shape women's decision-making as over time women have received conflicting advice about its suitability. What was formerly contraindicated for some is now being enthusiastically recommended to all women so users in the LARC era are conflicted between the pull/push of provider recommendation and the legacy of 'the coil.' Where typically the older women like Dotty and Kelly were told directly by clinicians

that IUC were unsuitable for them, other women have heard stories through the grapevine that are still couched in terms of risk to health and harm.

“I couldn’t have the coil because at that time, I was advised that you could only have it after your first child. They wouldn’t do it” (Dotty, Meeting 2 – c. 1995)

“I wasn’t aware of the implant when I was younger and the coil I wasn’t either and it was one of me mum’s friends, I was open with one of me mum’s friends too and she asked me ‘Are you on any contraception’ and I said ‘Just condoms.’ And she told me about the coil and it scared the life out of me cos she told me, I don’t know if this is relevant, but she told me that she’d had it for years and she wanted to take it out but because of how long she’d had it, half of it didn’t come out. So from there I’ve never wanted to have it and also I know somebody else who is always in and out of clinics because it misplaces, it moves and stuff like that” (Cara, Meeting 2 – c. 2008)

As noted in chapter 2, from a research perspective I have struggled to find clinical information about why (or how) the IUD has shifted from restricted use to being offered pro-actively as a part of the contraceptive repertoire. That said, interestingly, the women who had overwhelmingly positive attitudes to their method at the time of our meetings were all IUC users. Sam, one of these women, was a very satisfied IUS user; and drew together past and present perspectives on ‘the coil,’ indicating how she had reconciled the two:

“And, he sort of explained that they’d kind of got a bit of a bad name cos it’s, it’s an invasive thing and also it used to cause women to have sort of heavy periods or more pain during periods and things like that but he said about the, the *newer* one, which is the Mirena coil which actually lessens the pain and lessens the sort of

heaviness of periods....the only thing I can remember being told about the, about IUDs, was that it was basically like a fast track for sexually transmitted infections to get in to your womb!....it was because it's got 2 like little strings that hang down and it was mentioned, it was mentioned briefly by my doctor in that he kind of sort of said, 'Cos there is something that is inside your womb and it has a point outside your womb, then it is slightly more likely that, if you get an STI that it would go into your womb,' he said 'But to be honest if you get an STI and you don't catch it soon enough then it's gonna do that anyway,' so y'know. He was just kind of a lot more pragmatic about it rather than saying, as if it was just gonna race to your womb" (Meeting 2 – n.d.)

The perceptions of LARC methods as 'new' therefore reinforce, to some extent, the success of 'LARC' as an exercise in rebranding and remarketing of extant methods (Hillard 2013). However, I also suggest that drivers towards LARC, and more specifically the increases in the legitimacy of the IUD, represent a version of neoliberal governmentality that aims to confer a subject best suited to meet the myriad demands of contemporary Britain. These include: the willed pregnancy procreative ideology (Ruhl 2002); a response to the abject (and costly) teenage mother (Wilson and Huntingdon 2005); and normative versions of female and neoliberal subjectivities respectively. Hence extant but 'highly effective' and provider dependent technologies have been legitimated through discourse and the mobilisation of disciplinary power to confer a form of liberal governance that best meets these demands (Ruhl 2002; Nadesan 2008). Interestingly, however, LARC technologies require less *self*-regulation and more explicit provider dependence than their predecessors.

Currently, British women may be perceived as having more potential for agentic contraceptive practices due to the availability of greater method options, more opportunities to find, or make their own, knowledge and be afforded 'equal' status to men and so on. However increasingly restrictive contraceptive technologies maintain the regulatory gaze, coaching unruly fertile women into manageable and desirable

subject positions. The rhetoric of choice makes this circumstance more palatable by offering a veneer of agency for contracepting women. Because the 'added benefit' of this strategy in regimes of contraceptive bio-power is responsabilising women and encouraging compliance through the 'right' choices' (Carabine 2007) non-legitimate i.e. not-prescribed/medicalised alternatives remain unacceptable despite the emphasis on choice. This is evident in the accounts that comprise the next subsection.

8.2.3 Peripheral practices

In a research setting, being mindful of what is *not* mentioned can be as meaningful as events that are. As such it was interesting to note that none of these women (located in the post-pill era) had experience of, or even mentioned, methods such as the diaphragm. In this collective account, contraceptives that were formerly important and readily available were totally obsolete, whilst others, such as fertility awareness methods, were present but peripheral. Despite my best efforts to create a space for all modes and methods to be discussed, certain practices may still not have been interpreted by the participants as 'contraception'. Alternatively, others may have been understood to be risky or unacceptable and hence were omitted due to perceived social undesirability.

The withdrawal method was the main example of this in my research. When I asked about this practice directly (and perhaps legitimated it by doing so), some women confirmed that they had used it, but quickly qualified that its use had also been regrettable. These women's disclosures felt distinctly confessional and were made typically in our last meeting rather than during the main storytelling session in meeting 2:

"Eerrm yeh, I did once. Yeh, yeh I've done that where I've turned round and said 'before you're gonna come then pull out' yeh. I've done that. Yeh, a couple of times, yeh."

R: "So is that something that you've-"

"-It's still not safe is it? It's one of them things that you think, when you're younger 'well that's alright' but then, I think it was one time that somebody had something that they can pre-ejaculate and stuff like that so I think you think 'oh that's not like, it's a bit, it's still a bit risky, you can still get pregnant' but erm, yeh. Only a couple of times though really" (Kelly, Meeting 3 – n.d)

"I think from friends when we speak about it now, it's always 'Make sure you pull out before you, y'know,' that was it really that I would always say like literally just kick like 'Get off me now, that's enough,' y'know, there was still that bit of panic, I was never that drunk that I would be like 'Oh we've not got a condom but that's fine, let's just carry on 'til morning,' It wasn't like that but, that was still foolish of me" (Cara, Meeting 3 – n.d.)

Withdrawal has been a fundamental method of contraception throughout history and still is in many cultural contexts. However, Kelly and Cara discussed it in a way that exemplifies how normative versions of the 'right and responsible' have been internalised from recent, post-pill, post-medicalisation dominant discourses. In contrast, Helena made a more confident statement, in line with her tendency to reject the normative, noting an interesting shift related to withdrawal that she had perceived:

"I probably didn't add this but what I'm encountering even more is withdrawal methods.... I think we've got pornography to thank for that because when it comes to climax time, the majority of pornography that's aimed at men, they will literally ejaculate all over the female's face or tits or whatever so that's somewhat of a positive I suppose, in all that. Erm, so that's kind of an option as well."

R: "So you are saying that is something that you are finding is becoming more prevalent amongst partners for-

"I think so yeh.... I think that boys that use pornography from such an early age and try to pick up tricks they think that's what happens and that's what you do. But it does have its, if you are more pragmatic about it as you get older, it does have its pros to it really. As much as the very act of it could be considered to be quite derogatory, when it comes to sex its playtime for me as far as I'm concerned so." (Meeting 3 – c.2013)

Although I have used Cream's (1995) version of intelligibility thus far to refer generally to women using most effective (hormonal) methods, contemporarily the contraceptive service delivery environment is working hard to shift the 'woman on the pill' to 'woman using LARC.' However, as this chapter suggests, despite the growth in contraceptive technologies, there is a perpetuation of the 'pill and condoms' as the main contraceptive methods in women's consciousness despite more provider favoured alternatives (LARC). Building on the notion of a disconnection between the perspectives of providers and users this highlights a further disconnection between the agendas of the two.

Although the narratives in this research describe the change in method options from the perspective of the user, my analysis identifies the inter-relationship between contraceptive technologies and practitioners who are afforded the power to legitimate and recommend contraception accordingly. The following section captures how women in this research have experienced shifts in practice culture over time but argues that these accounts once again expose a distinct *lack* of progress as providers have ultimately maintained their expert status and frequently compel women to make decisions that respond to the needs of the state or organisation, rather than those of their own selves.

8.3 Permutations of paternalism

Dotty and Kelly's accounts of limited (two) method options both acknowledged that other options were available but were restricted by policy/practice at that time. However, there are other ways in which the contemporary clinical encounter circumscribes women's practices. In contrast to women's feelings of un-knowingness about their contraceptive selves as discussed in chapter 7, other material demonstrated how the women often feel confident in their knowledge about the motivations of providers – a knowingness that leads to a sceptical and distrustful relationship between them.

8.3.1 Power play – from services proscribed to promoted

Referring back to the 1980s, Dotty and Kelly described the service delivery environment as markedly different to that experienced today. Although specific sexual health services were mentioned, and indeed very valuable in Dotty's case, they were not widespread. Long serving family GP's were the central gatekeepers to contraception; a relationship that could be intimidating and prohibitive:

"I went to ask my older sister who I was really close to and she said she'd go doctors with me. And the doctor was absolutely horrified that I wanted to, cos he kept saying to me, 'Do you want to go on the pill because of your periods?' and I was like 'No,' y'know, cos I didn't have a clue. And he was like 'Well why do you want to go on the pill?' and I was like 'Cos I want sex,' and he was like 'But you're 16,' and I was like 'Yeh.' I was quite honest with him but he refused to prescribe it without me mum's consent. He completely refused to just prescribe it."

R: "So you were 16 then?"

"Yeh. But bearing in mind it was 1982. He refused. Point blank refused."

R: "So what happened then?"

“Well, I just, I didn’t have a clue. I asked my sister if she’d go to a chemist and she was like ‘No I’m not doing that!’ So to be honest we actually did the withdrawal and I absolutely shit myself. Convinced myself I was pregnant. I was absolutely petrified. I’d only do it the once though and I’d never do that again. And I told my sister and she was horrified and she took me to a Brook Advisory Centre...and they actively encouraged you to go on the pill to be honest, at the Brook Centre. They saw it as being responsible, which I was quite shocked about really considering the doctor was like ‘Oh my god no, I’m not prescribing you for sex. I’ll prescribe it if you say you want it for your periods but I won’t prescribe it because you wanna have sex with your boyfriend.’ (Dotty, Meeting 2)

Thus prior to more open provider models, like that epitomised by Brook in Dotty’s account, (contraceptive) risks were taken catalysed by the constraints of the service delivery environment. Specifically, for Dotty her family’s conservatism meant she felt compelled to marry to legitimate the terms of a sexual relationship and she did so at 17. The marriage was abusive and this experience strengthened her resolve to avoid children at all costs. As a Catholic, abortion was not an option for her and as earlier excerpts indicate, the other feasible methods were limited. For this reason, Dotty felt her only option was to seek sterilisation. The paternalistic and sexist overtones of her account are clear as her decision rested on the approval of her doctor and husband. Dotty’s decision-making about her body was not perceived to be valid and approval was necessary from more knowing sources (experts/men):

“My marriage was not a happy one and I knew I did *not* wanna get pregnant and at 26 I went to the GP and *begged* to be sterilized. Yeh because in my head I couldn’t break away from that marriage... But I knew that I did *not* want to bring a child up in that environment cos I was petrified anyway and so I begged to be sterilized, at 26. And I was told ‘No’ again and I asked if I got

pregnant what would I do and he said 'You can always have a termination,' and I said 'Well that's really against my upbringing really. I'd rather prevent a pregnancy than deal with a pregnancy.' But he refused and I just had to stay on the pill for longer...[DOCTOR] was adamant that I was too young, that I would change my views and sent me away basically...I kept asking the question; saying that my opinions had not changed and at least put me forward to see the consultant and if the consultant disagrees then, y'know. So they, they did agree for me to go to the consultant.... I have to say that my first husband was probably of the same mind as me, he didn't want a child. So he came with me to the consultation and I think he's what, what swung it really.... the consultant agreed to sterilize me and I went in the next week" (Meeting 2 – c.1992)

Kelly exemplified another type of medical power and paternalism in her account as she described her stay in hospital at a similar time. Although not her priority at that time Kelly described the management of her reproductive body in this setting:

"I wasn't well as well, it was a psychiatric hospital, erm, they were concerned about people getting pregnant because - they had loads of other people so *they* prescribed the pill and gave you Durex even though I wasn't sexually active with anybody else it was one of those things that they've done...I was proper out of me 'ead anyway on what they were giving me, the pills, so, I could, I didn't really bother. You didn't really 'ave much choice it were like - basically you come in hospital, I think they were more frightened of anyone getting pregnant because there was quite a few that was, I wasn't off me 'ead completely but I wasn't quite on the land of earth really so" (Meeting 2)

These examples of paternalistic practices could be attributed to 'the time' but how they had in fact *transformed* over time rather than disappearing entirely became clear as I listened to the layers of other women's stories. The directive and active encouragement towards LARC was one way this influence was exerted albeit more subtly. However, there are other more overt ways that this can happen too. For example, as detailed in chapter 6, Chloe's story epitomised her experience of domination by 'the system.' Her engagement with contraception providers per se was minimal and most of her sexual health needs had been subsumed into the practices of the care homes in which she grew up through in-reach sexual health services; or through engaging with maternity and abortion services. Further to her unintended pregnancy at age 16, Chloe described how she has contraception 'forced on' after her labour – see chapter 6. The clinicians in this setting made decisions about Chloe's needs, or arguably the wider social need to avoid Chloe having further unintended pregnancies, and made the choice for her. Similarly, following an abortion at 17, Cara was compelled to use contraception by staff, both clear examples of 'contraceptive choice' being circumvented:

"So when I was in the hospital she said to me 'Right, now, you need to pick a form of contraception, not just condoms' and I kind of looked at my friend and she was just like 'I don't know,' cos she just used condoms as well. And she was just like 'Your friend's not in the situation that you're in.' But they told me that when, once they have especially someone of my age who is having an abortion, they *have* to tell you what type of contraception you need to use; they can't have you leave saying 'Oh I'm gonna use condoms.' Right so I thought, I felt a bit pushed in a corner but I remember saying to her straight away 'Well I don't want the coil,' as soon as she said that. So she said 'The other options are the pill, the injection and the implant,' which I hadn't heard of." (Meeting 2 – c.2009)

When referring to contraception seeking in the recent past many of the women described this departure from discussion style consultation to directive. This is

interesting if we consider that neo-liberal discourses emphasise personal responsibility. These directive practices obviate the need for such responsible decision making to some extent as the provider is making the choice on women's behalf. Similarly, LARC methods with their provider dependent nature mean that women's personal responsibility for (daily) administration is actually reduced. This illustrates a way in which broader neo-liberal ideals (responsibilisation) not just the more specific concept of contraceptive choice, may also be fallacious.

The commitment to contraception promotion seemed to be particularly "in your face" (Joanne, Meeting 3 c.2005/2010) and directive in abortion and maternity settings but outside of these realms Joanne also illustrated how practitioners dictated the terms of use even though she was actively seeking a method. Joanne did not go back for some time after this experience:

"I'd been on a pill before, Microgynon and I'd been to the GP and said 'I don't want to go on Microgynon again,' 'Oh well it's the generic one,' I was like 'I don't want it,' 'Oh it's the cheapest one, the NHS, that's the first line of prescription.' So I was really angry when *despite* me going on about it she still prescribed that, I'd given it a go and it was really awful so.....I know that it was because it was the cheapest one, because you can read up on this stuff. So whilst I get that, given that I had expressed explicitly that I didn't like it last time and I didn't want to go on the same one....she knew that there were other brands but she was just adamant that she was prescribing this one..... So that is an abuse of power in a way. Because, I kind of said 'No' but I don't know if they think maybe if it's like, there is different fashions for different brands of pills anyway aren't there? Anyway the point is she didn't listen and it really didn't agree with me so there was no way that I was going to go back to her and say 'Look, I was right' so" (Meeting, 2 –c. 2008)

The power imbalance in the relationship between women and providers is implicit in the way that women speak of their experiences of seeking contraception. As mentioned earlier, I noted how women frequently spoke in a passive voice regarding this relationship- they were 'put on the pill' by the clinician rather than taking or using a method. This power was often exploited for other means such as to arrange STI screening:

"I told her I hadn't had sex before but she made me take a STI test cos she said it was regulation, they needed to do that to give me the pill. Even though I said I never had sex or anything so, but yeh so. I don't know why she made me, even to this day I remember thinking 'Why am I even doing this?' but I wanted the pill so I did that. Like now I would have said if she said that 'Well no, I'm not doing that' but at the time I was like young and naïve and stuff so I was like 'Whatever.'" (Gem, Meeting 2 – c.2007)

Or in Dotty's case, to ensure her participation in the cervical screening programme:

"To be honest it probably made me manage my, what's the word, good sexual things, cos I had to keep going back to the doctors to get a prescription so then I *had*, they wouldn't prescribe it unless I'd had a smear, they wouldn't prescribe it unless I'd had a, yeh? So it probably in all honesty, made me do all of that cos I would have avoided having the smear if I didn't have to go back."

R: "So did they say directly, 'If you want us to give you more of this you have to?'"

"You have to. Or they would say 'you're due for your smear' so you'd have to book in. Say you went for a prescription at the 6 months then they'd look and say 'Oh you're due your smear, can

you book in for your smear before you come for contraception,' and you knew you wouldn't get your prescription if you hadn't had your smear test. Or they would delay it or they would say 'Right we will do your smear whilst you are here.'" (Dotty, Meeting c. 1993)

In this way contraception, could be viewed as a type of currency with an exchange expected between the woman and provider. Therefore, through the channel of contraception, clinicians can control other aspects of women's lives. Expert knowledge and disciplinary power characterise these accounts and my analysis indicated that this has fundamentally changed little, if at all, during the period captured by these women's stories. Whilst the nature of the expert knowledge may differ, and methods are now permissible that were formerly restricted to certain use, particularly the IUD, the professional expert still circumscribes choice in myriad 'modern' ways. 'Choice-less' experiences, identified in these terms by women like Dotty - denied contraception without parental consent; or Kelly's obligatory contraception as a psychiatric inpatient may sound outdated, however there is arguably little difference between the power imbalances played out then and more recently with Cara being 'pushed into a corner' after her abortion, or Chloe's 'forced on' implant – the women's 'choice' is largely absent. More subtly perhaps, Joanne's accounts of 'intrusive' and 'in your face' counselling or Megan's experience of providers 'trying to get me to have the implant' represents a type of medicalised practice that infers there is a 'right' choice that should be made.

I suggest also that women have co-opted the notion that they *should* get their knowledge about contraception from an 'expert' source, as evidenced through the volume of material that they offered overall about sex education (despite their evaluations of sex education being overwhelmingly negative). Indeed, the medicalisation of contraception and the expert's gatekeeping and surveillance that mediate access, create a paradigm which implies that knowledge of the fertile and contracepting body must be sought from these expert sources.

However, both chapter 7 and 8 illustrate how that which is expected, can also be resisted through women's efforts to re/make contraceptive control or resisting provider offers of LARC -Megan consistently refused the offer of the implant; Joanne resisted the over-enthusiastic efforts of staff in maternity settings etc. This resistance is not without its challenges and when knowledge is not deferred to the expert, for example in Joanne and Angela's accounts regarding the pill and the injection respectively, the contraceptive consultation can become a battle ground where embodied/experiential and expert knowledge/evidence based medicine are pitted against each other. When the provider/expert prevails in these situations, especially with adverse outcomes such as Joanne's reaction to a pill she attempted to refuse, the 'abuse of power,' contributes further to poor relations between the two.

The expert's position as knowledgeable is arguably increasingly precarious as women have growing resources to draw on. These resources are first, practical, in the sense that there is more access to information and networks of sharing through the internet. This democratises knowledge about contraception and to some extent circumvents the expert (knowledge). The resources are also discursive in that the increasing legitimacy of sex and contraception in wider discourse over time has offered women greater opportunities to openly discuss and access an increasing range of methods and practices. Finally, there is scope to resist contraception use altogether due to its status as a 'lifestyle drug' more than one that is life-saving. For these reasons, I suggest that reproduction as a site of regulation of women through contraception (Marshall and Wolett 2000; Tone 2012; Padamsee 2011) is increasingly under threat. In response to which, technologies through which the 'regimes of (bio) power' play out (Bell and Figert 2012; Nadesan 2008; Mills 2003) have evolved, such as in the case of LARC, to suitably redress any possible shifts in power from expert to user.

8.4 Counter narratives

The material drawn together in this chapter is not meant to position all women as passive when seeking contraception. In fact, these women's stories are packed with

examples of resistance and challenge. Some women's personal accounts are characterised by active and agentic aspects of contraceptive use. 'Resource rich' El for example, has excelled in this way as she identified:

"I think a lot of the times that I've gone in I've been really clear about what I was going to come out with. I don't ne-, like I'll go in and I'll ask questions, well I'll ask questions but I'll have researched it massively on the internet before and it was again, when I went on the pill, I'd pretty much decided that I was going on the pill and then I went in and we went through a few options of pills and put me just in the generic one, cos probably it was the cheapest for the hospital, I dunno. And then I had no problems with it so, I was just stuck with that. And then like again with the coil cos my friend's had one, I kind of went in going 'I want a coil,' and yeh, got a bit more information on it but I think every time I've been pretty definitive about what I wanted and they've more just given it to me, rather than persuade me to or discuss other options. More okay like 'If that's your option then here's the info about it.' (Meeting 2 – n.d.)

As contraceptive delivery practices, especially those linked to LARC provision, are policy driven, it is not my intention to hold responsible individual practitioners. Indeed, the other contrast to this story is that many of the women express understanding and even actively encourage this type of 'provider knows best' practice. 'For her own good' approaches to Cara after her abortion for example, although pushy were appreciated as well intentioned and ultimately beneficial:

"When I had the abortion, they seemed more, y'know, worried. Y'know like 'You *have* to, you cannot leave here unless you've chosen and we've put you on one form of contraception. We either put you on the implant in your arm, put the coil in ya, or we give you the pill, now. And that's it.' So I'm glad, I did feel a bit pushed into a corner but I'm glad now I did that cos I think if I didn't get the

implant that day, I wouldn't have, I wouldn't have said 'I'm gonna get it next week, I don't think I would have, so' (Cara, Meeting 2 – c.2009)

Joanne expressed understanding about the hassle from midwives in post-partum contraceptive care, despite her irritation, and Dotty in retrospect valued the exchange of contraception for participation in the cervical screening programme. Going further still, from her first-hand experience of the care system and pain over her daughter's removal, Chloe showed how women as users may also have strong feelings towards imperatives to circumscribe reproduction:

"Look at all them people that end up having kids and don't want 'em. That's where they end up isn't it? They *should* be on summat so they *don't* get pregnant. I didn't want my kid to end up somewhere like that, cos it ain't my fault."

R: "Okay so are you're saying that you think care homes have a responsibility to make sure people don't have more children that will"-

-"End up in the system, yeh. And I don't get all that with whatever it is about AIDS. Put 'em all on something so they're not all gonna end up pregnant with babies that have got it. I mean what is the point in bringing a child up, with that. They're not gonna have no life are they? Just stop it. Stop 'em reproducing. Its easiest way to do it isn't it?" (Meeting 3 – n.d)

Admittedly, these examples could be understood as a result of women internalising 'expert knows best' discourses; particularly Chloe whose time in the care system saw her institutionalised and in a position where the state had control of all decisions about her from a young age. However, at risk of undermining these perspectives with my own interpretations I wanted to reflect the ways in which the women themselves

understood their experiences which, in these cases, was with a level of affinity for expert 'for her own good' service delivery.

I conclude overall however that despite these instances of resistance and/or support for provider practices, the material from this research troubles assumptions of 'progress.' Instead the material highlights how contraceptive innovation, such as that in the case of LARC, or cultures of directive practice in service delivery, can facilitate retrograde shifts in women's reproductive rights and choice. Thus, this chapter reflects the constraints of the wider contraceptive context on women's lives, or at least, how this is experienced by the women in this thesis. Whilst chapter 7 sought to illustrate how a woman can experience a disconnection from her natural or normal self, this chapter illustrates how women may also experience a disconnection with service providers due to incongruent priorities and perceived judgment about, or influence over, their choices. However, the women also revealed how much had changed for the better during the 30 years covered by their narratives. Echoing Weeks (2010) call to value the 'real life' changes that have taken place in the realm of sexual health and sexualities, method options *have* proliferated and women in the UK, regardless of age and marital status, can now access sexual health and contraception services with relative ease.

Chapter 9 will consolidate further the individual and wider contextual factors reflected in the women's narratives and build on my preliminary theorising from the preceding substantive chapters. In addition, the empirical, methodological and theoretical contributions of this research will also be drawn out, leading finally, to a series of conclusions about British women's contraceptive life experience; and relevant recommendations for policy.

Chapter 9 Considering the multiple dimensions of contraceptive lives.

In drawing together the arguments presented in the preceding three chapters, I will now discuss how the narratives and the methods used to elicit them have contributed to the field of sexual and women's health research at empirical, theoretical and methodological levels. My arguments will be exemplified, in part, through a series of theoretical models and visual representations. Firstly, however, I will summarise the findings and interpretations from the last three chapters to underpin subsequent discussion and recommendations.

Chapter 6 highlighted the diversity and dynamism of women's (contraceptive) lives and the interplay with their method use. The absence of any *typical* transitional life events that shift their practices was also noted. Congruent with other findings (Bruckner et al 2004; Borrero et al, 2014), the women in this research had more definite attitudes to their contraceptive methods than towards (future) pregnancy. The narratives also illuminated the fallacy of (free) 'contraceptive choice'; which was in fact shaped considerably by external forces. Intersectional perspectives illuminated the experience of these women further in a way that was closely linked to stratified reproduction. The characteristics of the women in this research made them more or less desirable reproducers (and contraceptors) depending on their particular circumstance (age, relationship status etc.). The situation of these women's lives within a neoliberal British, post-pill cultural context was the key consistent experience shared over time. This landscape, characterised by particular desirable subjectivities i.e. ways of doing femininity or meeting neoliberal demands, including conforming to the procreative ideology of the willed pregnancy, significantly shaped contraceptive experience.

Drawing on the discursive contextual norms, the experiences in chapter 7 demanded a reconceptualization of the impacts of hormonal contraception use and a re-positioning of 'side effects' from the periphery to a space where they can be understood to have a more central and holistic impact including through the

subversion of notions of self; a circumstance that undermines women's feelings of control. Contrary to much of the existing research and clinical approaches that present contraceptive impacts as discrete phenomena, these narratives represent an ongoing and dynamic process encompassing realisation, reflection and (un)knowing. Extending notions of Cream's (1995) 'woman on the pill', I suggest that hormonal contraceptive practices are intelligible in both feminine and neoliberal senses but that the feminine and masculine nature of these subjectivities respectively, creates a disconnection between the contracepting and natural selves. Grasping the extent of the impact of a method on the sense of self may be confounded by the fluid and illusory nature of the concept of selfhood. In addition, the inherent 'truth' that 'mood changes' may be linked to myriad other factors, also challenges understandings of method side effects. Furthermore, stereotypes of irrational and hysterical women confer further female intelligibility when women respond to their method unfavourably. Re/taking or being in control meant making efforts to reclaim a sense of the real self and improve knowing-ness about their contraceptive and normal states respectively.

Finally, chapter 8 drew on the temporal narratives to reconsider the assumed progress around contraception in Britain over the last 30 years. Once again, the ways in which women make contraceptive choices, illustrated by the participants in this research, were shown to be shaped by the wider context –the available/permissible methods and service delivery practices. The analysis revealed how, despite surface level shifts in methods (i.e. the availability of more methods) and adapted service delivery approaches, power continues to remain in the hands of providers, whose medicalised approach to contraception (increasingly) directed women into 'desirable' choice-making. In particular, the recent commitment to provider-dependent LARC methods has offered a way to observe evolving regimes of bio-power and, I suggest, resist any democratisation of power and knowledge between experts and users whilst maintaining women's reproductive bodies as a site of regulation.

9.1 Her-stories of disconnection - empirical contributions to research about contraception

The narratives collected during this research act as a political device by contributing to the proliferation of what have been historically, marginalised women's voices. They also re/write clinical *histories* of reproduction and contraception as *hers*, as lived experience. For all their disparity, the individual narratives challenge the normative assumptions that modern-day contraception use is unproblematic for British women. These rich, lived experiences illuminate the *meanings* of factors that are shaped by, and shape contraception use, and the ways that practices may shift over time and for what person-specific reasons. No story and no woman is the same. The heterogeneity of individual experience means that efforts must be made to respectfully recognise the myriad versions of women's contraceptive needs and practices to respond most appropriately and support sustainable contraception use. In contrast to the discourse that implies one relatively fixed 'right and responsible' -hormonal contraception use- a departure from the rigid perceptions about what constitutes 'good' contraceptive practices towards that which is *best* for the user is necessary. Stories like those in this research go some way to democratise our knowledge about contraception use and humanise the 'contraception user' giving meaning to women's experiences and demanding more compassionate contraceptive care.

Chapter 2 indicated how contraception policy in neoliberal Britain individualises and responsabilises users and how research agendas also emphasise the individual through their focus on attitudes and behaviours. Congruent with the objectives of this study, the whole contraceptive lives of individual women were explored and analysed in relation to their wider socio-cultural and temporal context. These situated and messy individual lives were profoundly complicated to unpick.

As the thesis illustrates, no 'typical' life transitions shaping contraceptive practices were identified, suggesting that recent attempts to elevate the importance of 'life stage' models (DH 2013) may be of limited use in responding to women's contraceptive needs. What did stand out, however, was the simplicity of the 'bigger

picture' of women's contraception use, a circumstance that this thesis demonstrates has remained relatively unchanged throughout the time-frame captured in the narratives. Therefore, I suggest that despite the unpredictability of individual women's lives and needs, the broader context has remained relatively consistent. Methods, access and availability may have changed, but the underpinning agendas and associated practices have barely wavered.

This reflects those arguments that indicate how, despite change and progress purported through, for example, shifting party politics, neoliberalism is the shared and increasingly-evolving ideology of the last 30 years (see chapter 2). Therefore, I would suggest that the service delivery environment may offer a more coherent site for development and change, rather than focusing on the diverse and disparate lives of individual women – as research and policy tends to do.

I also set out to explore factors that shape women's decision-making about contraception throughout their lives. In doing so I identified that a crucial part of the picture is the relationship that women have with their contracepting selves. Developing the arguments presented in chapter 7 further, I suggest that women who use hormonal contraception can experience 'contraceptive dysphoria' as a result; a phenomenon I characterise as a holistic experience resulting in distress, confusion or anxiety about a perceived disconnection from the 'normal' self. This experience sits in contrast to more reductionist clinical approaches that typically describe mood, sexual or physical 'side effects' as discrete, peripheral and measurable events represented through labels such as 'mood swings' or 'nuisance side effects' (Kane et al, 2009; Hoggart et al, 2013a; Grimes 2009; FSRH 2006; Walsh 1997). Instead contraceptive dysphoria represents an interplay of these effects and is most often lived out over a period of time as an ongoing, fluid and insidious process of adversity or anxiety about (possible) effects. This ultimately leads a woman to understand her contracepting self as a different and frequently problematic version of her 'real' self. Contraceptive dysphoria also means that women occupy a precarious contracepting position and are liable to stop or switch methods in an effort to return to what they understand as their natural or normal self.

Although not intentionally a means to undermine the contributions of evidence based medicine I do acknowledge that my concept of 'contraceptive dysphoria' conflicts with this approach. Contraceptive dysphoria offers instead a critical alternative which not only challenges the ways in which 'evidence' is produced and legitimated but troubles the value of evidence based medicine for women using contraception. This concept is grounded in the observation that women's perceptions of the impacts of contraception, and their importance in women's sense making about themselves, *regardless* of the evidence base, often translates into shifts in contraceptive practices including switching and discontinuation. To women experiencing contraceptive dysphoria their embodied, lived experience is as 'real', if not more so, than the evidence drawn on by clinicians to legitimate and or discredit contraceptive side effects. Rather than understand contraceptive dysphoria as an abstract concept therefore I suggest that it should be (re)conceptualised by providers as 'real' like evidence based medicine. Thus, the contributions of women, their accounts of contraceptive dysphoria, need to be considered alongside the evidence base as a means to address the users experience in the most meaningful way. In addition, given that the individual self is a notion we, in the British context, are heavily encouraged to draw on to explain ourselves, our choice-making and ir/responsible practices; it is unfair to undermine women's feeling of compromise to their sense of self in this way. In the absence of support from providers, these experiences can be remedied by women taking control through (dissenting) practices such as developing embodied knowledge or discontinuation of hormonal contraception. This is being seen increasingly through the development of fertility apps and the growing legitimisation of natural family planning through these 'modern' technological means (see for example: <https://www.kindara.com/home> ; <https://www.fertilityfriend.com/>).

The relationship that women have with providers/service delivery environment was the other key relationship to emerge from my analysis. The women's narratives indicated not only how this relationship shapes and frequently undermines their contraceptive choices, but that over time, the increasing emphasis on provider-dependent methods such as the implant or IUC and the directive strategies used to

confer their use, pose increasing threats to women's contraceptive agency. The perceptions of 'new' method types and thus 'more choice' is also misleading, and instead represents the legitimization of extant methods (such as IUD) driven by economic and social imperatives. The power imbalance inherent in the relationship between a woman and provider and the disconnection between their respective priorities leads to a distrust and scepticism. The women's accounts highlight how the biomedical framework, embedded within a neoliberal context through which contraception is delivered is often fundamentally incompatible with their contraceptive needs. Without an improvement in the relationship between users and providers, in circumstances that may be strained and inequitable from the outset, compelling women in directive ways to accept contraception as a 'natural' (long-term) state may perpetuate this disconnection and even widen the gulf between the two.

My research has therefore elucidated two key 'disconnections' that influence women's contraceptive practices and which I refer to as the 'disconnection thesis'. First, that the individual woman user may be compelled to feel disconnected from her 'real self' through an experience of contraceptive dysphoria. Second, that provider perspectives, which situate contraception as the natural state and/or adopt pushy practice to confer use, also result in a disconnection of the woman user from the service delivery environment or practitioner. The lived experiences of these disconnections can also be theorised around clashing masculine and feminine characteristics; a discussion that is consolidated and developed further in the next section.

9.2– Theorising contraceptive lives

9.2.1 The impossible fertile woman in neoliberal Britain

In addition to the challenges described by the women in their own terms, these accounts are also illustrative of an identity crisis on a theoretical level; between the neoliberal and female subjectivities. I argue that it is the disconnection between these subject positions that locates contracepting women in an impossible position as they become torn between 'right and responsible' choice-making and the intelligibility of

hormonal contraception use on the one hand; and, their lived experiences of contraception that can undermine their sense of self, including their feminine and sexual selves, on the other. Therefore, whilst contraception use can re/constitute female and neoliberal subjectivities, its impact may also simultaneously threaten them. Drawing on Tyler's (2013) concept of an "interpellation of impossibility," through which an individual's identity is constituted through social and political institutions in a way that is contradictory, I argue that contraception-use 'interpellates' two different subjectivities in this same contradictory way, creating the identity crisis in question. Thus, the experience of this impossible position, as lived out by fertile women using contraception can lead to dissatisfaction, distress and/or discontinuation of methods. Congruent with the visual methods in this thesis I have represented this tension graphically in Figure 9.1 to clearly highlight the competing characteristics inherent in female and neoliberal subjectivities; and the subsequent impossibility of meeting these expectations.

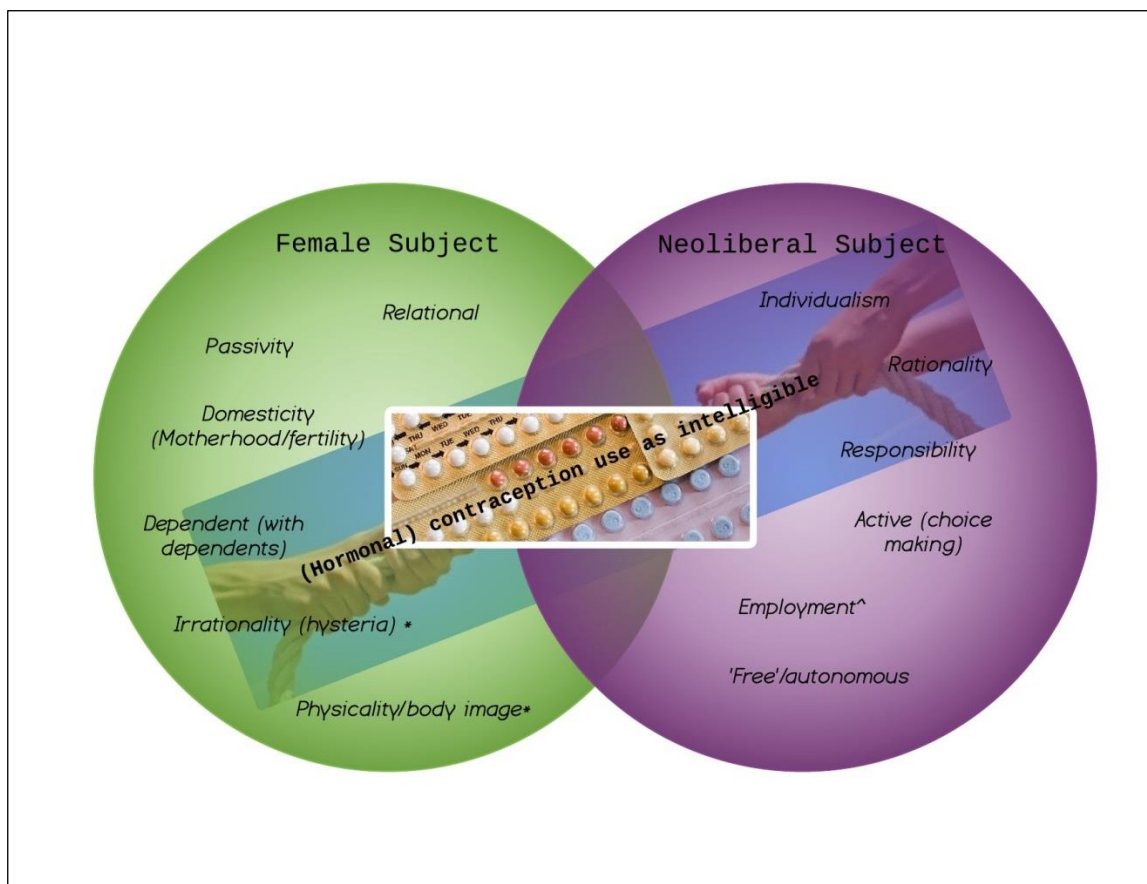


FIGURE 9.1 – TENSIONS INHERENT IN BEING A CONTRACEPTING WOMAN IN BRITAIN

To further theorise the empirical contributions referred to in section 9.1, I wish to draw on another gendered phenomenon: madness. As evident in some of the women's accounts, their challenges to self through contraception use were frequently articulated through the vocabulary of madness; resonating with historical accounts of hysteria and the deviance and 'lunacy' of female sexuality (Barrett and Harper 2000; Bryant and Schofield 2007; Mort 2000; Lowe 2005b). Discourses about hormones and the legacy of hysterical femininity had been co-opted by the women in this study to understand and explain their experiences of this contraceptive dysphoria. Rosie's 'psychosis'; Emma's robotic emotional-ness; Sam's 'mental health'; Cara's potential Jekyll and Hyde amongst others. It was for this reason that the typically psychiatric term 'dysphoria' (see for example APA 2013) lends itself to being adopted as an umbrella term to describe the diverse presentations of the iatrogenic phenomena that I characterised as contraceptive dysphoria.²

I briefly suggested in chapter 7 that this irrational female, albeit undesirable from a rational neoliberal perspective, is arguably intelligible in relation to female subjectivities; with the historic and tenacious stereotypes of 'mad, bad and sad' women and the 'woman problem' being well characterised (Appignanesi 2009; Ehrenreich and English 2005). In this way, experiencing contraceptive dysphoria could also be contributory to the re/constitution of female subjectivities. What could be more female than erratic moods, uncontrollable hormones and unruly bodies? I assert that this overlap confounds women's efforts to distinguish between the 'pill me' and the 'normal' 'natural' (female) self. This was the same for others, both providers and wider society, who could/can explain away any adverse events by drawing on the dominant version of this typical woman. The stereotype of which, despite any contraceptive intervention, is inherently irrational and emotional. Thus, this female template confers characteristics that make both the self and others sceptical and distrustful of experiences of contraceptive dysphoria whilst reinforcing this gender paradigm. This also contributes to these experiences being undermined within the

² Iatrogenesis is a term introduced by Ivan Illich in 1976 (2010) that refers to illness that is caused by medical intervention including the side effects of medication.

service delivery environment exacerbating the strain on the relationship between contraception users and providers which is also frequently disconnected.

In theorising this disconnection, I suggest that it can be explained through epistemological differences between (female) contraception users and the providers. The latter of whose inherently masculine evidence-based rationality and neoliberal service delivery imperatives create a tension which can foster distrust and antagonism between the two. In considering the term 'masculine' to describe provider approaches, I was troubled by my own practice experience; the experiences of the women in this research; and the wider literature (Lowe 2005b) which all indicate that the service delivery environment of contraception/sexual health is highly feminised. Indeed, the gendered nature of this profession has been cited as advantageous to the contraceptive consultation, as the embodied knowledge of the provider is valued by users (Lowe 2005b). Therefore, to reconcile this discrepancy, I borrow from Holland et al,'s (1998) work to suggest that providers occupy a 'male in the head' approach to contracepting women. Rather than male power as enacted through hetero-sex, I use the term in this context to represent how the power of (masculine) biomedical models and neoliberal agendas are mobilised through contraceptive provider practices. Congruent with the clashes between the female and neoliberal subject positions as illustrated in Figure 9.1 the contraceptive service delivery environment is similarly antithetical to the women who access it due to the characteristics included in Figure 9.2.

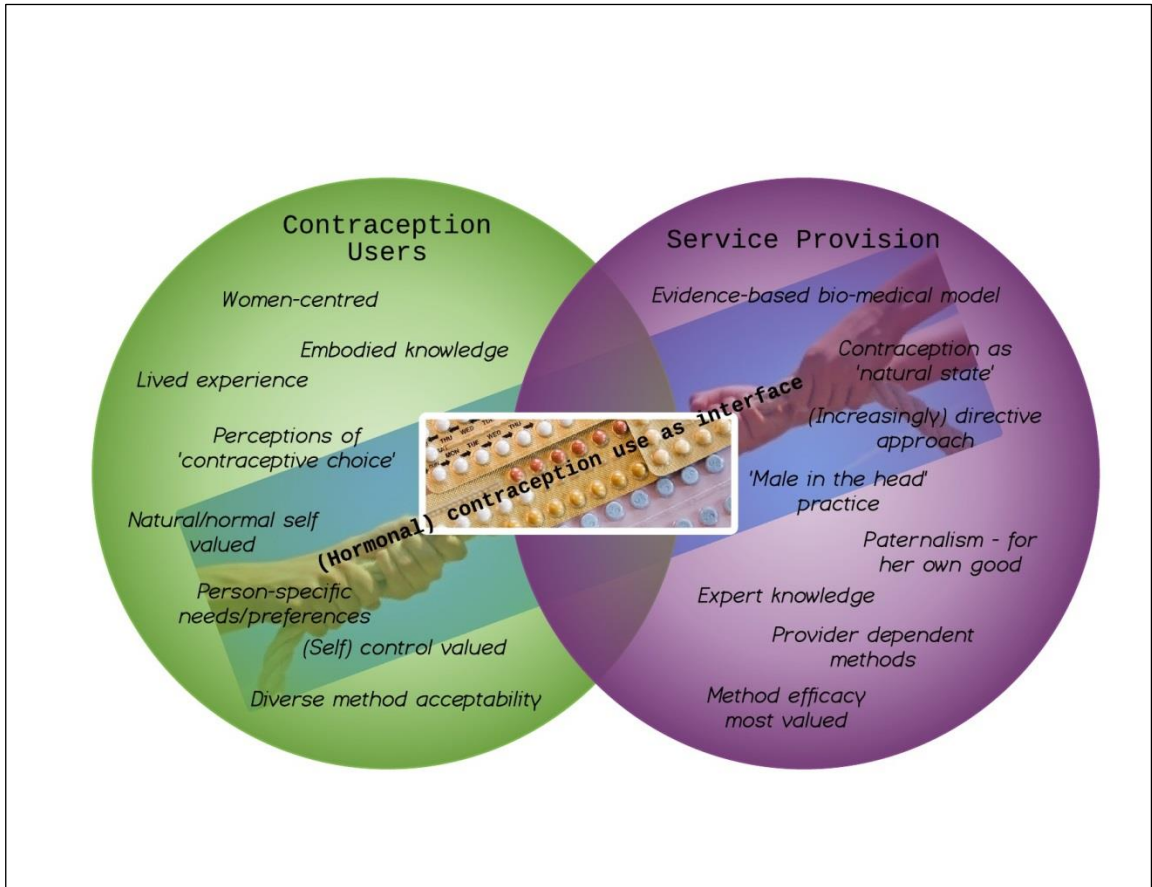


FIGURE 9.2 – TENSIONS BETWEEN USERS AND SERVICE PROVIDERS

This representation mirrors Figure 9.1 but instead of capturing competing expectations experienced by contracepting women, it captures the conflict in the values of contraception users and providers respectively; opposing cultural perspectives that are drawn together through contraceptive provision.

So, in the current post-pill neoliberal British context, the reproductive-age fertile woman occupies a frequently impossible position, 'interpellated' into competing female and neoliberal subject positions that are re-constituted in part through hormonal contraception use (Figure 9.1). The narratives in this research indicate that this 'impossible fertile woman' has remained relatively unchanged during the 30-year period captured by the study. The normative discourse/s reflected, were relatively consistent across the women regardless of their ages. This is coherent when considering their shared location in place and time broadly speaking, where imperatives to be contraceptively responsible, sexually self-controlled, responsible for planning an inevitable pregnancy etc. apply ideologically to all women. These

women are situated within a wider context where the service delivery environment, despite changing shape over time due to improved access, different provider approaches, increased emphasis on 'patient choice' and constantly evolving policy initiatives, has essentially stayed the same. By this, I mean that the service delivery model has remained within a biomedical framework that privileges medical expert knowledge. The key characteristics that define the service delivery environment and the user group respectively (Figure 9.2) have also remained relatively unchanged throughout this time.

Notions of progress in women's contraceptive choice can therefore be troubled in this way. These contextual and theoretical *consistencies* inspired and enabled me to consolidate this situated experience of contraception use.

9.2.2. Contracepting in Britain - current and future models

Although many women may use contraception throughout their lives unproblematically, I argue that 'right and responsible' choice still confers a precarious position as women may (re)choose to switch or discontinue at any time (see for example, Wellings et al, 2015; Inoue et al, 2015; Wigginton et al, 2016). For others, contraceptive experiences can re-constitute mad, bad and/or sad versions of female subjectivities. With each experience of disconnection from the self or the provider, these relationships become increasingly strained and the users more dissatisfied. I conceptualised the current situation in the model represented in Figure 9.3, overleaf.

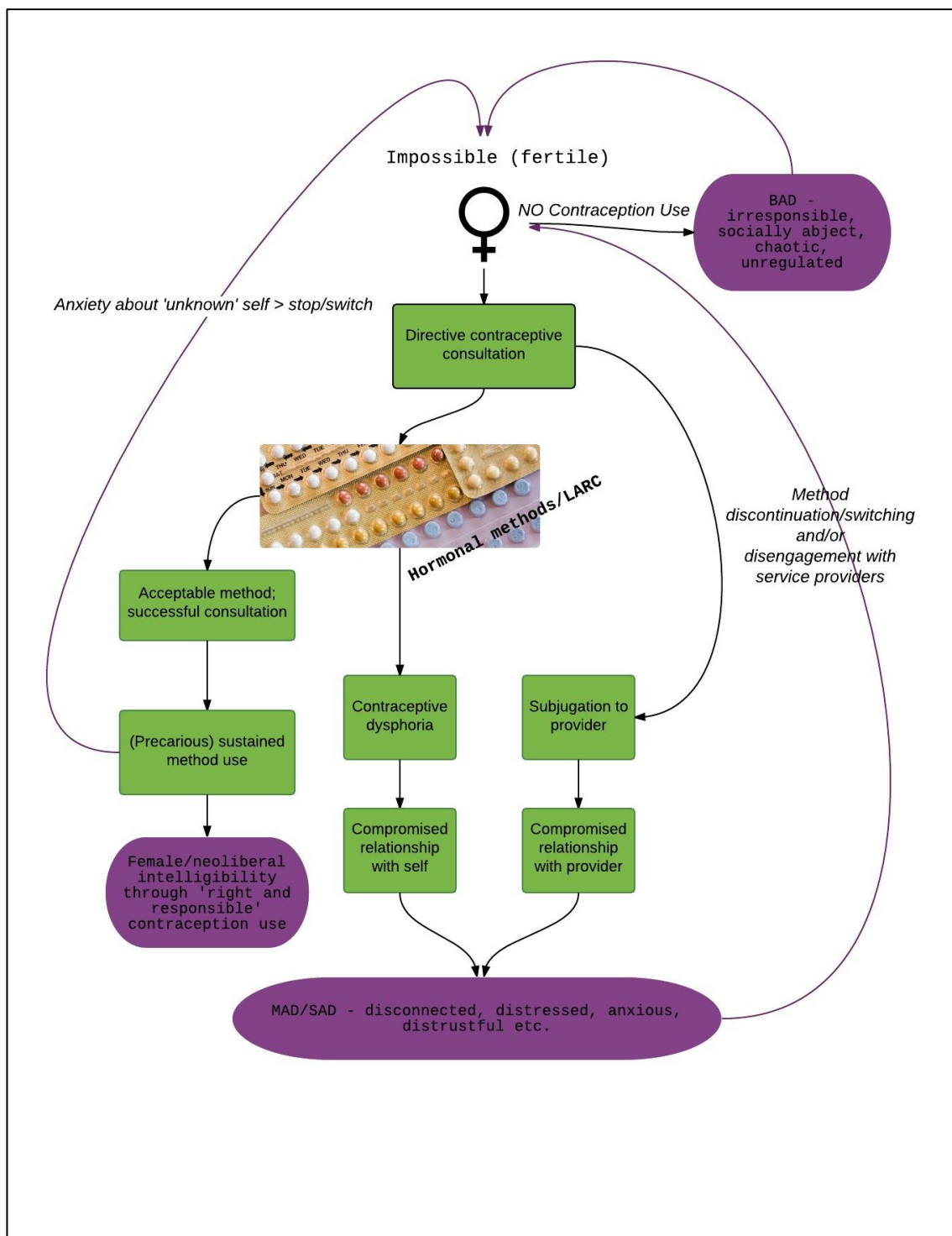


FIGURE 9.3 –CURRENT STATUS OF CONTRACEPTIVE SERVICE DELIVERY

I also drew on structuration theory’s emphasis on duality, that highlights how structures can be constraining *and* enabling to individual agency (Giddens 1986) when considering the consistencies in contraceptive context. This directed my attention to the structural level as a (more) stable and coherent site for proposed change,

compared to the diversity of dynamic individual lives. Thus, I assert that it falls to the service delivery environment, as an institution, to be more enabling and to recognise the ways in which it functions to constrain, for example, through pushy paternalistic approaches. I suggest that more critical reflexive practice is necessary to depart from conceptualisations of the problematic and risky 'impossible fertile woman' and to adopt a salutogenic approach that recognises a woman's agentic potential regardless of age, class, race etc. *Enabling* women to do that which is 'otherwise' by, for example, supporting alternative method use when it is preferred by that individual, or responding attentively to the unacceptability of any methods, cultivates a landscape which supports agentic contraceptive practices and promotes better (self) control and satisfaction amongst users.

Next, linking to recommendations of critical reflexive practice, I make an argument regarding gender specifically. Although I have critiqued the intrinsic masculinity of neoliberalism it is not my intention to suggest that it is problematic for women to depart from characteristics associated with typical femininity. Instead this research highlights the tensions inherent in women's roles in contemporary Britain and the challenges they face through being increasingly situated as able to 'have it all' or in this case 'be it all' or 'do it all' in feminine and neoliberal respects. Considering gender more flexibly as a construct, and problematising the male/female gender binary and associated stereotypes, is important for practitioners seeking to offer person-centred care; or in this case, women-centred contraceptive services. Drawing on typical concepts of the feminine is clearly unhelpful for both service providers and contracepting women who are seeking to understand the impact and suitability of different methods; for example, distrust of irrational and hysterical women confounds understandings of 'side effects' and the legitimacy of reports of contraceptive dysphoria; or pressures to be a mother (fertile) or issues regarding body image (weight, skin, bodily disgust) can influence a method's acceptability.

In addition, the inherent relationality of women's lives to others (peers, family, partners) should not be assumed, especially regarding contraception. This became clear from narratives in this research that indicated how the relationship that women

have with themselves is the most important one of all. Although theorised as typically 'masculine' the emphasis on the individual need not be discounted. As highlighted by Nussbaum (2000, p63) liberal principles could helpfully meet need where *"it is clear that women have been too rarely treated as ends in themselves, and too frequently been treated as a means to the end of others."*

In response to the previous model of 'impossibility' (Figure 9.3) I have therefore developed an alternative for improving the acceptability of outcomes for women who use contraception – Figure 9.4. This recommendation hinges on re/connecting and fostering healthy relationships with self and providers. I assert that better self-knowing and more trusting, egalitarian partnership working between provider and user may confer best fit, sustained contraception use as follows overleaf:

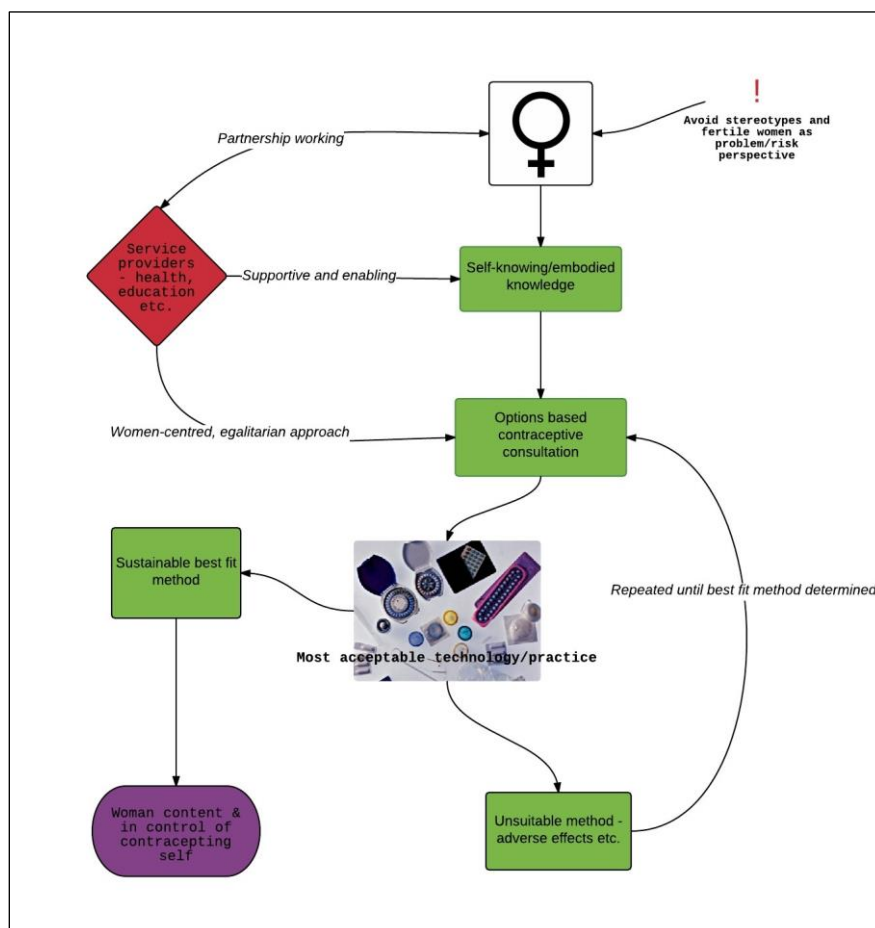


FIGURE 9.4 – SUGGESTED MODEL OF CONTRACEPTIVE SERVICE DELIVERY

It is important to note that the suggestions made in this model are permissible because of the specific, atypical nature of contraception as a facet of medicine, where the risks of non-use are smaller (lifestyle) than with other pharmaceutical regimes (life-saving). I stress that this model would not be translatable to other clinical interventions where consequences for possible non-use could be significantly more harmful. Although I do accept that unintended pregnancy carries its own risks to health and wellbeing, the fact that contraception is elective ('consumer choice') rather than therapeutic, in addition to the extent to which the notion of 'contraceptive choice' is the credo, creates space to suggest that the embodied/experiential accounts of users *can* feasibly be privileged over evidence-based medicine in circumstances where the method is unacceptable.

As noted in the literature review, chapter 2, the introduction of the pill prompted the assimilation of contraception into a biomedical framework. Without suggesting that it is possible to de-medicalise contraception entirely, I do wish to encourage a departure from the hegemony of evidence-based medicine and the privileging of so-called 'rationality' in all contraceptive matters. I assert that this preoccupation can be detrimental to the relationship between the contracepting woman and her provider and although I do not suggest the evidence base should be ignored entirely, greater flexibility when negotiating the contraceptive consultation, particularly through a more respectful perspective of what counts as 'knowledge,' could lead to better more sustainable outcomes for users. Indeed, I suggest in this contraceptive choice culture that women's (choice to) use their embodied knowledge and (choice to) respond accordingly to their experiences should be re-conceptualised as wholly rational. Users disconnection from 'male in the head' service delivery demands a replacement with truly women-centred practice that acknowledges the importance of the holistic experience of contraception (psycho sexual, social and physical) and interrogates the notion of the contracepting self as 'normal' for British women.

9.2.3. A continuum of choice: The implications of stratified reproduction

I constructed the previous representations and models (Figures 9.1-9.4) to consolidate my interpretations clearly, but I acknowledge that it also represents women in a crude essentialist fashion, implying a homogeneity that means each is equally free to choose a pathway- 'right and responsible' or otherwise. To re-iterate, contraceptive choice represents a specific classed, raced and aged privilege and thus taken in isolation these diagrams do not reflect the heterogeneity of women. In doing so, it therefore fails to capture issues of intersectionality and associated inequalities where, as evident in the 'continuum of representativeness', there is also a 'continuum of choice' as individual characteristics and stratified reproduction may further mediate women's lived experiences with contraception. The narratives in my research support the critiques that expose the fallacy of contraceptive choice and trouble the assumption that all women have the same capacity to choose. Considering, then, the possible impact of stratified reproduction on the individual's experience, alongside the disconnection thesis, adds another dimension to this representation captured in Figure 9.5. The challenges inherent in being an 'impossible fertile woman' are exacerbated further depending on the individual woman's (reproductive) desirability.

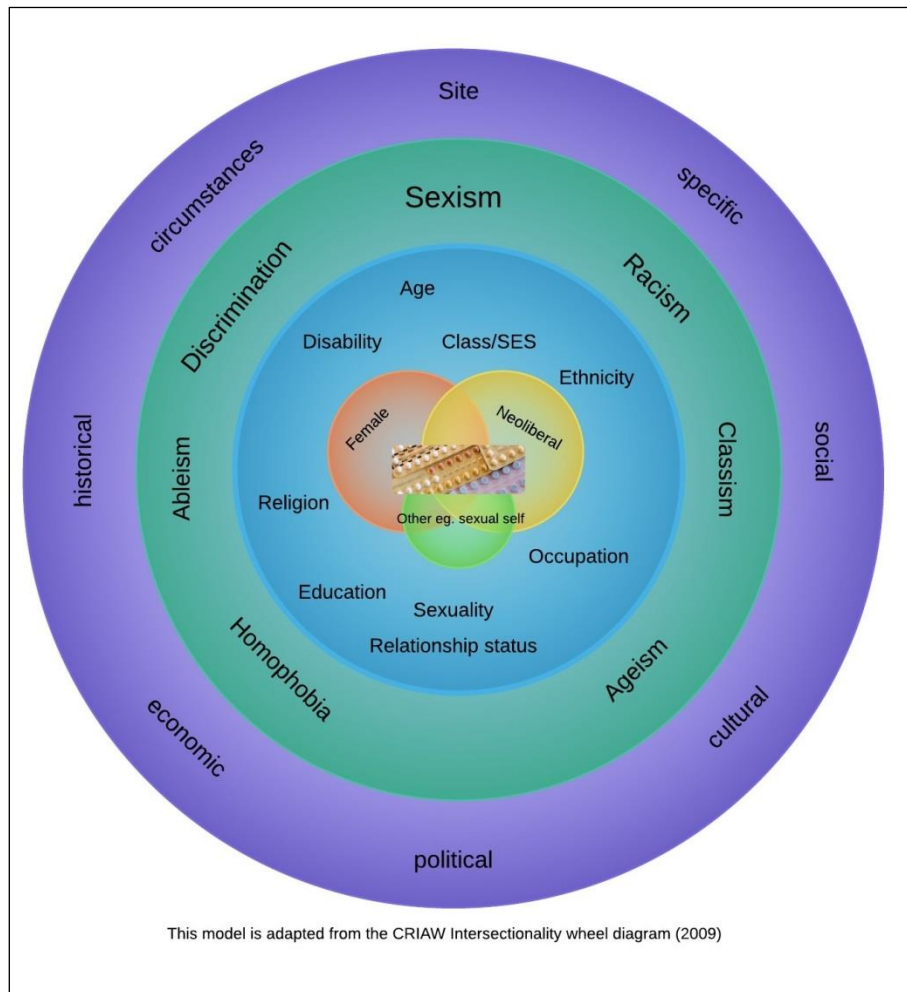


FIGURE 9.5 – INTERSECTIONAL CONSIDERATIONS AND THE IMPOSSIBLE FERTILE WOMAN

Figure 9.5 has been constructed to represent that the woman’s unique circumstances specifically in this situation as an impossible fertile woman (situated at the centre of this diagram), are further shaped by other factors. These include: Site specific social, cultural, political, economic and historical circumstances - as represented by the outer ring; different forms of oppression and discrimination; and specific facets of identity- although these are just an example of possible influencing factors.

It is in relation to these inequalities that it is pertinent to examine, however disconcerting, the possibility that contraceptive initiatives and practice cultures may continue to have impacts that are eugenic in nature, however indirectly. As cautioned by Higgins (2014), the merits of LARC methods should not be fetishised over the needs of women; and the eugenic drivers that have pervaded the ‘birth control

movement' historically should not be forgotten, nor these legacies undermined. Many of the women's narratives, where young women post-abortion were 'backed into a corner' or post-partum had methods 'forced on' for example, were disturbingly reminiscent of historical evidence of eugenic practices; and considering notions of stratified reproduction, are arguably underpinned by similar agendas. Thus, without individualising and responsabilising service providers, it is imperative that the wider impact of contraceptive initiatives and policy is critically appraised to defend human and reproductive rights accordingly.

9.3 - Methodological contributions

In addition to the empirical and theoretical contributions derived from my doctoral research, my study also contributes on a methodological level. As outlined in chapters 4 and 5, I used naturalistic, detailed and feminist participant-led approaches. The research process was creative and accessible, particularly in relation to the use of map-making. This method did not rely on verbal articulation only, and acted as both a prompt and a site of connection between both researcher and participant. The method was ideal for collecting the meaningful and context-specific data that I was aiming for. The women were free to start their stories from points that did not directly relate to their own contraception use – setting the scene, describing their backgrounds and locations within broader social structures and relationships.

The participants responded very well to the research experience and it is their accounts that I would like to draw on to illustrate the contribution of this method for researching experiences of contraception. The strengths of this approach could, I suggest, be successfully translated to researching other facets of (women's) sexual health. Indeed, the method would be useful in any other areas of research that require an unpacking of the individual story within its wider context. In the spirit of collaboration, it was important for me to find out how the women evaluated the project. In many cases, I actively explored with the participants how they felt about their involvement. At other times, women made unsolicited comments. Dotty, for

example, noted how the approach allowed her to consolidate her thoughts and reflect:

I just thought right from the very beginning. Some of the notes that you gave about thinking about your values and your family, that's what made me think 'Oh, how did I form these opinions, why did I feel like that?' So I just started from the beginning thinking 'When did I start thinking about it?' 'What was it like in our house talking about it?' Cos I hadn't really thought about it to be honest, but now I think 'My god.' You don't realize how much your upbringing impact on, you think that you've made that decision and yeh you have but you've made it because this has happened or because you've experienced this.' (Dotty, Meeting 3)

Helena viewed her reflective account as a form of catharsis, a chance to represent herself and to some extent make a social/political statement through her map creation:

I made it in that way cos obviously my approach to it was that it was a cathartic exercise and I, I was well aware of the fact that I deviated from the main thing but I think that my promiscuity, in relation to my contraceptive choices are strongly interlinked and that's why I wanted to show that side of it. Erm, and I wanted to make it fun at the same time, for me. So although it does kind of err away from the whole matter in hand I didn't want to do it very clinically, I just wanted to play around with it a little bit. But yeh, the magic number business and all that jazz, that's important, that's important cos I think I need to be demonstrating the kind of person that I am and the choices that I've made and the bad choices I have made cos I won't be the first, I won't be the last. So, y'know I could have been completely dishonest about it all but that's not me to be honest (Helena, Meeting 3)

Kelly reflected on the practical benefit of the map-making exercise that offered her a focus for her life history narration:

I just thought it was easier to do a timeline and use key points in me life and that would make me think about contraceptives so that was especially around getting married, long term relationships, having a baby, infertility, erm, and it was easy to talk through the journey through that stage. Give me a lot more focus and then I just didn't just waffle on about anything really erm, and it made me think about key stages and key decisions that I'd made by doing it, doing it that way. It was easier, easier to see. The less things on it was easier to see and expand about on it but just key pointers about being in hospital and influences and decisions and times in me life and ages, so yeh (Kelly, Meeting 3)

Therefore, my doctoral research also illustrates the benefits of adopting creative and co-productive methods – a contribution that can potentially make a welcome addition to the extant qualitative methods literature. Women's experiences of involvement in the project also warrant further comment to understand both the merits of this method and the relevance of the research. One notable motivation for participation, expressed by both Emma and Megan, was that involvement in the study was viewed as a 'challenge.' They both cited trepidation and nervousness about open discussion on sexual matters and their involvement was, in part, a chance to prove to themselves that they could cross this boundary. Similarly, Rosie, having experienced various traumatic events that she had not shared before, thought it would be helpful to 'face her fears,' and openly confront her experiences. Alternatively, Chloe, currently unemployed, expressed a desire for 'something to do,' something specific and meaningful, as the motivation for involvement.

Other women commented that the nature of the project was 'important' and 'interesting' and expressed perceptions of its value for women and women's health. Angela for example, indicated that she thought the inclusion of her story, involving restrictions and difficulties around contraception for medical/health reasons, would help other women and practitioners who deal with similar issues. For many of the participants, it was clear that the project presented an opportunity to have their stories heard as a complete whole. There was recognition amongst the participants that 'usually' women only get a short time (within healthcare settings) to discuss contraception; or that there is only 'usually' an interest in select details of their experiences. It seemed valuable for them to engage with someone who was interested in hearing an uncensored, detailed account of the whole.

Although possibly unintentional from the perspective of the women involved, the political action inherent in life history work is visible in this project (Plummer 2001; Brockmeier and Carbaugh 2001). The participants can be perceived to have contributed forms of activist resistance to the dominant, mainstream and 'malestream' (Ribbens and Edwards 1998; p1) narratives of contraception and managing pregnancy. Although not all women offered explicit narratives of dissent, experiences of side effects, fear, psychological and emotional distress, these issues were regularly discussed and explored by many women, despite having been contested, denied, ignored and undermined by health professionals. Involvement in this research offered the women a platform to foreground their lived, every-day, private and embodied knowledge over that of professional, 'rational' disciplinary knowledge – an opportunity I understood from listening to their accounts to have been a rewarding and empowering experience.

Various other factors also appeared to be 'rewarding' for the women involved. Researchers may be perceived as a therapist and the same drivers that may encourage an individual to engage in therapy, may also draw people to participate in research (Dickson-Swift et al, 2006). This may be more likely in this instance, as the research method encouraged detailed sharing and trust building. Although there was no clear indication that I was considered as a therapist by participants and no obvious

blurred boundaries between roles that I had to actively negotiate, there was a direct explication by some, that the *process* was therapeutic in nature. Helena and Gem, for example made direct comments about their storytelling being like 'therapy' and 'counselling.' Rosie's self-identified traumas were disclosed to me gratefully after a previous and sustained silence.

Bagnoli (2004) comments that the narrative reconstruction of one's autobiography encourages a reflexive attitude and can function as an instrument of self-scrutiny and point of change for participants. This was apparent for some of the women involved whom I perceived to undergo a process of 'discovery' about themselves as the research progressed. It was a privilege to witness some of the women, via the detail and reflexivity inherent in the life history narrative, making realisations, asking themselves questions and in some cases experiencing 'eureka' type moments about the nature of their lives and in relation to contraception. Many of the women directly expressed their 'enjoyment' of the research process, noting that they valued the personalised nature of the project, i.e. that contrary to expectations that the research would resemble an 'interview' in which they were asked a series of standardised questions, the process was largely dictated by their own specific personal experiences.

Although it is possible that the 'thank you' gift voucher was also motivating and rewarding for many of the women, based on my relations with the participants, the notion that this was the sole intention for involvement in the research seems unlikely. Several hours of time and activity were contributed by each woman and many gave unsolicited comments on the various 'motivations and rewards.' Although the voucher was a fitting reflection of gratitude for their contribution, it became apparent during the research process that Cara and Gem were not aware that anything would be gifted at all.

The final concluding chapter will briefly summarise these contributions and link them to recommendations for future policy and practice in the realm of contraceptive service delivery.

Chapter 10 Conclusion

"Our advice still holds true: no matter how many degrees the experts dangle in front of you, no matter how many studies they cite, dig deeper, value your own real life experiences and think for yourself." (Ehrenreich and English 2005, pxx)

The above quote reflects the feminist commitments I made to my doctoral thesis. I wish to end this work with generative recommendations and an optimistic perspective on the current landscape which, as evaluated at the end of my 3 years of research, offers exciting potential for the future of contracepting women. Currently in Britain concepts of choice and reproductive rights are embedded in public health and wider cultural discourses, but assumptions that contraception use is unproblematic are belied by the statistics; such as those regarding unintended pregnancy. In a realisation of contraceptive acceptability work, I have drawn together the 'service system/user/technology interface' whilst attending to the temporality of the women's experiences expressed through their life history narratives. In doing so, this thesis has made empirical, theoretical and methodological contributions to the field of sexual health research.

Empirically this project has 'gone beyond' the typical clinical and bio-medical conceptualisations to explore contraception use as a dynamic socio-cultural phenomenon. The thesis reveals how the wider macro-level context can have a significant impact on the acceptability of contraception in the lives of individual British women; and has gone some way to capture the dynamism of what I visualised to be a fluid and multidimensional entity (the individual woman) situated, albeit precariously, in the context of contemporary Britain. However, the detailed subjective accounts of the women in this thesis do go some way in providing a meaningful understanding of the diversity and complexities of women's life history experiences of using contraception. In addition, my research has reconceptualised the reductionist perspectives of 'side effects' to illustrate how the disconnection of a woman from a version of her 'normal' self through hormonal contraception use and experience of 'contraceptive dysphoria' is a potentially detrimental experience that

places contracepting women in a precarious position with regards to method sustainability. The analysis of women's lives over time demonstrated the diversity of critical junctures in women's contraceptive careers and questions the helpfulness of prescriptive life course models that have pre-defined life stages and make assumptions about experiences related to age. The narratives also support the view that attitudes towards different contraceptive methods are more influential than fertility intentions at any given time.

The disconnection of women from the contraceptive providers through practitioner's undemocratic practice is also a source of challenge for contracepting women and despite the veneer of progress through the credo of contraceptive choice; women are frequently subject to paternalistic and 'pushy practices' that circumscribe their method options or contraceptive practices.

Theoretically the thesis has developed the concept of contraceptive pill use as culturally intelligible to show how hormonal contraception-use more broadly is intelligible from both feminine and neoliberal subject positions. Shifts in policy over time mean that the cultural intelligibility of the 'woman on the pill' is being driven increasingly towards 'woman on LARC.' This is an active policy driven strategy which, from a Foucauldian perspective, due to increasing provider dependence, confers the hegemony of the expert and acts as a form of bio-power that counteracts the increasing democratisation of women's knowledge about their reproductive bodies and contraception. The simultaneous occupation of feminine and (masculine) neoliberal subject positions through contraception use, however, can also create tensions which, through drawing on notions of 'interpellations of impossibility' have led me to conceptualise the 'impossible fertile woman'. This concept represents a British woman with a contraceptive need for whom the demands of normative versions of femininity and neoliberal subjectivity confer myriad challenges with regards to finding and sustaining contraception – the experience of which frequently results in her being perceived as 'mad, bad or sad.' In addition, women's experiences with contraception and its providers are complicated further due to stratified

reproduction that positions some women as more suitable than others for reproduction at any given time.

Methodologically the research has contributed to the ever-proliferating body of narrative and life history analysis in health research, supporting the value of such methods for understanding the situated and subjective experience of health service users. As evidenced through the reflections of the women who participated in the research, my specific approach conferred the suitability of my methodology for feminist, women-centred research and the creative facet, the map making, acted twofold as both valuable data and a very effective practical tool for enhancing data collection. Listening Guide analysis has proven successful in elucidating the multi-dimensional narratives of contraception use, centring the accounts of the women who try to use contraception and allowing for their experiences to be defined in their own terms as much as possible.

Regarding the research overall, there are some important reflections to make as part of my commitment to reflexivity and transparency. Specifically, it is important to note that the empirical material could have arguably been subject to another 'layer' of analysis which would have further shaped my theorisations. However, I did not want to critically analyse the women's claims to the extent that it would disconnect their accounts too much from their own understanding of their experiences. This decision was made as a means of working respectfully and collaboratively with the women and their life histories i.e. so they could still identify their experiences rather than them having been 'subverted' beyond recognition through the analytical process. In addition, this upheld my approach which values the notion that what people understand to be their reality, in this case the way that the women understood their experiences of contraception at the time they were shared with me, will shape what they do regardless of the 'truth' of the claims.

As mentioned in the introduction, I also struggled at times to maintain a critical distance with regards to the public health framework within which this project was originally, albeit unwittingly, conceived. At the outset, the public health audience was

much more central in my thinking about this phenomenon and over time my feminist and political commitments to do women's centred research that could make a difference to women's lives created some epistemological tensions. These are reflected in this thesis, for example through some of the variation in terms used. It was my intention to critically reflect the public health discourses without alienating the public health audience that I was conscious have, to some extent, the 'power' to action shifts in policy and practice which in turn could have real impacts on women's contraceptive experience. At the same time, this tendency to re/produce a public health approach through language or contextualisation, can be incongruent with the commitment to the individual women who participated in the research and to women-centred reproductive health and rights more broadly. This critical balance was challenging and part of this reflection is a further effort to make this a rigorous piece of research.

10.1 Recommendations

From a policy perspective, many of the findings from this thesis may be challenging to translate into practice due to the fundamental differences between the emphasis on the socio-cultural, sexual and historical facets that are captured in this research, and the extant biomedical framework for contraceptive service delivery. A more meaningful model of contraceptive service delivery to ensure best-fit methods requires a paradigm shift in contraceptive provision. The ethos of policy and practice directed towards women's contraceptive care needs to reflect women's lived experience of contraception and deliver truly women-centred services. As such, suggestions targeted at individuals fall significantly short of shifts that are required at a structural level and risk undermining the central argument of this thesis.

Considering the current circumstances as they are however I do make the following practice based recommendations that may be possible to operationalise at a more localised level and confer some beneficial shifts in contraceptive service delivery. These include:

- Drawing on other models of extant women's health resources, the development of a website that unites balanced information about 'medical' versions of contraception, how to access them and 'patient rights'; with information about other contraceptive practices and signposting to support/guidance for these. Thus, a platform to depart from the rhetoric of 'contraceptive choice' towards its actual delivery;
- Better supported learning by specialist trained sex educators (non-school based) about the reproductive and sexual self, prior to the commencement of hormonal contraception use. This offers women the embodied knowledge to observe and respond to any adverse effects of contraception and make decisions about which methods best suit their needs;
- More non-clinical practitioners trained to advise and guide women about non-hormonal method use including 'natural family planning' as a specific response to women for whom hormonal methods are not acceptable. So, reconceptualising peripheral practices as legitimate;
- The development of inclusive tools for training contraceptive providers that challenge inherently sexist practices that mean that outdated stereotypes of women are used to understand and respond to women's experiences with contraception; and
- The development of clinical practice tools that consider the psycho-social, cultural and sexual components of contraception for use in the contraceptive consultation to locate best/better fit sustainable contraception to meet the needs of individual women.

10.2 Final remarks

This project has had a profound influence on me personally. The stories I heard from the women were moving, confusing, amusing and inspiring amongst many other things. I learnt from their narratives (and my subsequent interpretations) about my own position and myself – a circumstance that after 15 years of consistent hormonal contraception use became more problematic than ever before. Despite thoroughly appreciating the opportunity to make use of contraception, easily and for free, and

without suggesting others should do the same, I have been inspired during this project to discontinue my own method use and make a departure from my 'pill me'; curious and learning every day about an alternative, previously unknown version of myself that has been a stranger for most my adult life. Therefore, from a personal perspective throughout this thesis I have started to re/make my own embodied knowledge and do contraception in a different way; albeit outside the realm of the 'right and responsible' version. During this time, I have also observed changes in the scholarly approaches including more cultural resistance to accepted versions of 'contraception use'. Exciting agendas such as those regarding sexual pleasure increasingly address the impacts of contraception on the sexual self; including through the commitment of some practitioners and the research community. The increasing popularity of mobile phone fertility apps has started to shift possibilities for self-knowing literally into the palm of women's hands and popular media has started to address contraceptive choice more critically in books, news media and film. These shifts along with the myriad examples of resistance in this research offer real women-centred alternatives where 'contraception' varies conceptually and the choices made are congruent with the needs and the priorities of the woman rather than dictated through normative 'right and responsible' discourse of hormonal contraception use, introducing exciting ways to re/make an ontology of contraception that is truly liberatory.

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Appendices

Appendix 1



Participant Information Sheet

Negotiating the Fertile Body: Using Life History Methods to Explore Women's Experiences of Managing Pregnancy

Thank you for taking the time to read this information sheet. If you decide to participate in the study, 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 or ask questions if you wish. Please ensure that you do wish to take part. Thank you for reading this.

What is this study about?

Women in the UK now have access to a wider range of contraceptives to prevent pregnancy than ever before. However each woman has different preferences with regards to sex and contraception and a huge number of factors may influence a woman's choice to use, or not to use contraception. This study wants to understand the experiences and challenges that women have in managing their fertility whilst trying to pursue an enjoyable sex life. It is also hoped that the research will offer insights into current issues such as why unintended pregnancy appears to be increasing in women aged over 25.

This study will aim to explore:

- The factors that influence choices to use contraception or otherwise.
- The experiences and challenges that women have had over their life in negotiating contraceptive use or attempting to prevent pregnancy
- How these factors have changed, developed and evolved throughout the course of a woman's life.

Your participation

Your involvement in this study is entirely voluntary and you may stop your participation at any time without giving a reason. If you are happy to take part, we will ask you to sign a consent form to ensure that the project meets the requirements of good ethical research but you are still free to withdraw at any time for up to two weeks following the final interview.

If you are unable to complete all stages and have to stop your involvement but the data collected up until that point is deemed to be useful, it will be kept for analysis. If you do not want this to happen, you have two weeks following the last meeting to withdraw the material and it will not be included.

What will happen?

You will be asked to have three meetings with the researcher.

Meeting one – will be an opportunity to discuss the project, ask any questions and ensure that you want to be involved. The researcher will also provide materials and instructions for you to complete a “life map” (in your own time) which will form the basis of the first interview session and act as a tool to help you tell your story. This meeting will be recorded to act as field-notes however it will not be transcribed and will merely serve as a prompt to the researcher.

Meeting two will be the first interview in which the researcher will support you to describe the experiences you have had throughout your life with regards to preventing pregnancy and using or not using contraception. You will need to bring the “life map” you have made to share with the researcher and this will act as a guide for your discussion in this interview.

Meeting three will be a final interview in which you will have an opportunity to check the transcript from the previous interview and to add any details you would like to your story. The researcher may also ask you some questions or to develop some parts of the story from the first interview.

The meetings are likely to average approximately one hour but will also depend on the length and depth of the stories that you wish to share. If they go on for one hour or longer, you will be offered the chance to have a break. There are no right or wrong answers and you can tell as much or as little as you are comfortable with.

The first meeting and subsequent two interviews will be audio recorded with your permission.

The meetings will be arranged in a location and at a time most convenient for you. It is aimed to complete the meetings approximately two weeks apart from each other but this can be flexible to account for your needs.

What do you need to do?

At the first meeting you will be asked to take away some materials to create a “life map” in preparation for the first interview. Examples, tools and instructions will be given at the first meeting in order for you to do this but there is no right or wrong way. The “life map” will be specific to you and reflect the experiences in your life that you feel are relevance to the topic.

You will be asked to bring this “life map” with you to the second meeting. You will be asked to share this with the researcher as it will form part of the data for analysis but you will be offered a copy to keep if you wish.

During the interviews there is nothing specific that you will need to do. You will be asked to tell your stories using your "life map" as a guide. Please try and enjoy the opportunity to chat about the topic and your life experiences honestly and openly.

Are there any risks from taking part?

There is no risk expected from the process. However, if you should feel uncomfortable at any time, please let the researcher know. You are free to pause, stop, decline to answer and/or leave the interview (s) at any time.

Are there any benefits from taking part?

It is hoped that this work will ultimately lead to improvements in understanding about women's experiences of contraception and sexual health.

You will also receive £50 for your involvement in the project upon completion of the three meetings. This incentive is a gesture of thanks for your commitment to the research and the sharing of your story.

Reasonable travel expenses to and from meetings will be reimbursed if they are carried out outside of your home.

Will anyone know that you have taken part in this or what you have said?

Please be assured that your involvement in this study will be totally confidential.

All personal information about you will be kept strictly confidential in accordance with the Data Protection Act 1998.

Anything that you have said will be reported anonymously i.e. your name and any other identifying details will be removed so no-one will know that it is you. You may select alternative names and details for yourself if you wish and withhold or alter any details as you see fit during the interviews.

Only the lead researcher will have access to the data and it will be stored securely with only the researcher having access to decrypt the identifying details.

What will happen to the results of the study?

The results will be written up into a PhD thesis. It is hoped that they will be published but at the very least a copy of them will be available from Lancaster University.

You will be asked if you wish to be sent a copy of the final report and if you would like, this will be sent to you as soon as the project is completed.

Once again, you will not be identified in any report or publication related to this study.

The data collected during this project may also be used to inform further research.

Who is organising the research?

This research is organised by Rachael Eastham as part of a PhD thesis for a Doctorate in Health Research that is being completed at Lancaster University.

Who has reviewed the project?

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee and reviewed and approved by the University Research Ethics Committee at Lancaster University.

Who to contact for further information

If you have any questions about any part of the study or would like any information about any of the issues discussed, sexual health service or other support services, please contact:

Rachael Eastham at r.eastham1@lancaster.ac.uk or Rachael Eastham C/O Division of Health Research, Lancaster University, Lancaster. LA1 4YT

Complaints

If you are unhappy with any part of the focus group and wish to make a complaint please contact Professor Christine Milligan, Project Supervisor at c.milligan@lancaster.ac.uk or The Division of Health Research, Lancaster University, Lancaster, LA1 4YT, who will be happy to help.

Alternatively, if you wish to speak to someone outside the Division of Health Research, please contact Professor Paul Bates, Associate Dean for Research at p.bates@lancaster.ac.uk or Faculty of Health and Medicine (Division of Biomedical and Life Sciences), Lancaster University, Lancaster, LA1 4YD or by telephone on 01524 393 718.

Finally, it is important that you understand that your participation in this project is very valuable and that we're very grateful for you taking the time to be involved – thank you!

Appendix 2



Consent Form

Negotiating the Fertile Body: Using Life History Methods to Explore Women's Experiences of Managing Pregnancy


We are asking if you would like to take part in a research project to explore your experiences with contraception and efforts to prevent pregnancy over the course of your life so far. Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Rachael Eastham.

- | | Please initial box
after each
statement |
|--|---|
| 1. I confirm that I have read the information sheet and fully understand what is expected of me within this study | <input type="checkbox"/> |
| 2. I confirm that I have had the opportunity to ask any questions and to have them answered. | <input type="checkbox"/> |
| 3. I understand that all 3 meetings will be audio recorded and the 2 interviews will be made into anonymised written transcripts. | <input type="checkbox"/> |
| 4. I understand that audio recordings will be kept until the end of the research project in 2015. | <input type="checkbox"/> |
| 5. I understand that I am not obliged to take part in this study and can withdraw my participation before, during the process at any time, or up to 2 weeks after my final interview. | <input type="checkbox"/> |
| 6. I understand that information from my first interview may be used even if I withdraw from the process unless I specifically request otherwise. | <input type="checkbox"/> |
| 7. I understand that the information from my interviews will be pooled with other participants' responses, anonymised and may be published. | <input type="checkbox"/> |
| 8. I consent to information, quotations and excerpts from the 'life map' and from either of the two interviews being used in reports, conferences and training events. | <input type="checkbox"/> |
| 9. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with her research supervisor. | <input type="checkbox"/> |
| 10. I consent to Lancaster University keeping written transcriptions of the two interviews for 5 years after the study has finished. | <input type="checkbox"/> |
| 11. I consent to take part in the above study. | <input type="checkbox"/> |

Name of Participant _____ Signature _____ Date _____

Name of Researcher _____ Signature _____ Date _____

Appendix 3



LANCASTER
UNIVERSITY

Applicant: Rachael Eastham
Supervisors: Prof Christine Milligan, Dr Mark Limmer
Department: DHR

22 April 2013

Dear Rachael, Christine and Mark,

Re: Negotiating the fertile body: using life history methods to explore women's experiences of managing pregnancy

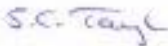
Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, Debbie Knight (01542 592605 ethics@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,



Sarah Taylor
Secretary, University Research Ethics Committee

Cc Professor T McMillan (Chair, UREC); Professor Paul Bates (Chair, FHMREC)

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