Birth Controlled: Reproductive Choice among Female Graduate Students in Montreal

Shannon Sears

A Thesis

in

The Department

of

Sociology and Anthropology

Presented in Partial Fulfillment of the Requirements

for the Degree of Master of Arts (Anthropology) at

Concordia University

Montreal, Quebec, Canada

April 2012

CONCORDIA UNIVERSITY

School of Graduate Studies

This is to certify that the thesis prepared

By: Shannon Sears

Entitled: Birth Controlled: Reproductive Choice among Female Graduate Students in Montreal

and submitted in partial fulfillment of the requirements for the degree of

Master of Arts (Anthropology)

complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Signed by the final Examining Committee:

____Dr. Beverley Best_____ Chair

____Dr. Chantal Collard_____ Examiner

____Dr. Homa Hoodfar_____ Examiner

____Dr. Sally Cole_____ Supervisor

Approved by _____
Chair of Department or Graduate Program Director

_____ 2012 _____
Dean of Faculty

ABSTRACT

Birth Controlled: Reproductive Choice among Female Graduate Students in Montreal

Shannon Sears, MA

Reproduction has been studied extensively in anthropology, yet scholars have focused predominantly on menstruation, pregnancy, and childbirth—events which take place for a limited duration (a matter of hours, days, or months) each time a woman experiences them. The reproductive cycle, on the other hand, continues essentially unabated for decades of a woman's life. It is this largely unexplored area of women's lived experience, and the contraceptive choices women make with regard to their ongoing fertility, that are addressed in the course of this thesis. Research was conducted through a variety of methods. First, multiple virtual and physical sites of information were examined, including websites, television advertisements, and published materials related to sexual health. Second, three medical professionals and a number of volunteers were interviewed about their perspectives and practices toward sexual education and reproductive health. Third, the methods and activities of a university sexual education volunteer group were observed and analyzed. Finally, eleven women were interviewed regarding their sexual education, history of contraceptive usage, and their perceptions of their fertility and birth control options. Ten of these women also participated in a brief contraceptive questionnaire. This thesis considers the ways that contraception is part of a system that not only provides reproductive power to women, but paradoxically contributes to ignorance of female biological processes, governs birth control choices, and manages women's fertility. By exploring this system alongside women's understandings and experiences, I examine the complicated ways that women are, in fact, controlling their reproduction.

Acknowledgements

I would like to thank the members of my graduate cohort, who impressed and encouraged me as we made our way through the program together. I also give my sincere thanks to the faculty of the Anthropology department, including Dr. Chantal Collard and Dr. Homa Hoodfar, for their sincere commitment to excellence which challenged and guided me. And I offer my gratitude to Dr. Sally Cole, whose insight, support, and calm conviction truly made all the difference.

For my mother and father, who taught me the value of intelligence, determination, and a keen wit. You are my staunchest supporters and my favorite peanut gallery.

For Darby, Meghan, and Mikaela, who kept me sane and focused. Thank you for always supplying chocolate, coffee, and chats when I needed them most.

For David, who inspires me. Thank you for your friendship, for laughing at my jokes, and for always cheering me on. This wouldn't be any fun without you.

Table of Contents

Introduction

Contemporary public discourse on women's health implicitly tolerates, and in some cases even encourages, ignorance about the female body. Media outlets in film, television, and the internet specialize in marketing womanhood in a number of complex ways; for example, in advertisements for hormonal birth control that present viewers with types of women (the "athletic woman," the "romantic woman," the "independent woman"). There is at the same time an intent to target both men and women with a message of cultural ignorance about female fertility, in effect to confine the female body to the private sphere. Ironically, it is this message of ignorance which has permeated public discourse. It is a long-running joke in films and on television that a man will not dare peek inside his wife's purse for fear of the mysterious "feminine items" he might find within. When such unmentionables are sold or advertised, they are dubbed "feminine hygiene products," as though the menstrual cycle is somehow unclean.

Furthermore, a pervasive medical hegemony exists in North America, in which doctors and nurses are perceived as authority figures, and ever-more advanced medical technology is wielded against misbehaving bodies. Pharmaceutical companies advertise (and doctors routinely prescribe) hormonal contraceptives that delay a woman's period for months so that she can avoid for as long as possible the "hassle" of her period. Additionally, the pill is commonly perceived as the primary means for a woman to avoid pregnancy, and few other contraceptive choices are as widely used and promoted. The assumed use of hormonal contraception (especially the pill), combined with widespread ignorance about reproduction and other forms of birth control, leads to dependency: a woman may feel that she must rely on hormonal contraception to avoid pregnancy, but

her access to it is limited by her income, her access to health care, her awareness (or lack thereof) of all birth control options, and even her doctor's judgment.

Reproduction has therefore become a medical event, and accordingly anthropologists have studied reproduction and power increasingly over the last few decades. The study of reproduction allows ethnographers to explore social contexts and local meanings, as well as class divisions, access to resources, and forms of power and control. Yet scholars have focused primarily on only a few aspects of reproduction, most often the experiences of menstruation, pregnancy, and childbirth. This is surprising, given that most women will be pregnant for drastically less time than they will spend using contraception: "According to the Guttmacher Institute, the average woman who has two children will spend parts of three decades trying to avoid an unintended pregnancy" (Neergard 2012)[1]. In his 2007 book *Fixing Men: Sex, Birth Control, and AIDS in Mexico,* Matthew Gutmann attempted to broaden anthropological studies of reproduction by focusing on birth control. In his study of men in Oaxaca, Mexico, Gutmann not only made a rare effort to include men's perspectives in a field of study that is extremely female-oriented, but he also addressed a subject that has traditionally lacked scholarly attention. As he explained,

> This book seeks to contribute to another area of study that is woefully underexamined in anthropology: contraception. Despite the fact that hundreds of millions of women and men use birth control worldwide, and despite the considerable attention paid within anthropology to new reproductive technologies, as Russell and Thompson (2000:3) point out, interest in contraception has been scant (2007:10).

[1] The Guttmacher Institute provides access to resources relevant to sexual health and reproduction. According to its website, the Institute "continues to advance sexual and reproductive health and rights through an interrelated program of research, policy analysis and public education. … The Institute's overarching goal is to ensure the highest standard of sexual and reproductive health for all people worldwide." From http://www.guttmacher.org/about/index.html (accessed 2011-2012).

Studies of contraception provide a glimpse into matters of access to information and reproductive control that have largely gone unexamined, both culturally and ethnographically. It is to this branch of anthropology that I hope to contribute.

In this thesis, I examine how women's reproductive decisions appear to reflect private and individual choice, but are in fact linked to larger public forces that shape and manage contraceptive options for women. Specifically, I ask what are the ways that women are distanced from their fertility, and to what extent are they truly in control of their reproduction? In my focus on female graduate students, I also respond directly to Gutmann's call for "a well-grounded study of the modern sex habits of university communities" (2007:8). This allows me not only to examine a well-educated group who might be assumed to have greater reproductive awareness and control, but also to engage in a kind of reflexive anthropology as I use anthropological methods and critical research "at home."

Chapter 1 ("Literature Review") provides a sampling of the literature that has informed this thesis. Although few scholars have published about contraception specifically, there is nevertheless a wealth of information about reproduction and women's bodies that was invaluable to my own research. Chapter 2 ("Field Sites and Methodology") describes my approach to the research I conducted as well as the many locations (both physical and virtual) in which I sought information. In Chapter 3 ("Background"), I offer the reader an opportunity to brush up on their knowledge of the male and female reproductive systems, as well as the many forms of contraception that are available today. It is my belief that a basic familiarity with these subjects will make the content of subsequent chapters all the more meaningful.

Chapter 4 ("Reproducing Contraception") investigates a variety of sites in the cultural sphere that present hormonal contraception as a treatment for menstruation, and also encourage women to act as consumers of birth control (and of lifestyles). In Chapter 5 ("Empowering Ignorance"), I analyze perspectives and tactics of medical professionals who provide health services and sexual education, and the ways that they inform and manage women's awareness (and use) of contraceptives. Chapter 6 ("Birth Controlled") considers the ways that contraception is part of a system which not only gives reproductive power to women, but paradoxically contributes to ignorance of female reproductive processes, governs birth control choices, and manages women's fertility. Ultimately I examine the complicated ways that women are, in fact, controlling their reproduction. Finally, in the Epilogue I address the debates that are currently raging in the United States around women and contraception, and consider the implications of cultural, medical, and political management of women.

Chapter 1: Literature Review

Anthropology of Reproduction

During the last several decades, anthropologists have increasingly studied issues of reproduction and power. As Ginsburg and Rapp explained in their article, "The Politics of Reproduction," when second-wave feminism and anthropology intersected in the 1970s, anthropologists began to explore social norms and political systems in light of women's reproductive experiences. The study of medical systems, in particular "western medical control of women's bodies, especially during pregnancy, became a focus of both popular and scholarly investigation" (Ginsburg and Rapp 1991:312). The field of medical anthropology grew rapidly, along with the attention paid to political influence on the social arrangements that surround issues of reproduction. This evolving anthropological approach focused "on the intersecting interests of states and other powerful institutions such as multinational and national corporations, international development agencies, Western medicine, and religious groups as they construct the contexts within which local reproductive relations are played out" (Ginsburg and Rapp 1991:312).

In addition to broadening anthropological scholarship, feminist movements also contributed to a wave of sexual liberation for women. In particular, the revolutionary book *Our Bodies, Ourselves (OBOS)*, first commercially published in 1973, collected women's knowledge and experience into a single volume that was intended to empower women by placing information about their reproductive health directly into their hands. As Kathy Davis explained in her book *The Making of Our Bodies, Ourselves: How Feminism Travels Across Borders* (2007), the beginnings of *OBOS* came in 1969, which was "a time of activism (the civil rights movement, draft resistance, student protests) and

a budding counterculture. The women's liberation movement had just begun" (2007:20). The women who would eventually constitute the "Boston Women's Health Book Collective" (BWHBC) originally met at a workshop entitled "Women and their Bodies" where they discussed reproductive health and sexuality, but they continued meeting to talk about personal experiences with doctors and their sense that they couldn't access "the information that women needed. …Because, unlike today, there was so little information available on women's health, they began doing the research themselves" (2007:21). Eventually twelve women were selected as the official members of the BWHBC, and their unprecedented accumulated findings and shared experiences were organized into the first edition of OBOS.

Although it met with resistance from a few conservative organizations who "tried to have it banned in libraries on the grounds that it was obscene, antifamily, and anti-Christian," the book was nevertheless a huge success; by 1976 it had sold nearly 2.5 million copies, it was repeatedly a *New York Times* bestseller, and the American Library Association named it "one of the ten all-time best books for young people" (2007:24). Since that time, OBOS has become a resource for millions of women, and is currently in its ninth, fortieth-anniversary edition. The substantial reach of the book has gone far beyond the United States and Europe; as Davis explained, over time "the book moved steadily farther afield, changing from a publisher-based translation to a project supported by international foundations and nongovernmental organizations (NGOs)" (2007:14). By 2011, the introduction of the newest edition of OBOS described its Global Initiative, which has "collaborated with organizations across Africa, South and Southeast Asia, the Middle East, Latin America, and Europe to bring culturally meaningful and reliable

information to communities where it is most needed. …Resources based on the book are now available in more than twenty-five languages and in print, digital, and other socially interactive formats" (2011:xii). OBOS provides crucial information to women around the world, and remains an empowering tool for women's sexual health and well-being. Since the publication of its first edition, and continuing over three decades into the present, OBOS is an exceptional work that "has enabled women to learn about their bodies, gain insight from the experiences of other women, and consider how best to achieve political and cultural changes that would improve women's lives" (2011:xi). As the book's cover states, OBOS is a "bestselling classic, informing and inspiring women across generations" (2011).

In addition to the creation of works like OBOS that presented information about sexual health and reproduction, by the late 1970s anthropological study of the physical body began to emerge more explicitly than in much previous research. In her 1993 essay "Cultivating the Body: Anthropology and Epistemologies of Bodily Practice and Knowledge," Margaret Lock examined the work of several anthropologists who attempted to analyze the body. Lock engaged with a number of articles by researchers who, as she argued,

> …endeavored explicitly to situate the body as a product of specific social, cultural, and historical contexts; who have engaged the nature/culture or mind/body debates in a substantial way; or who have grappled with the poetics and politics of the production and reproduction of bodies (Lock 1993:134).

This attempt to move forward with anthropological research thus situated in the body marked a major change in the direction of the discipline. Instead of trying to "overcome a radical separation of knowledge and practice," dualities like "nature/culture" or "mind/body" could instead be "self-consciously interrogated" (Lock 1993:136).

Similarly, the intersection of bodies and politics became a site for anthropological attention. As Susan Bordo explained,

> Feminists first began to develop a critique of the "politics of the body" not in terms of the body as represented… but in terms of the material body as a site of political struggle. When I use the term *material*… I mean what Marx, and, later, Foucault had in mind in focusing on the "direct grip" (as opposed to representational influence) that culture has on our bodies, through the practices and bodily habits of everyday life (1993:16).

The self-consciousness Lock explored, along with a new sense of interdisciplinarity as science and technology studies began to be incorporated into anthropology, contributed to a further broadening of the discipline.

In addition to studying the body, anthropological research on reproduction added technology to the list of domains that merited investigation and analysis. In "What Do Women Want? Issues of Choice, Control, and Class in Pregnancy and Childbirth," Ellen Lazarus explored the intersections of technology, reproduction, medicine, and social structures in the United States. As she explained,

> In analyzing what women want, it is important to focus on the hegemony of technology and medical ideology that dominates birth in the United States. Equally important is a focus on the social structure. …The distribution of power in social relationships, particularly in asymmetrical relationships sometimes involving class and ethnicity, shapes behavior (Lazarus 1994:40).

Women's reproductive experiences should therefore be examined in light of subjective experience, social expectations, and cultural hegemony, all of which are inextricably intertwined.

Despite excellent research during the 1990s by many scholars on women's rights, reproduction, fertility, and medical anthropology (Lock 1993; Ginsburg and Rapp 1991; Ginsburg and Rapp 1995; Lazarus 1994; Gottlieb 1995; Browner 2000; Martin 2001), much anthropological literature in the last decade seems to have moved sharply toward

globalization, biomedicine, and new reproductive technologies (see for example Haraway 1997; Rapp 1999; Rapp 2001; Inhorn 2003; Inhorn 2008; Coleman 2002). While these matters certainly deserve scholarly attention and feminist insight, I find it surprising that so many researchers of late seem focused on only the events surrounding pregnancy, and that fertility practices in the years between menstruation and pregnancy appear to have been studied little if at all by either medical or social science. As Matthew Gutmann points out in his book *Fixing Men*, "despite the fact that hundreds of millions of women and men use birth control worldwide, and despite the considerable attention paid within anthropology to new reproductive technologies… interest in contraception has been scant" (2007:13).

Pregnancy, childbirth, and menstruation are events that take place for a limited duration (a matter of hours, days, or months) each time a woman experiences them. The reproductive cycle, on the other hand, continues largely unabated for decades of a woman's life. It is this largely unexplored area of women's lived experience, and the contraceptive choices women make as a result of their ongoing fertility, that I address in the course of this thesis.

There have been many developments in biomedicine and reproductive technology in the last ten or twenty years, and anthropologists have tracked its progress accordingly. In 2010, Margaret Lock and Vinh-Kim Nguyen published *An Anthropology of Biomedicine*, an exhaustive review of anthropological and social studies of the interaction between science and bodies. The nearly 500-page tome is full of chapters with titles like, "Biomedical Technologies in Practice," "Who Owns the Body?" and "Genomics,

Epigenomics, and Uncertain Futures." An excerpt from the back cover of the book explains:

> *An Anthropology of Biomedicine* introduces biomedicine from an anthropological perspective, exploring the entanglement of material bodies with history, environment, culture, and politics. …Tracking the historic global application of biomedical technologies, the authors reveal the intended and unintended local consequences and the exacerbation of global inequalities and health disparities that such technologies bring about.

This volume is an example of continuing anthropological studies of the ceaseless development of new biotechnologies, and contributes robust analyses of globalization, bodies, and politics. Yet surely these aren't the only topics requiring investigation in today's ethnographic studies of womanhood, reproduction, and fertility.

Several authors have pointed out the tradition of feminist ethnographers whereby researchers became their own subjects, having drawn research topics from "the personal dilemmas we interpreted as worthy of social analysis in the realm of women's and then maternal/child health, adding the new reproductive technologies, infertility issues, and women's aging to our agendas as we ourselves moved through our own life cycles" (Rapp 2001:467). It is as though the feminist researchers who began working from subjective experience in previous decades have now lost their connection to those important years before a woman becomes pregnant. They have gotten older, perhaps become pregnant themselves, and personally encountered situations that led to new research (for example, forming the basis for Rapp's work on amniocentesis, 1999). This is a perfectly natural transition, yet I feel it is still important to ask what is going on in women's lives *between* their monthly periods, *before* they conceive a child for the first time, *before* they undergo tests during pregnancy, and *before* they give birth.

Rapp stated that research on reproduction emerged and flourished through "a collective achievement of feminist anthropologists and fellow travelers who saw 'reproduction' as invisibly central to social life [and who] dragged that topic to the heart of our empirical and theoretical work" (2001:472). While the focus of many current reproductive studies may have shifted, women's experiences pre-conception are as central to their social lives now as they have ever been, and deserve continued attention. Like Greenhalgh, as quoted by Gutmann in *Fixing Men*, in this thesis I attempt to continue to "challenge 'the mainstream demographic view of fertility as a one-time biological event (childbirth)' and to rethink reproduction as 'an ongoing social and political construction'" (2007:13).

Rapp's book, *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America* (1999) is focused on new reproductive technologies, yet much of her approach is relevant to my own work. Like Rapp, I approached my research as a participant observer: I am a woman, I interviewed women in the city where I also live and work, and I experience reproductive and contraceptive needs that are similar to theirs (see Chapter 2). Although Rapp worked with pregnant women dealing with reproductive technologies (a group I did not encounter), her interview and participant observation methods nevertheless informed my approach. Furthermore, her exploration of the intersections of science and culture, medical anthropological analysis, and the power of language provided an instructive base from which to begin my own research.

Matthew Gutmann's work is similarly relevant to my study. Although Gutmann's research in *Fixing Men* primarily involved Mexican men, I found his ethnography especially compelling, particularly with regard to the study of birth control and his

methods for exploring sexuality and decision-making among individuals and larger, cultural structures. Like Rapp (and others), Gutmann's attention to the intersections of culture, government, medicine, industry and material bodies contributed to a thorough and compelling portrait of sexuality and reproductive health.

More recently, Tsipy Ivry published an ethnography that was the culmination of nearly 15 years of personal and professional research, and follows a similar methodological approach. *Embodying Culture: Pregnancy in Japan and Israel* (2010) began with Ivry's experience of her first pregnancy, but her book is not just one more example of the "western medical control of women's bodies" that I quoted from Ginsburg and Rapp above (1991:312). Although Ivry shares "deep concerns about biomedicalization and technologization" with prior scholarship on the anthropology of reproduction, she centers her analysis not on biotechnology but on pregnancy, "as it is experienced and managed within its socio-cultural and political context at a particular historical moment" (2010:6). Ivry uses "multiple perspectives on pregnancy – those of pregnant women, their partners and relatives, doctors and strangers – to obtain a broad socio-cultural understanding of [pregnancy]" (2010:6-7). She suggests that an "anthropology of pregnancy" should encompass multiple contexts, from intimate relationships to "local cultures of pregnancy" (2010:261), and should thereby incorporate concepts of power, knowledge, gender, medicalization, technology, and culture (2010:7). By studying these many and varied contexts, Ivry is able to "synthesize a broad picture of the multiple loci of power within which reproductive relations are played out in both Japan and Israel… [and] to develop a model of the interactive production of authoritative knowledge" (2010:9).

In recent scholarship, this type of reproductive ethnography appears increasingly common. *Reproduction, Globalization, and the State* (2011), features a collection of works by a number of leading anthropologists including Rapp, Gutmann, Inhorn, and eds. Browner and Sargent, to name just a few. Susan Erkison, in her chapter in this volume entitled "Global Ethnography: Problems of Theory and Method," describes her style of research, which follows a similar approach to Ivry's (2010), as a process that involves starting with an individual and moving "through the various dimensionalities that directly affect their experiences" (2011:27). Although Erikson points out that "in global ethnography we try to do too much," she argues that one way for global ethnography to successfully "link individual experiences to large-scale structural factors" is through the process of "aggregating multiple dimensionalities, with an emphasis on aggregating and collecting multiple and methodologically different types of research data" (2011:25-27). She did so by beginning with a study of a single individual ("Ingrid") and exploring each cultural context or social structure that intersected Ingrid's life, from the ob-gyn performing ultrasounds, to the health regulations around pregnancy and prenatal testing, to the marketing department at the company that created the ultrasound equipment. Although a global perspective runs the risk of losing sight of the direct experiences of the individual, Erikson asserts that anthropologists nevertheless "stand to gain a broader understanding of how power, medicine, technology, and women's lives converge in reproductive praxis" (2011:33).

Medicalization of Reproduction

For Rapp and others, language can be a tool for empowerment or division. Just as medicalization and increased technology can contribute to women's sense of alienation

from knowledge and power, terminology in textbooks and scientific language reveal gendered stereotypes that "reinforce a subjective experience of fragmentation and alienation among American women, especially in medical encounters" (Lock 1993:145). In *The Woman in the Body: a Cultural Analysis of Reproduction* (2001), Emily Martin documented negative metaphors of reproduction and their social impact. She found that in many instances, texts that dealt with the female body used much more negative terminology than for male (or male and female) bodies. For example, Martin compared descriptions of menstruation to the periodic shedding of the stomach lining, which follows a similar process:

> ...One can choose to look at what happens to the lining of stomachs and uteruses negatively as breakdown and decay needing repair or positively as continual production and replenishment. Of these two sides of the same coin, stomachs, which women and men have, fall on the positive side; uteruses, which only women have, fall on the negative (2001:50).

Rather than teaching menstruation as a process of "continual production and replenishment," it is often described as something messy, inconvenient, highly unpleasant and evidently undesirable. Women buy "feminine hygiene products" named as though the process itself is unclean or unhygienic. "Menstruation" still sounds like a dirty word in many contexts, to be whispered among women, and has a long history of being treated as a purpose which has failed. As Martin notes, a 1985 textbook for medical students explained "it used to be taught that 'menstruation is the uterus crying for lack of a baby'" (Martin 2001:45).

Martin's study is now more than a decade old, yet her insights into medical terminology and linguistic bias remain relevant. A persistent medical hegemony exists in North America, and it can be felt in more than just medical textbooks. Many scholars have cited what Ivry refers to as "Foucault's treatment of power and knowledge as

mutually constituted through discourse and practice" (2011:10), and Foucault's theories of managing and disciplining bodies seem equally relevant here (see for instance Foucault 1978, 1979, and 1980). Doctors and nurses are perceived as authority figures, and increasingly advanced medical technology is the weapon of choice to be wielded against "misbehaving" bodies. As medical services are increasingly privatized, "they are supported by institutions that control the purse. In U.S. medicine, the priority is profit, as it is in the wider society" (Lazarus 1994:40). Medical institutions are encouraged to bring in as much "business" as possible, and areas of human life that might have previously been considered "private" fall increasingly within the realm of the medical profession. Additionally, those procedures that require new technologies can often be the most lucrative for hospitals (and doctors) when it comes time for reimbursement by insurance companies.

Reproduction, including contraceptive choice, has therefore become a medical event. From the moment a girl is old enough to experience menarche (her first period), she may be treated as though she is ill, suddenly subject to a list of inconveniences, aggravations, and even "symptoms" of her period. Menstruation is an aspect of reproduction that has received much scholarly attention, from before the advent of NRTs and into the present day (see Birke and Gardner 1982, Bleier 1984, Buckley 1982, de Beauvoir 1952, Delaney et al 1976, Gottlieb 1982, Laws 1990, Mead 1928, Ussher 2006, and Young and Bacdayan 1965, to name only a few). In 1988, Thomas Buckley and Alma Gottlieb compiled *Blood Magic: The Anthropology of Menstruation*. The book gathered ethnographies of menstruation in response to "new anthropological approaches to the topic of menstruation," and featured work that addressed "the varying contexts of

menstrual symbolism, the ambiguity of much of this symbolism, the possibility of intracultural diversity in its meanings, and the interface between biological and cultural systems in the makings of human society" (1988:4). Emily Martin, in her chapter in this volume entitled "Premenstrual Syndrome: Discipline, Work, and Anger in Late Industrial Societies," wrote about the "physiological/medical model" of premenstrual syndrome (PMS) as "a variety of physical, emotional, and behavioral 'symptoms' that women 'suffer.' The list of such symptoms varies but is uniformly negative and indeed worthy of the term 'suffer'" (1988:161). Martin included a table of symptoms originally compiled by Judy Lever in 1981, illustrating her point (1988:162):

Complete Checklist of Symptoms of PMS		
	Physical Changes	
Weight gain	Epilepsy	Spontaneous bruising
Skin disorders	Dizziness, faintness	Headache, migraine
Painful breasts	Cold sweats	Backache
Swelling	Nausea, sickness	General aches and pains
Eye diseases	Hot flashes	
Asthma	Blurring vision	
	Concentration	
Sleeplessness	Lowered judgment	Lack of coordination
Forgetfulness	Difficulty concentrating	
Confusion	Accidents	
	Behavior Changes	
Lowered school or work performance	Avoid social activities	Drinking too much alcohol
	Decreased efficiency	
Lethargy	Food cravings	Taking too many pills
	Mood Changes	
Mood swings	Restlessness	Tension
Crying, depression	Irritability	Loss of sex drive
Anxiety	Aggression	

This list of symptoms is not unfamiliar to modern women, nor is Martin's description of medical "treatments" that can alleviate the "psychological and physical states that many women experience as extremely distressing or painful" (1988:163), a point to which I shall return later in this chapter.

A new book from Chris Bobel addresses many of the same issues that were tackled by Martin and other's in *Blood Magic*. Bobel's book, *New Blood: Third-Wave Feminism and the Politics of Menstruation* (2010), takes an interdisciplinary look at modern menstrual politics and "menstrual activists" (women who "want to experience their bodies fully and naturally, and as eco-feminists, they also boycott, or 'girlcott,' commercial single-use products"), through the lens of third-wave feminism (practice that "demonstrates inclusion of all types of feminism, recognizes each person's multiple identities and the consequent ambiguities and contradictions in standpoints, and embraces living feminism in everyday activities") (2010:xi-xii). Bobel's book not only explores what "feminism" means to today's young women, but also illustrates the continuing tensions and resistances between women, their periods, and medical and cultural expectations of what it means to menstruate.

Like the discomfort many women associate with menstruation, a newly pregnant woman will learn of a variety of maladies that she can expect to plague her until the birth of her child. There are many books, articles and websites that offer extensive catalogs of the many discomforts that a pregnant woman can anticipate. For instance, the website for the American Pregnancy Association lists the following as just those symptoms that a woman can expect at the very onset of pregnancy (never mind the following 7 to 8 months): implantation bleeding, swollen/tender breasts, fatigue/tiredness, nausea/morning sickness, backaches, headaches, frequent urination, darkening of areolas, and food cravings or food aversions.[2] Should a woman survive all the perils and discomforts of pregnancy, she must next face the experience of childbirth; this moment in particular is

[2] http://www.americanpregnancy.org/gettingpregnant/earlypregnancysymptoms.html (accessed 2011-2012).

often depicted as a traumatic event, fraught with danger and requiring the proximity of the best medical technology available. "This medical view of birth as potential pathology, in which something could go wrong at any time, is a powerful and dominant model" (Lazarus 1994:27).

The various internal and external manifestations of each stage in the reproductive process, what I call the "symptoms of womanhood," are discussed with the same types of medical terminology as any illness. Often these symptoms are discussed alongside mention of the many medical "treatments" available to "help" women through these processes, which reflects an assumption that all women must surely desire such management. These treatments could include an epidural during labor to ease the mother's pain, acupressure bracelets to combat morning sickness during pregnancy, and even the prescription of birth control pills to adjust the intensity of cramps during periods. In short, medicine offers to "correct" womanhood with medical interventions against bodily processes.

Martin posits that any potentially useful or positive "side effects" of menstruation that have been recognized and valued in other cultures (such as a capacity for increased sensitivity, an ability to relax, and high creativity; see Gottlieb 1988) are culturally overwritten in the U.S., and she argues that "the foregoing list of negative traits is not so much a list of traits that would be unfortunate in any circumstance but ones that happen to be unfortunate in the particular social and economic system… that we live in" (1988:170). She laments the unquestioned, invisible male authority that leads to physical coercion, that is, "in focusing on women's bodies as the locus of the operation of power, and insisting that rage and rebellion, as well as physical pain, will all be cured by the

administration of drugs such as progesterone, which has known tranquilizing properties" (1988:179-180). As Rapp notes, many feminist activists and authors have commented on the long tradition of medical intervention into childbirth (and, Martin and I argue, reproduction generally), particularly given "the increasing fragmentation of all aspects of sexuality and reproduction accompanying medical specialization… and a seemingly boundless male obsession to take over and control the mysteries of the female womb" (1999:47).

Of course, there are now many female doctors who work toward women's best interests, and not all male doctors are striving for control of wombs, yet I think Rapp and Martin would agree that it is hard to shake the looming specter of the historically masculine medical hegemony. Also, as Gutmann notes, "much of the decision making – about what birth control methods, and about what antiretroviral treatments for people with HIV and AIDS, are available – takes place in the boardrooms of pharmaceutical companies located in Basel, Switzerland, and New Jersey. It is there that men, for the most part, develop and market contraceptive products and antiretrovirals – or not" (2007:14). It is for this reason that Susan Erikson felt it was useful to take her ethnography beyond the level of individual experience, and up through global structures of government policy, health insurance programs, and even corporate marketing initiatives (2011).

And yet, still, it is predominantly women who assume most of the contraceptive burden. In 2003 the United Nations claimed that "worldwide 61% of all 'women of reproductive age' who are married or in a consensual union are themselves using contraception" (Gutmann 2007:41). Given the millions of women around the world who

are responsible for their fertility and birth control, perhaps a new anthropology of contraception and women's reproductive cycles is warranted. I hope to contribute to such an endeavor through the ethnography presented here.

Chapter 2: Field Sites & Methodology

Between June and November, 2011, I conducted my research in Montreal, Quebec. The first substantial part of my fieldwork consisted of one-on-one interviews. I interviewed eleven women, primarily graduate students in their 20s who were enrolled in master's or PhD programs at Concordia or McGill University. I chose these individuals because, as a graduate student myself, I anticipated ease of communication and collaborative research relations. Because of the sensitive nature of the materials that were discussed, many of my informants were familiar to me outside of the project, and were (or are) friends or acquaintances of mine. While this familiarity helped and hindered my research in a number of ways, ultimately I believe the combination of casualness and professionalism made it easier for my informants to trust and confide in me.

Although a few of the women told me they were willing to be identified by their real names, I made the decision to assign pseudonyms to each one for the purposes of this thesis. In the interests of protecting private information, when I quote them here I will refer to them by the following fictitious names: Penny, Sarah, Kinsey, Nadia, Josephine, Chloe, Lensa, Isabelle, Hilary, Grayson, and Melanie. All of these women were between 23-38 years old, and all but one were current or former graduate students at McGill or Concordia University. Several of the women were in long-term relationships, some few were single or dating, and most were sexually active (although one person had never had sex, and another is gay). Every woman who told me she had ever had sex (with men) also told me that she has used at least one form of hormonal contraceptive at some point; for eight of the nine women to whom this applied, this contraceptive was the birth control pill. Of the eleven women, only one was actively trying to conceive; one said that if she

got pregnant it would be all right, although she wasn't trying for it; and the rest were concerned about being careful to avoid pregnancy at this time in their lives. (For more information about the women I interviewed, see Appendix 1.)

For our interviews, I met each woman either at my home, at her home, or in an empty room in Concordia's graduate student offices. I did as much as possible to ensure a completely confidential environment, and chose spaces that were quiet and isolated so that our conversations could be absolutely private. Each interview lasted from forty-five minutes to over two hours. The interviews were semi-structured: I asked each woman to fill out a brief questionnaire, and then I referred to a list of questions I had prepared to guide the discussion (see Appendices 2 and 3). Although the content of each interview varied from person to person, in general I tried to keep the questions consistent and tailored them only slightly when necessary.

In addition to the individual interviews, I also held a focus group of female students. Four of my informants, all McGill graduate students, met to provide a forum for discussion of their experiences with menstrual cycles, use of contraceptives, personal histories with the pill, and so on. The discussion was very informal; we met at my apartment and chatted almost casually. I began and guided the conversation with a short list of topics and questions, but for the most part the discussion was free-flowing and organic. To my surprise and delight, it took nearly two hours before everyone felt that enough had been said. The forum provided a space to address some of the most salient matters surrounding reproduction, contraception, and the pill, and helped me hone in on the issues most relevant to my informants.

During the group discussion and individual interviews, I began to realize that some of the women I interviewed were more than slightly interested in the topics they discussed with me. In the days and weeks following my interviews with them, a few women in particular transitioned from "informants" to "collaborators" as they began sending me bits of information that they thought were relevant to my research. Josephine, Penny, Sarah, Chloe, Lensa, and Hilary all provided me with links to articles, videos posted online, news segments, and really anything related to fertility and the pill that struck them as potentially of interest to me. Hilary was one such collaborator:

> I remember I sent you an article. It seemed so relevant… to me, to the fact that I was not aware. The article itself… said, "Women don't know anything about their bodies, there's not much education on it," and I was like, "Wow, this is so relevant to me!" I thought of that, and then I sent it to you.

Toward the end of my fieldwork, I asked four of the women who had most actively engaged with my research (Chloe, Penny, Sarah, and Hilary) to meet with me again for a second group discussion. Two of the women had been in the first group session, and two had only done one-on-one interviews, but all four had sent me follow-up information that resulted from their own interests and curiosity in the subject. We met for an hour at my apartment, and had an unstructured discussion about the ways (if any) that my interviews and our discussion topics had affected each woman. It was not only informative, but interesting as well, to hear how these women perceived my research and their own reactions to it. As Penny said about our one-on-one interview,

> It triggered me. Women's health (or women's rights) has been something I'm always interested in, but [after we talked] I was like, "Oh! There's this ad, or that ad!" It made me pay more attention to all the messages. …It made me start paying attention again. Because I had mostly been like, "I've got *my* thing figured out, so I don't really need to [think about it]."

Thanks to the information sent along by my informants, as well as my own substantial interests in popular culture, media, and advertising, I developed a multi-sited methodology over the course of my fieldwork. As a result, my research also included a review of advertisements related to fertility and birth control, particularly those television or print ads that are related to prescription contraceptives. These ads provide a window into the dominant discourses on the multiple meanings, uses, and even types of womanhood that are marketed in relation to birth control. In conjunction with the results of my interviews, investigating these media helped me to explore the ways that contraceptives are currently both marketed and perceived.

Although my fieldwork took place in Montreal, I must include the internet as a site of my research as well. There are a number of websites that feature content that is highly relevant to my research, and although they may not be based in Montreal or even Canada specifically, the content is nevertheless available to my subjects, and therefore a potential site of knowledge-making, information gathering, etc. Some of the sites that interested me include: university health center websites; home pages for organizations such as Planned Parenthood, the Canadian Federation for Sexual Health, and the Sexual Health Network of Quebec; websites devoted to explaining contraception, fertility awareness, and reproductive health; websites for pharmaceutical companies like Bayer; social networking sites (including Facebook and YouTube); and blogs and articles scattered across a multitude of sites, just to name a very few.

When I was theorizing my fieldwork, I thought it would be useful to investigate high school sexual education programs in Montreal, but I wasn't sure how I could access such programs. All of my interviewees discussed their memories of elementary and high

school sex ed in great detail, and many lamented an education that they retrospectively considered to be inadequate. Penny, for example, explained: "Maybe I just forgot most of it. Or I blocked it. [But] the thing I noticed from sex ed is that it taught me how babies are made, but that's really kind of *it*." After I had heard a lot about this topic in my first few interviews, it seemed that I could gain valuable insight by researching what exactly is taught in sex ed these days. But gradually I came to realize sexual education is no longer a mandatory course in Quebec high schools. Rather, it is up to individual teachers to decide if they will provide sex ed to their students. If they choose to do so, there are no government directives for how exactly to go about it. As I tried to find out more about this situation, it became clear that I would be unable to observe any kind of sexual education at the elementary or high school level. I did, however, eventually become aware of a program that offered sexual health information to university students – a group called SHAG, or the Sexual Health Awareness Group. ("Shag" is also a pun: it's a British term for having sex.) When I first came across SHAG I had no idea what impact the organization would have on my research, but in retrospect I am profoundly thankful to have been given the opportunity to work with them.

SHAG is affiliated with McGill University Student Health Services, is housed alongside the Health Clinic inside the Brown Building on the McGill campus. It is run by Dr. Pierre-Paul Tellier, or "Dr. T," who is the Director of Health Services at McGill. SHAG is a part of Student Health Promotion at McGill, and one of four Peer Health Educator groups that work to educate students and encourage safer sex practices. The current Coordinator of SHAG is Marcie Jacobs, who has been assigned a pseudonym to protect her identity. Marcie works directly with Dr. T to develop and execute SHAG

events. SHAG's staff is comprised of a few individuals who are paid staff members, each of whom leads a team of volunteers in various campus-outreach programs. SHAG volunteers hold dozens of events, clinics, workshops, and demonstrations throughout the school year, and target mainly undergraduate students.

Upon becoming aware of this organization I initially applied to be a volunteer, but soon thereafter I contacted Marcie directly, who very graciously allowed me to tag along as a kind of pseudo-volunteer. This meant that I had access to all SHAG events without being held to the requirements of regular volunteers (such as a minimum number of hours spent volunteering each week for the duration of the entire school year, or attending weekly volunteer meetings). This was a real bonus for me, for although I would have been happy to contribute as a regular volunteer, my graduate courses, part-time work, and fieldwork obligations were keeping me more than busy enough already. Although it was not technically required of me, I still did my best to give back to the group whenever possible; anything from carrying loads of materials for the set up or dismantling of a display booth, to brainstorming topics for a blog on student health, to recording videos of volunteer training sessions, and even attempting to recruit students to attend SHAG events.

The first advantage of my affiliation with SHAG was that I gained access to several medical authority figures who I might not otherwise have been able to interview. I interviewed Marcie in a discussion that lasted over two hours and provided me with an incredible degree of insight into the operations of SHAG, the challenges and rewards of conveying sexual health information to university students, and the ways that the volunteer group operates under the umbrella of the health clinic. I also informally

interviewed several volunteers, including one who was so passionate about SHAG that she came back to work as a paid member of the team, and thereafter provided training to all incoming volunteers. Finally, after a few months of effort, I was also granted an interview with Dr. T, in an appointment that would have been substantially harder to achieve without my connections through SHAG. My interviews with SHAG personnel lasted from 45 minutes to two hours, and took place in or near McGill's health clinic. These discussions provided me with a great deal of insight into the "other side" of contraceptive decision making, through a glimpse at the perspectives of medical authority figures and their opinions with regard to women's fertility, reproductive health, and contraceptive choice – perspectives I could only have guessed at without the advantage of these one-on-one interviews.

The other major boon from working with SHAG was that I was able to actively participate in a number of SHAG events, both as a volunteer (receiving training and subsequently distributing information) and as a student (receiving or encountering information from SHAG volunteers). These activities took me all around the McGill campus, although most of my time was spent in and around the student health clinic. Through the course of my fieldwork in the summer I participated in substantially more events than I anticipated when I first contacted SHAG, and these events provided a wealth of information. First, I attended an orientation session for new volunteers in the sexual health group, which gave me an overview of what SHAG was about and what kind of volunteers had signed up. A few weeks later, I took part in a two-day training clinic that was mandatory for all new volunteers; it was an intensive workshop that not only discussed methods of volunteering and engaging with students, but presented

comprehensive reviews of sexual health and biological processes. A few days later I stopped in at a tabling demonstration, where volunteers had set up a booth and a huge sign advertising the SHAG shop, and were distributing free condoms and sexual health pamphlets to students who walked by. I helped to distribute materials, and at the end of the day I helped to dismantle the booth and carry all the materials back across campus to the SHAG office. I later distributed pamphlets, newsletters, and other SHAG paraphernalia around the health clinic and Brown building.

As time went by, in some ways I became more of an "expert" on sexual health matters. It was reflected not only in the way I participated in volunteer events, but in the way that SHAG staff related to me. In the late fall, and following our one-on-one interview, Marcie decided to hold a contraceptive information session to provide information to women about the various forms of birth control that are available. She asked me to help set up the room for the session, and also asked me to present information if anyone had questions that I could answer. Unfortunately the only person who showed up was actually a friend of mine, so the session was cancelled. It was a shame, but informative nonetheless. I also attended a residence hall demonstration where I thought I would be an observer, or possibly a volunteer who would convey information to the students who showed up for the games and free condoms. In fact, I inadvertently became a participant with the undergraduate students, when a young man sat down next to me and asked me to pick the next question for "our team."

It became a pattern that I kept trying to attend events to strictly observe them, but was somehow drawn into participating as either a volunteer or as a student participant. I think this culminated when I attended a sexual education training workshop for current

Education students who might one day be high school teachers. Marcie presented the session, entitled "Best of the Classroom Experience: The Power of Sex Education Activities." Since there are no guidelines for teaching sexual education in Quebec high schools, this workshop was intended to provide some guidance for those who might choose to teach the information one day. I had planned to sit in the back, but Marcie asked me to sit toward the front to encourage others to move forward and engage in the discussion. Subsequently I was assigned to a "team" of just three people, and we went through various exercises that required us to formulate answers to a variety of questions. Ironically our team was given the prompt, "explain the female reproductive cycle," a topic which (to my surprise) severely intimidated my teammates. Realizing I was "the expert" in the group, I finally gave in and provided my understanding, and then was called upon by Marcie to explain the process to the entire room (nearly 40 people). In the course of just a few minutes I had moved from silent observer, to member of an audience, to member of a group, to authority figure within my group, and finally to expert/instructor to dozens of people. It was quite a day.

SHAG has an office adjacent to the health clinic, and it's called the "Shag Shop," so named because it sells a variety of sex-related items to students at discounted rates. Not only can students come in and talk to SHAG volunteers and staff about any sexual health questions they may have, but they can buy non-prescription contraceptive items (such as condoms, 4 for $1), lubricants, menstrual products like all-natural tampons and the Diva Cup, massage oils, and books about sex, orgasms, and even parenting. The Shag Shop is quite small, approximately 10^2 feet, and rather hard to find; it is tucked away in the Brown building, nestled behind the health clinic and impossible to see from the street

outside. Consequently a lot of SHAG's events are not only focused on spreading information about sexual health to students, but also toward simply spreading awareness of the existence, purpose, and location of the Shag Shop.

On at least two occasions I was surprised to find SHAG's presence on campus. Evidently they keep a stack of pamphlets and a fishbowl full of condoms in the women's bathroom of the Graduate Students' Association building at McGill (the Thomson House), something I didn't know until I came across the display by accident after my softball team played a game nearby and I went to the restroom. Then a few months later, on Halloween SHAG sent volunteers to stand outside the doors to Thomson house and dispense condoms to incoming graduate students, who were there to attend the big Halloween party. This was notable for a few reasons: first, it was a rare effort by SHAG volunteers to reach out to graduate students; second, I had no idea that SHAG would be there and so I encountered the volunteers from an outsider perspective, as I was there as a partying graduate student (in costume) and not with SHAG; and finally, the way the condoms and SHAG handouts were treated (opened, played with, and discarded on the floors, walls, and surfaces of Thomson house) revealed another instance of how perhaps SHAG volunteers are not reaching students in quite the way they would like.

Throughout the course of my research, I constantly encountered not only SHAG's promotional items at McGill, but also the many billboards, posters, pamphlets, handouts, and other materials that I encountered around Montreal that advertised contraception, sexual health matters, and sites for health services. While I of course gathered the materials available at McGill and Concordia's student health centers, I was really surprised by the amount of material I encountered beyond those sites. For example, it was

hardly a challenge to find six-foot tall posters on walls in university buildings or mounted in the metro; signs placed inside bathroom stalls on the university campuses as well as in bars around town; and printed advertisements in school newsletters and in well-known magazines.

When I began this project I assumed that the bulk of my research would be done through the interviews I conducted, and to a large extent this was the case. Yet many of the women I interviewed made reference to some or all of the sites I have discussed above, and with their help and my own observations it was easy to spot relevant materials for research in a variety of sources. The abundance of public advertisements on TV and in print, the numerous publications and hand-outs, and the many websites and online resources I encountered, as well as my interviews and participant observation, provided me with a real wealth of resources related to sexual health and contraception, and helped me contextualize women's decision making with regard to birth control.

Chapter 3: Background

At this point, I believe it will be useful to present an overview of male and female reproductive systems, as well as the many forms of contraception available for women. When I conducted interviews with women in the course of my research, I asked everyone the following question: "How would you describe the process of menstruation and the reproductive cycle?" Unfailingly, this question elicited a bit of squirming, a sheepish grin or a blush in the cheeks, and sometimes a request for clarification; evidently most of my interviewees were rather embarrassed to try and answer. I assured them that it wasn't a "right or wrong" kind of situation, and that mostly I wanted to hear their impressions of the process. The answer, nearly every time, was something like what Kinsey told me: "I probably just know the basics of what happens." When prompted to explain just exactly what "the basics" entailed, several respondents indicated that although at one point in their lives they might have known all the details of reproductive processes, at the time of our interview they were just not prepared to explain the biology to me.

It became clear that many of the fundamental processes of reproduction were an unexplored mystery for most of the women I talked to, a topic that many hadn't revisited since their earliest elementary school sexual education classes. When I went on to ask each woman *how she felt* when I asked her about reproduction (and why she felt that way), most expressed a sense of dismay or chagrin. As Chloe told me, "When I first went on [the pill], I definitely knew everything. … But honestly I've forgotten and I don't know… [laughs embarrassedly] Sorry!" Or Hilary, who said, "I *should* know how my body works, and why!"

The mixture of embarrassment, anxiety, and even a bit of guilt was present later on in the interviews as well, when I asked the women to describe the way various contraceptives (and specifically the pill) work to prevent pregnancy. It actually became difficult for me to ask this question as time went on, because I anticipated the ashamed response it would likely elicit. When possible, especially if someone seemed particularly embarrassed after their answer, I was eager to provide clarification or my own explanations. Because so many of the women I interviewed expressed a desire to know more about these topics, and projected such a sense of embarrassment and even shame at their lack of knowledge, I include this section for them.

In Part One of this chapter, I provide a basic outline of male and female reproduction, and in Part Two I list the contraceptives currently available in Canada. I've chosen to include this information for three reasons: first, an understanding of the male and female reproductive system will help to clarify the way contraceptives work to prevent pregnancy; second, the observation of a complete list of all contraceptive options will (later) illuminate the narrow selection of methods that came up routinely in my interviews; and third, I hope to benefit the women I interviewed and my readers with this information. Few people in our day-to-day lives really study menstruation and the reproductive cycle, much less the physical and chemical processes of contraception. I hope that anyone who may feel under-informed about these processes can take comfort in knowing that they are not alone, and will find a useful resource in the information presented below.

The following text was excerpted from the website www.sexualityandu.ca, which was created by The Foundation for the Promotion of Sexual and Reproductive Health,

and is administered by The Society of Obstetricians and Gynaecologists of Canada. Part One is targeted at young adults, but provides a straightforward overview of sexual reproduction of both sexes. Part Two lists the many hormonal, non-hormonal, and "natural" forms of contraception available. All text and images are the property of sexualityandu.ca.

Part One: Sexual Reproduction[3]

The Body and the Hormones

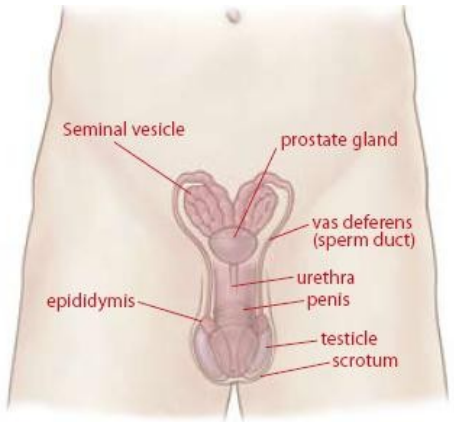
Most of us are equipped to have kids. Of course there are exceptions, for example when individuals suffer from certain diseases. In addition to organs like the liver, heart, and lungs, we have reproductive organs and we produce hormones inside our bodies. Hormones are courier substances that travel in the blood to carry messages from one organ to another. There are many different types of hormones. One group, sex hormones, controls the ability of women and men to reproduce.

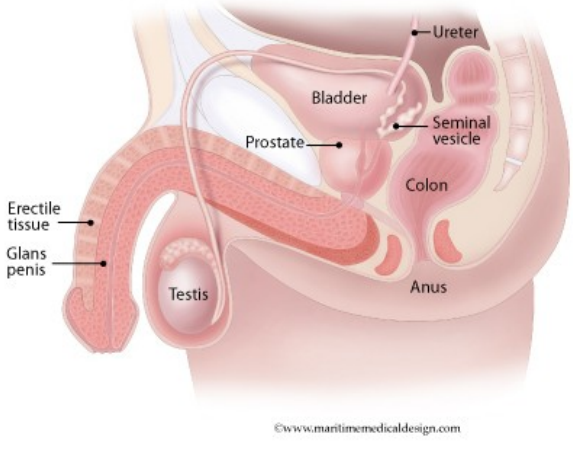
The most important sex hormones in the female body are estrogen and progesterone. The male hormones are called androgens. The most important androgen is testosterone. It is not true that androgens are found only in males and estrogens are found only in females. Men carry female hormones and women carry male hormones as well.

Did You Know?
25% of young women who have intercourse without using a method of birth control at any time during the cycle will become pregnant within one month. 85% will become pregnant within one year.

Let's look at the difference between the male and female reproductive organs. When choosing a method of birth control (contraception) these "little" differences actually make a big difference.

The Male





[3] The following excerpt is taken from http://sexualityandu.ca/en/sexual-health/all_about_puberty/sexual_reproduction (accessed 2011-2012).

From the reproductive point of view the major differences between males and females are:

- Starting at puberty, men can make babies basically anytime provided they ejaculate.
- Sperm can stay alive in a woman's reproductive organs for up to three days.
- Men are able to conceive children almost until the end of their lives.
- Men do not have a cycle to regulate fertility like women do.
- Men need to reach orgasm and ejaculate in order to reproduce.

The sperm production - How men produce babies

The male body has internal and external reproductive organs. The internal organs are (epididymis, vas deferens, prostate, urethra) and external reproductive organs are (penis, scrotum holding the testicles or testes).

Sperm production begins at the onset of puberty, at an average age of 13 years, and lasts throughout the life of a man. The sure sign for a young man that he is able to reproduce is that his erection is followed by an ejaculation. This is of course only "physically speaking". Emotionally, you might be very far from being ready to take on the responsibility of becoming a father. Sperm, more precisely spermatozoa, are produced by the testicles, which are glands within the scrotum. The scrotum functions like a thermostat, regulating the temperature of the testicles. If you're a male then you know that the scrotum becomes smaller and more wrinkled when you enter a cold pool. The scrotum contracts to bring the testicles closer to the body to keep them warm. The testicles produce hormones and sperm. Sperm production is an ongoing process. It takes about 70 days for one sperm to mature.

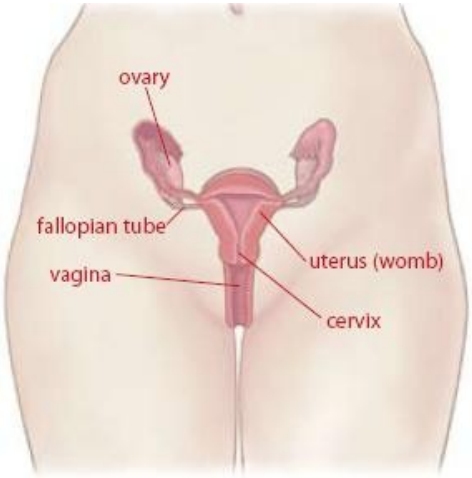
Let's have a look at how sperm actually grow. At the beginning, sperm forms in the testicles, then travels through the epididymis. After that, the sperm reaches the vas deferens. It is stored there until ejaculation occurs. The prostate gland produces a liquid that helps sperm to survive after leaving the male body. During ejaculation, spermatozoa and liquid from the prostate and other glands make a mix while travelling through the urethra. This mix is called semen. The urethra is a tube that also connects to the bladder for passing urine. During sexual excitement, for example during lovemaking, this connection is interrupted so that the semen does not come into contact with urine. A sperm has the ability to swim and travel on its own. It has an oval-shaped head and a tail that serves as a propeller. Sperm carry the genetic information from the male and can unite with the female egg to produce an embryo. After two months, the embryo becomes a fetus, and later becomes a baby.

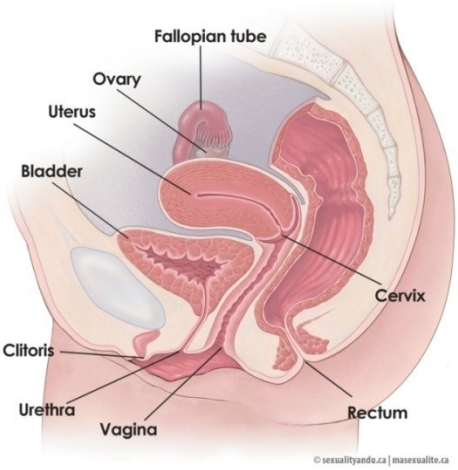
Survival of the fittest

Spermatozoa are very fragile and their chances of survival are very low. This is why the testicles of each individual produce millions of spermatozoa each day. The milky or creamy looking ejaculate consists of hundreds of millions of sperm, but only a few of them will survive the journey through the female vagina to the fallopian tube where the female egg is waiting to meet a sperm. Out of those few, only one will actually penetrate the egg and fertilize it.

Sperm, although it is very fragile, can also be very persistent. Occasionally pregnancy can occur without intercourse and even if the hymen is intact. The hymen is the membrane that partially covers the virgin vagina. This is called "splash pregnancy". Sperm have been known to move very quickly from outside the vagina into the uterus. After intercourse sperm can survive up to three days in the reproductive organs of a female.

The Female





Remember what we said earlier about the differences between the sexes? Here are the little differences that make up a female:

- The woman is able to have children from the time she begins to produce eggs (around 12 years) to the onset of menopause (around 52 years).
- The woman can conceive only during the three days (approximately) surrounding ovulation each month (2 days before and on the day of ovulation).
- The woman has a menstrual cycle that determines her fertility.
- The female egg can only be fertilized by male semen in a time period of 6-12 hours.
- The woman can become pregnant without being sexually aroused and reaching orgasm.
- The woman could be a virgin and still get pregnant (splash pregnancy).

Puberty: When hormones start working overtime

The female body has internal and external reproductive organs. The exterior ones are: Mons pubis, clitoris, urethra, opening of the vagina (6-10 cm), inner and outer lips, and hymen. The interior organs are: cervix, uterus (womb), fallopian tubes (8-10 cm) and ovaries. The cervix is the entrance to the uterus

Already at birth, the female body is equipped with a bank account of 300,000-400,000 egg cells, which are located in the ovaries. Of this large amount only 300-500 will be released during the reproductive years of a woman's life. Starting between the ages of 8-10, hormone production rises and makes the body change from a girl to a young woman. The first menstruation, between ages 11-14, is the sure sign that the body is preparing to have children. This is of course only "physically speaking". Emotionally, you might be very far from being ready to have children of your own.

From puberty on:

- The female produces one egg (ovulation) every month in the left or the right ovary.
- This egg is released to start its journey to the uterus through one of the fallopian tubes.
- The body prepares for a possible pregnancy.

Keep in mind that we're talking about the usual stuff here. Of course there are exceptions such as the production of more than one egg, which might lead to two or more babies. This all happens

due to the amazing teamwork between the hormones and organs. These things go on over and over again each month and this is what we call the female cycle.

The Amazing Female Cycle

The cycle covers a time frame of 23-35 days. The average cycle lasts 28 days. The first day of the cycle is the first day of menstruation. The last day of the cycle is the last day before the following menstruation. Cycle lengths vary individually and they are not always regular. Stress, weight gain or weight loss, for example, can disturb it. After the first menstruation it may take 1-3 years until a woman gets a regular cycle.

During the first 14 days of the cycle (usually, but depending on cycle length) an egg is ripening. A hormone in the brain, which is called follicle stimulating hormone (FSH), stimulates the ripening process. The coat around the egg produces estrogen. This most important female hormone makes the lining of the uterus grow to form a nutritious and secure bedding for the egg to settle into after fertilization.

Approximately at day 14 of a 28-day cycle, an egg is ready to be released. Another hormone in the brain, which is called luteinizing hormone (LH), gives the impulse for the egg to emerge from the ovary and be taken up by the fallopian tube. This important event is called ovulation. This is also the most fertile time of the month for the woman to get pregnant. The egg then travels through the fallopian tube to the uterus. The journey takes about seven days. In the meantime, another important hormone produced in the ovary, progesterone, is preparing the uterus for a pregnancy by securing a sufficient blood supply and by preventing the uterus from contracting and losing a fertilized egg.

Sperm can fertilize the ready egg in the fallopian tube during a 6 to 12 hour period. Fertilization happens when a sperm enters the egg and the embryo starts to form. Two cells divide and become four, the four cells divide and become eight, and so on. By the time the cluster of cells reaches the uterus and settles down into the lining of the uterus, it has become an embryo. This settling down is called implantation. It takes about seven days from fertilization to implantation. The rise of estrogen and progesterone in the blood stream of the woman, along with the pregnancy hormone HCG from cells surrounding the embryo, signals pregnancy. From now on, the female body concentrates on the growth of the embryo and stops the cycle until a few weeks after the baby is born. This is why women cannot conceive again while they are pregnant. A woman can only have one pregnancy at a time, but this does not exclude the possibility of having more than one embryo or fetus at a time, e.g. twins.

The rise in estrogen and progesterone signals to the ovaries: Do not produce any more eggs for now. We have to take care of this embryo first! A pregnancy test can be positive 8-10 days after ovulation. If no fertilization of the egg occurs, the production of progesterone stops. So does the production of estrogens. The message is basically: We do not have a fertilized egg to produce an embryo this month, so stop all the preparations and start all over again! The end of the story is that the thickened lining of the uterus, which was supposed to be the bed for the fertilized egg, is no longer necessary. The same applies to the egg, which did not get fertilized. The body rids itself of this bedding and the egg by bleeding. This is known as the period or menstruation.

The link to contraception

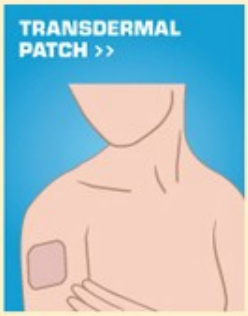
This was a brief description of what's happening with our bodies when it comes to reproduction. What does this have to do with contraception then? Remember we were talking about the principles of contraception:

- Hormonal methods: make the body believe that the ovaries produce hormones while they are, in fact, resting and not producing eggs. Most hormonal methods stop ovulation.
- Barrier methods: prevent sperm and egg from meeting each other.
- Chemical methods (spermicides): destroy sperm upon contact.
- Surgical methods: interrupt the transportation route of eggs or sperm.
- Emergency contraception: delays egg release.

Part Two: Contraception[4]

The Sexuality & U website features a contraception comparison chart, where the many birth control methods are listed side-by-side. Below are screenshots taken from the online chart in the order in which they originally appeared, and grouped (per the website) according to hormonal, non-hormonal, and "natural" methods.

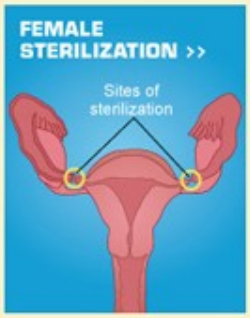
<u>Hormonal Methods</u>

	WHAT IS IT?	HOW DOES IT WORK?	EFFECTIVENESS	ADVANTAGES	DISADVANTAGES
	• "The Pill" is the most popular method of birth control. • Oral contraceptive pills contain estrogen and progestin. • They come in packs of 21 or 28 pills, or extended cycle packs of 91 pills. • Progestin-only pills ("mini-pill") are also available. They contain only progestin and can be prescribed to women who can't take estrogen. Discuss with your healthcare provider for more information. • Requires a prescription	• One pill is taken every day • Prevents the ovaries from releasing an egg • Thickens cervical mucus so sperm can't pass through it • Causes changes in the lining of the uterus	• The pill is 99.7% effective when used perfectly • With typical use, it is 92% effective	• Effective and reversible (not permanent) • Makes periods more regular and decreases menstrual cramping • Extended cycle pills can reduce the number of periods per year to four • Less acne and less hirsutism • Decreases the risk of endometrial and ovarian cancer	• Must remember to take everyday • A possible side effect is irregular bleeding or spotting • Other possible side effects are nausea, bloating, breast tenderness, and headaches • Women over the age of 35 who smoke can't use it • May increase the risk of blood clots • Does not protect against sexually transmitted infections (STIs)
	• A small patch placed on the skin on the buttocks, upper outer arm, lower abdomen or upper body • Two hormones (estrogen and progestin) are released slowly and absorbed through the skin • Requires a prescription	• Apply patch once a week for three weeks and then one week without the patch • Like the OC, the patch prevents the ovary from releasing an egg, thickens the cervical mucus, and causes changes in the lining of the uterus	• The patch is 99.7% effective when used perfectly • With typical use, it is 92% effective	• Effective and reversible (not permanent) • Once a week • Makes periods more regular and decreases menstrual cramping • Probably similar benefits as OC but no research available yet	• Possible side effects include irregular bleeding or spotting, breast tenderness, and headaches • Possible skin irritation where the patch is applied • Patch may detach from skin (less than 2%) • May increase the risk of blood clots • Does not protect against sexually transmitted infections

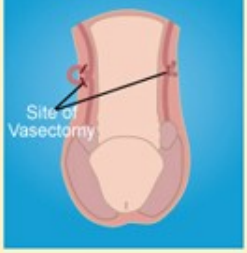
[4] The following excerpt is taken from http://www.sexualityandu.ca//en/games-and-apps/contraception-comparison-chart-choosing-a-contraceptive-thats-right-for-you (accessed 2011-2012).

	WHAT IS IT?	HOW DOES IT WORK?	EFFECTIVENESS	ADVANTAGES	DISADVANTAGES
	• A flexible ring that measures 54 mm across • The ring releases two hormones (estrogen and progestin) that are absorbed through the vagina • Requires a prescription	• The ring is inserted into the vagina where it stays for a total of three weeks. The ring is then removed and the woman has one "ring-free" week • Like the OC, the ring prevents the ovary from releasing an egg, thickens the cervical mucus, and causes changes in the lining of the uterus	• The ring is 99.7% effective when used perfectly • With typical use, it is 92% effective	• Effective and reversible (not permanent) • Once a month contraception • Makes periods more regular • Does not interfere with intercourse • Probably similar benefits as OC but no research available yet	• Possible side effects include irregular bleeding or spotting, nausea, breast tenderness, and headache • May cause vaginal discomfort or irritation (but uncommon) • The ring may fall out (expelled) but this is uncommon
	• An injection that is given in the arm or buttocks 4 times per year (every 12-13 weeks) • It contains only one hormone (a progestin) and does not contain estrogen. It can be used by women who cannot take contraceptive methods with estrogen, for example women over 35 who smoke. • Requires a prescription and the injection has to be given by a healthcare professional	• Prevents the ovary from releasing an egg • Thickens the cervical mucus making it difficult for sperm to get through • Causes changes in the lining of the uterus	• The "shot" is 99.7% effective when used perfectly • With typical use, it is 97% effective	• Effective and reversible (not permanent) • Does not contain estrogen • Only 4 times per year • May be suitable for breastfeeding women • May stop having periods (amenorrhea). After 1 year, over 50% of users will stop having periods, and after 2 years, over 66% of women will stop having periods • Improves symptoms of endometriosis • Decreases the risk of endometrial cancer	• Irregular bleeding is a common side effect • Causes a decrease in bone mineral density. This appears to be reversible when the injection is stopped • May cause weight gain • Delay in getting pregnant when it is stopped. May take up to 9 months after the last injection for the ovaries to start releasing an egg again. • Does not protect against sexually transmitted infections (STIs)
	• A T-shaped device that contains the hormone levonorgestrel (also called the "hormonal IUD") and sits inside the uterus • The hormone is released slowly over time and acts on the lining of the uterus • The intrauterine system can be left in place for up to 5 years • Requires a prescription and has to be inserted by a physician	• Mainly by preventing the sperm from fertilizing the egg • Thickens the cervical mucus making it difficult for the sperm to get through • Causes changes in the lining of the uterus • In some women, it prevents the ovaries from releasing an egg	• The IUS is 99.9% effective	• Effective and long acting (up to five years) • Does not contain estrogen • Does not interfere with intercourse • Decreases menstrual bleeding and menstrual cramping • May decrease endometriosis pain • May decrease the risk of precancerous cells developing in the uterus • 20-30% of women will stop having periods	• Possible side effects after insertion include irregular bleeding or spotting • Perforation of the uterus may occur at the time of insertion (but rare) • May be expelled (fall out) in up to 6% of women • Does not protect against STIs • A physician must insert and remove the IUS

Non-Hormonal Methods

	WHAT IS IT?	HOW DOES IT WORK?	EFFECTIVENESS	ADVANTAGES	DISADVANTAGES
	• A T-shaped device that contains copper and sits inside the uterus • The copper IUD can be left in place for up to 5 years • Requires a prescription and has to be inserted by a physician	• Mainly by preventing the sperm from fertilizing the egg • Causes changes in the lining of the uterus • Causes changes in the cervical mucus	• The IUD is 99.2-99.4% effective	• Effective and long-acting (up to 5 years) • Does not contain estrogen • Does not interfere with intercourse • May decrease the risk of endometrial cancer	• Possible side effects after insertion include irregular bleeding or spotting • May increase menstrual bleeding or menstrual cramping • Perforation of the uterus may occur at the time of insertion (but rare) • May be expelled (fall out) in 2-10% of women • Does not protect against STIs • A physician must insert and remove the copper IUD
	• A surgical procedure to permanently close or block the fallopian tubes • Sometimes called "having your tubes tied" • Minor operation done in a hospital or clinic, often as day surgery	• Laparoscopy: A camera is inserted through a small incision below the belly button and a second instrument is inserted through a small incision just above the pubic bone. The tubes are then blocked by applying a clip or a ring or by burning them • Mini-laparotomy: A small incision is made in the abdomen. The tubes are then blocked by applying a clip, a ring, by burning them, or by cutting out a small piece of the tube • Hysteroscopy: A small camera is inserted through the cervix into the uterus. Tiny plugs are inserted into the fallopian tubes where they enter the uterus. A special x-ray is done 3 months later to make sure that the tubes are blocked	• Female sterilization is 99.5% effective • Failure rates vary depending on the type of procedure. • For example, female sterilization by laparoscopy is 99.5% effective while no pregnancies have been reported to date for sterilization done by hysteroscopy.	• Permanent • Does not interfere with intercourse	• Permanent and difficult to reverse • May regret decision in the future • Possible risks of surgery include risk of anesthetic, bleeding, infection or damage to organs in the pelvis (bowels, bladder, blood vessels) • Short term side effects after surgery may include abdominal and shoulder tip discomfort and bruising • If pregnancy does occur, there is a risk that it will be an ectopic pregnancy • Does not protect against STIs

	WHAT IS IT?	HOW DOES IT WORK?	EFFECTIVENESS	ADVANTAGES	DISADVANTAGES
SPONGE >> 	• A soft foam sponge that contains a spermicide to disable sperm. • Available in stores, pharmacies and online	• Sponge is placed inside the vagina over the cervix where it acts as a barrier, absorbing and disabling sperm. It is effective for up to 12 hours.	• The sponge is 91% effective for women who have not given birth (nulliparous) and 80% effective for women who have previously given birth (parous) when used perfectly. • With typical use, it is 84% effective for nulliparous women and 68% for parous women	• Does not contain hormones • Can be used by women who smoke or are breastfeeding	• Does not protect against certain sexually transmitted infections • Sponge users may experience vaginal infection or irritation • If the sponge is left in the vagina for excessive periods of time, symptoms of toxic shock may appear • Some people may be allergic to spermicides
SPERMICIDE >> 	• Spermicides come in several other forms, including creams, jellies, tablets, suppositories, foams and film. • Available in stores, pharmacies and online	• Spermicides are inserted into the vagina, and contain ingredients that disable sperm. They can be used together with other forms of contraception.	• Spermicide is 82% effective when used perfectly • With typical use, it is 71% effective • Spermicides are very effective when used with a barrier method.	• Does not contain hormones • Can be used by women who smoke or are breastfeeding • Spermicide may also provide lubrication	• Does not protect against sexually transmitted infections • Some people may be allergic to spermicides
FEMALE CONDOM >> 	• A soft, disposable, polyurethane sheath • Available online and in some stores and pharmacies	• Placed in the vagina before vaginal intercourse. • Lines the vagina and prevents direct genital contact and exchange of body fluids • A new condom should be used for each act of intercourse	• The female condom is 95% effective when used perfectly • With typical use, it is 79% effective	• Available without a prescription • Protects against some sexually transmitted infections	• Must be available at time of intercourse • Needs to be inserted properly • More expensive than male condoms • Makes a noise during intercourse. • May slip or break.
DIAPHRAGM >> 	• The diaphragm is a latex dome with a flexible steel ring around its edge that is positioned in the vagina, over the cervix (non-latex diaphragms also available) • Requires a prescription and needs to be sized by a healthcare professional. Available in pharmacies, family planning clinics and online.	• Block the entry to the uterus so sperm cannot enter and fertilize an egg • Must be left in the vagina for 6-8 hours after intercourse • Spermicide should be reapplied for each act of intercourse	• The diaphragm is 94% effective when used perfectly • With typical use, it is 84% effective	• Contains no hormones • Can be used by breastfeeding women • Some protection against certain sexually transmitted infections • Can be inserted several hours before intercourse	• Must be available at time of intercourse • Requires proper insertion technique • Does not protect against certain sexually transmitted infections • Diaphragm may increase the risk of recurrent urinary tract infections • May be dislodged during intercourse (consider morning after pill) • Some people may be allergic to spermicides

	WHAT IS IT?	HOW DOES IT WORK?	EFFECTIVENESS	ADVANTAGES	DISADVANTAGES
CERVICAL CAP >> 	• The cervical cap is a thimble-shaped silicone cap that fits over the cervix • Requires a prescription and needs to be sized by a healthcare professional. Available in pharmacies, family planning clinics and online.	• Block the entry to the uterus so sperm cannot enter and fertilize an egg • Must be left in the vagina for 6-8 hours after intercourse • Spermicide should be reapplied for each act of intercourse	• The cervical cap is 91% effective for women who have not given birth (nulliparous) and 74% effective for women who have previously given birth (parous) when used perfectly. • With typical use, it is 84% effective for nulliparous women and 68% for parous women.	• Contains no hormones • Can be used by breastfeeding women • Some protection against certain sexually transmitted infections • Can be inserted several hours before intercourse	• Must be available at time of intercourse • Requires proper insertion technique • Does not protect against certain sexually transmitted infections • Cap may cause vaginal odour and discharge • May be dislodged during intercourse (consider morning after pill) • Some people may be allergic to spermicides
MALE CONDOM >> 	• A soft disposable sheath that fits over the erect penis • Available in different sizes, shapes, thicknesses, colours, and flavours • Most are latex but non-latex condoms are also available (polyurethane, silicone, lambskin) • Available in stores, pharmacies and online	• Physical barrier acts to prevent direct genital contact and the exchange of genital fluids • A new condom is used for each act of intercourse	• The condom is 98% effective when used perfectly • With typical use, it is 85% effective	• Available without a prescription • Latex condoms protect against sexually transmitted infections • May help to avoid premature ejaculation	• Must be stored and handled properly • Must be available at time of intercourse and may reduce spontaneity • May slip or break (consider the morning after pill) • May reduce sensitivity for either partner
MALE STERILIZATION >> 	• Also called vasectomy • A surgical procedure to permanently close or block the vas deferens (the tubes that carry sperm to the penis) • Minor operation, usually done in physician's office and can also be performed in a hospital or clinic	• No sperm is released in the man's ejaculate, so the egg cannot be fertilized	• A vasectomy is 99.9% effective • The main reason for failure after a vasectomy is because back-up contraception was not used between the time of surgery and the follow-up semen analysis. Another form of contraception is required until that analysis shows no sperm.	• Does not interfere with intercourse • No significant long term side effects • Less invasive and more cost-effective than female sterilization	• Difficult to have reversed • Possible short term surgery related complications include: pain & swelling, infection at incision sites • Does not protect against STIs • Not effective immediately. Need follow-up sperm analysis that shows no sperm are present in the semen

Natural Methods

	WHAT IS IT?	HOW DOES IT WORK?	EFFECTIVENESS	ADVANTAGES	DISADVANTAGES
	• Natural family planning methods rely on a woman's knowledge and awareness of her body and menstrual cycle to avoid pregnancy. • They do not rely on contraceptive devices, hormones or barrier methods to provide contraception. • There are several methods: Calendar, Ovulation, Sympto-Thermal, Post-Ovulation • Instructions and materials available in pharmacies. Contact SERENA Canada for expert advice	• A woman monitors her monthly cycle by tracking the days on a calendar and/or by taking her temperature and/or by monitoring changes to her cervical mucus • This information helps her determine when her body releases an egg (ovulates); Ovulation is when she is most likely to become pregnant from intercourse • Intercourse is avoided during this fertile period	• Depends heavily on the method used, motivation, and experience • The sympto-thermal method is 98% effective when used perfectly. Other natural family planning methods are not as effective. • The typical use failure rate is 25%	• Women become familiar with their body and menstrual cycles • Information can also be used later to plan a pregnancy • Inexpensive and natural	• Requires willpower, periodic abstinence, and motivation • Takes time and effort to learn to use the method properly • Does not prevent STIs • Reduces spontaneity

I conclude this section with a brief discussion of "Natural Methods." In multiple places on sexualityandu.ca, contraceptives are identified as hormonal, non-hormonal, and what are called "natural" methods. One of the latter is the Fertility Awareness Method, or FAM, a method that I have used for several years and about which I have received many questions from the women I've interviewed. Often FAM is perceived as a method used exclusively by women who have stopped using birth control and are hoping to conceive, because a woman who knows precisely when she ovulates will likely have an easier time getting pregnant. However, FAM can be used by anyone, not only as a means for avoiding or achieving pregnancy, but also to more fully understand one's body and reproductive cycle. Because the process involved in avoiding pregnancy is slightly more complicated than, say, slipping on a condom, I post below the summary of FAM from sexualityandu.ca.

Natural Methods[5]

Natural birth control methods teach women to determine the fertile phase (typically 7 to 10 days long) of their menstrual cycle. To avoid pregnancy, women avoid intercourse on fertile days.

There are many variations of natural birth control. The most effective methods teach women to chart the signs of fertility that ebb and flow with the natural hormonal changes of each menstrual cycle. There are two main approaches: 1) the sympto-thermal approach, where waking temperature and cervical mucus are charted; and 2) the mucus approach, where only cervical mucus is charted.

It is helpful for women and their partners to know about the two most common methods:

1. **Fertility Awareness Method (FAM)** refers to a natural birth control method outside of a religious framework that supports the use of barrier methods (condom, diaphragm, and spermicide), emergency contraception, and abortion. Justisse is a Canadian developed variant of FAM that teaches both the mucus only and the sympto-thermal approaches.
2. **Natural Family Planning (NFP)** typically refers to natural birth control that is taught and practised within a religious framework, most commonly Catholic centred organizations. It does not support the use of barrier methods, emergency contraception, or abortion. Billings Ovulation Method teaches only mucus observations. Serena and Couple to Couple League methods are sympto-thermal NFP variants. The Creighton Model will teach both mucus only and sympto-thermal approaches.

How natural birth control works

The FAM/NFP sympto-thermal method is explained below. It is considered the most effective of all the natural birth control methods.

Sympto-thermal teaches a woman how to observe, chart and interpret her waking temperature (basal body temperature or BBT) and cervical mucus to understand what days she is fertile and what days she is not fertile. She then knows when she is likely and when she is less likely to become pregnant from intercourse.

A woman who has a regular menstrual cycle will usually experience the following sequence of events:

- 3 to 7 days of menstruation
- several days where she does not feel or see mucus in her vagina or on her vulva
- several days of a ‘wet’ or ‘slippery’ sensation at her vulva or in the vagina where she sees and/or feels mucus, which becomes progressively more slippery, stretchy, and clear as ovulation approaches
- after ovulation her waking temperature rises, mucus disappears from the vulva, and the vulva and vagina feel “drier

Fertile days begin with the first sensation of mucus at the vulva and continue until both the mucus has dried up and the waking temperature has been high for 3 days in a row. With days of higher

[5] The following excerpt is taken from http://sexualityandu.ca/en/birth-control/birth_control_ methods_ contraception (accessed 2011-2012).

fertility and lower fertility determined, a woman can time intercourse to avoid or achieve pregnancy.

If a woman's cycle does not follow a typical pattern, using natural birth control will be more difficult. However, she can still use natural birth control but she is advised to seek consultation with a trained FAM/NFP instructor in order to use the method most effectively. In general, FAM/NFP are not recommended for women with the following difficulties: irregular cycles, inability to interpret the fertility signs correctly, or persistent infections that affect the signs of fertility.

Cervical changes are a third fertility sign that a woman may find useful in determining her fertility. She checks for variations in the position, firmness and openness of the cervix that relate to fertile and infertile days.

Effectiveness

In order to effectively use FAM/NFP a woman needs to accept responsibility for charting and interpreting her fertility on a day-to-day basis. The possibility of an unplanned pregnancy should not represent a devastating occurrence in order to use this method of family planning. As with all forms of birth control, motivation, intention, and cooperation between partners are the key to effective, successful use.

Successful use of FAM/NFP methods depends on the accuracy of the method in identifying the woman's actual fertile window, a woman's/couple's ability to correctly identify the fertile time, and the couple's ability to follow the instructions of the method they are using. The effectiveness of FAM/NFP (Strauss and Barbieri 2004, Hatcher 2004) varies depending on the method:

1. 95-98% effective with perfect use (user strictly follows rules to avoid pregnancy)
2. 75-88% for typical use (user may not always follow rules)

Benefits of FAM/NFP

1. Effective method of birth control
2. Has no negative health side effects
3. An alternative for women who cannot or do not want to use hormonal methods
4. Promotes positive body awareness
5. Consistent with many religious beliefs and lifestyles
6. Alerts women to reproductive health and fertility concerns
7. Fosters communication between partners
8. Encourages partners to enjoy a variety of romantic or sexual activities as alternatives to vaginal intercourse during fertile periods
9. Encourages male involvement

Disadvantages OF FAM/NFP

1. Provides no protection from sexually transmitted infections
2. Often difficult to find trained FAM/NFP instructors
3. Requires time to learn (usually 3 to 6 cycles)
4. Requires discipline and commitment to chart fertility signs and follow the rules to avoid pregnancy
5. Times of abstinence from intercourse may be a challenge for some couples

For more information about the Fertility Awareness Method, see the book Taking Charge of Your Fertility by Toni Weschler. It provides a comprehensive look at women's reproduction, and offers tools and tips on how to practice FAM, how to avoid or achieve pregnancy, and how to be more intimately aware of one's personal fertility. The book's website[6] also features discussion boards, charts to download, and additional resources.

[6] www.tcoyf.com (accessed 2007-2012).

Chapter 4: Reproducing Contraception

> I don't really remember thinking about other options; [the pill] was just the obvious one to me. –*Chloe*

> Pills. Now that you mention it, I have seen ads for the Ring. And (now that you mention it) I *have* seen ads, peripherally, for the patch. But clearly it didn't stick with me well enough for me to actually consider them seriously. –*Nadia*

In the United States and in Canada, many forms of contraception are available to women. The range of hormonal, non-hormonal, and natural methods offer a variety of possible benefits (and drawbacks), and supposedly there is a potential "right" option for every woman. In *Fixing Men*, Matthew Gutmann referred to "what Columbian anthropologist Mara Viveros (2002) calls 'the female contraceptive culture,' in which women worldwide are overwhelmingly responsible for birth control" (2007:40). Women are the expected consumers of birth control, and certain brands or types of contraception are marketed as appropriate for certain "types" of women (for instance, the "educated career woman," the "modern woman," or the "natural woman"), a point to which I shall return later in this chapter. Yet in my research it has become clear that one method is by far the most promoted, prescribed, and used: the birth control pill. Despite the availability of other options, some with higher efficacy rates and fewer side effects, the pill takes center stage where contraceptives are concerned. It is heavily marketed and advertised, it is prescribed to grown women and young girls, and it is both promoted and perceived as the standard method to use. For Chloe and Nadia (quoted above), and others like them, the question isn't so much "should I use the birth control pill," but rather, "which birth control pill should I use?" In this chapter, I will explore how certain messages about contraception, and the pill in particular, are reproduced in advertising, media, and culture, and how this leads to the normalization of use of a select few contraceptives.

Treating the Symptoms of Womanhood

> I took it because I had horrible periods, but… I didn't like the way I felt on it. I wasn't dating anyone seriously, and I was like, 'what's the point?' One more thing to pay for, one more thing to remember. …I have never gone back to using the pill as a form of contraception. Because I didn't want to, I didn't like it. And now that I'm on [Yaz, to treat my cramps,] I'm just not that religious about taking it; I don't really trust it. …I would prefer not to have to take any medications, but I also prefer to be able to do something for more than an hour on those days."
> –*Isabelle*

Among hormonal contraceptives, the birth control pill in particular has emerged as a kind of cure-all prescription for the many "symptoms of womanhood" (like those listed in Emily Martin's collection of symptoms in Chapter 3 of this thesis). Often these "treatments" start early in a woman's life; pills are often prescribed to teens (or even pre-teens) who experience severe acne, cramps, and headaches. Before these girls have even experienced the biological changes that lead to menarche and their individual bodies' responses, they may be put on prescription medication to treat assumed "universal symptoms" that have only just begun to materialize. In her recent book *The Body Scoop for Girls: A Straight-Talk Guide to a Healthy, Beautiful You* (2009), Dr. Jennifer Ashton ("an ob-gyn specializing in adolescent care") attempts to provide an overview of the changes that girls experience during puberty, with particular focus on the reproductive cycle. Ashton is a correspondent for CBS and therefore well-placed to reach a large audience, and her book is a recent example of the few mainstream resources available to today's North American teenage girl. Ashton makes an astute point, that "sex ed is still taught *exactly* the way it was thirty years ago (often it's abstinence-all-the-time)" (italics in original 2009:5). These sex education classes can be extremely brief, offer minimal instruction, and rarely provide girls (or boys) with a truly thorough understanding of the way their bodies work. This is the case in Montreal schools as well, where sex education

classes are no longer mandatory and are only taught at the discretion of individual teachers. There are no standards or guidelines for how to teach sexual health to students, and teachers may choose to skip the topic altogether. In Chapter 5, "Empowering Ignorance," I will discuss this situation and some of its consequences in greater detail.

Ashton's book attempts to fill a perceived void by providing a source for girls to learn about their bodies, reproductive systems, and contraceptive choices. Ashton states repeatedly that she wants to give girls the information they need to make "smart" choices, and claims to offer a neutral approach to doing so. As she states, "I'm not going to take sides or preach one school of thought over another. You're smart. You know how to get information and you know how to think. I'm going to give you the right information at the right time and let you make the choices that are right for you" (2009:6). In general I applaud this approach; it is refreshing to see someone (a woman doctor, no less) present facts in an easy-to-understand format that can be accessible to many young women. Unfortunately, despite her claim not to "take sides," Ashton's position is not neutral, and fails to fulfill her promise of a neutral stance.

In chapter after chapter, Ashton discusses the many benefits of taking the birth control pill, and not necessarily for contraception. She suggests it for use as a treatment for a variety of ailments (bringing us once again to Martin's table of period symptoms), including depression, excessive hair growth, pain from periods, polycystic ovarian syndrome (PCOS), weight control, and also (eventually) for contraception. I do not claim that the pill *can't* help women with problems such as these, which can certainly manifest as legitimate discomfort around a woman's period. Isabelle, for example, has suffered from extremely heavy periods and debilitating cramps since she started menstruating.

Although she doesn't use the pill for contraceptive purposes, she takes Yaz (a birth control pill manufactured by Bayer) every month to help minimize her discomfort. As she explained to me, "[Yaz] has more active pills, which generally leads to a shorter period, and also implies just being lighter, with not as many days of being terrible. Since [I went on it] it's been much, much better. Immediately, the first month was so much easier. [*snaps fingers*] I was like, 'That's it?! Sweet.'" While women like Isabelle can benefit from the positive side effects a pill can offer, the mainstream willingness to treat quite young girls with the birth control pill should be examined, particularly in the way it seems to be prescribed almost as the remedy for *any* pain or discomfort a girl may experience, and long before she may be sexually active. This approach teaches young women that any form of menstrual discomfort is "bad" (instead of "normal"), and that periods should immediately be "treated" (rather than coped with or, even more implausibly, embraced).

Ashton also uses manipulative language on this topic. As she states, "when I prescribe oral hormones for period problems – especially for patients who are under 18 and still virgins – I don't call them 'birth control pills.' I make a point of calling them 'oral hormones,' to drive home the idea that this is a treatment for a *medical condition*, not a prescription to go out and start having sex" (italics mine, 2009:67). Ashton attempts to normalize the control of women's natural bodies by technological intervention, literally describing periods as a "medical condition" in need of "treatment" (using language that could have come out of any of the old medical textbooks dissected by Emily Martin over a decade ago [2001]). Ashton also distances birth control pills as far from sexual behavior as possible for girls who are culturally deemed "too young" to be

sexually active (a category that may be complicated by class, ethnic, and geographical factors). This is an area where medical science and culture intersect, and the pill can be read as "an open-ended 'complex cultural object'" along the same lines as the reproductive technologies that Rapp studied in her work on amniocentesis (Rapp 1999: 13). Ashton is not alone in her efforts to redefine the meaning of the pill through calculated language; this tactic is frequently used by pharmaceutical companies and in advertising, as we shall see in the next section of this chapter. It's worth noting that young women who wish to use the pill sometimes adopt similar treatment-oriented language, in an effort to win over uncomfortable parents by minimizing any implication of sexual activity. Although Chloe started taking the pill at age eighteen, because she and her boyfriend decided she should start it before they had sex for the first time, the story she told her mother was very different:

Chloe: I told my mom after the fact, and she wasn't very happy about it, because I think she just assumed that meant that I was going to become sexually active. And I tried to convince her that that wasn't the case. I was having really irregular cycles... and I had really bad cramps one month, and not the next. And I had terrible acne, and so that was one of the other things that kind of made me feel like it was a good choice. And all of those things cleared up once I was on the pill. So my acne went away, and of course your cycles are regular, so I felt like I had more control over the aspects of me that I didn't have control over before.

Shannon: But your mom didn't buy it?

Chloe: Well, I dunno. My mom was disappoint… er, I just remember a very brief conversation and I told her very matter-of-factly that "these are the reasons," and I could tell she wasn't 100% convinced. But that was like the last that she heard [of it].

In her book, Ashton frequently refers to the safety of the pill, and provides lists of benefits while minimizing any possible health risks. "Oral hormones really work well. They reduce menstrual symptoms and make periods lighter, shorter, and less painful. Plus they cut the risk of ovarian cysts and pelvic inflammatory disease and have lots of other benefits" (2009:66). Ironically, two pages after this statement she addresses "FAQ's"

about the pill and acknowledges (rather dismissively) the risks of breast cancer, cervical cancer, blood clots, strokes, migraine headaches, and even the closure of growth plates in teens' bones from the pill. She closes the section by stating that as long as you are "generally pretty healthy," oral hormones "are incredibly safe… the risk of dying from taking an oral hormone is lower than that of dying in an automobile accident… For most girls with severe period problems, the big benefits outweigh the smaller risks" (2009:69).

Although Ashton may not be a household name, I have focused on her book because it is a best-selling publication easily accessible to many girls and women, not just in the U.S. but around the world. Ashton's standpoint epitomizes the mainstream willingness to prescribe the birth control pill to young teenage girls whose cycles may not yet be regular, who may not truly understand how their cycle works or even precisely what the pill does, and who may in fact be at risk from those very pills. This attitude reflects an attempt to normalize the use of the pill in a manner that is repeated in many cultural sites (on television, on the internet, in advertising, etc.), and hearkens back to Foucault's theories of knowledge and power once again (1979). Starting a young girl on the pill can have a number of negative consequences, not least of all by masking her natural cycle, which can take years to fully develop. By forcing her body into a regular, 28-day cycle, she will not know what to expect (and what is normal) should she ever go off the pill, and may find herself dependent on it if she wants to avoid pregnancy. There is also a strong implication that pregnancy itself is something very negative: at best it is inconvenient, and at worst it can destroy any chance of furthering one's career or education. This construction of pregnancy as a worst-case scenario for young women is a point to which I will return in Chapter 5.

Moreover, some pills have negative side effects for women of all ages. Experimentation with several brands of pills is often required before a woman finds one where the benefits outweigh any unpleasant side effects. Speaking from personal experience, I went through three brands of birth control pills before giving up on them altogether: the first gave me the physiological equivalent of morning sickness, so that I went through bouts of vomiting nearly every morning; the second caused extreme dizziness and near-blackouts; and the third gave me severe migraines that lasted for months after I stopped taking the pill. Among my female friends, I can't think of a single one who didn't try at least two types of birth control pills before finding one she could stick with.

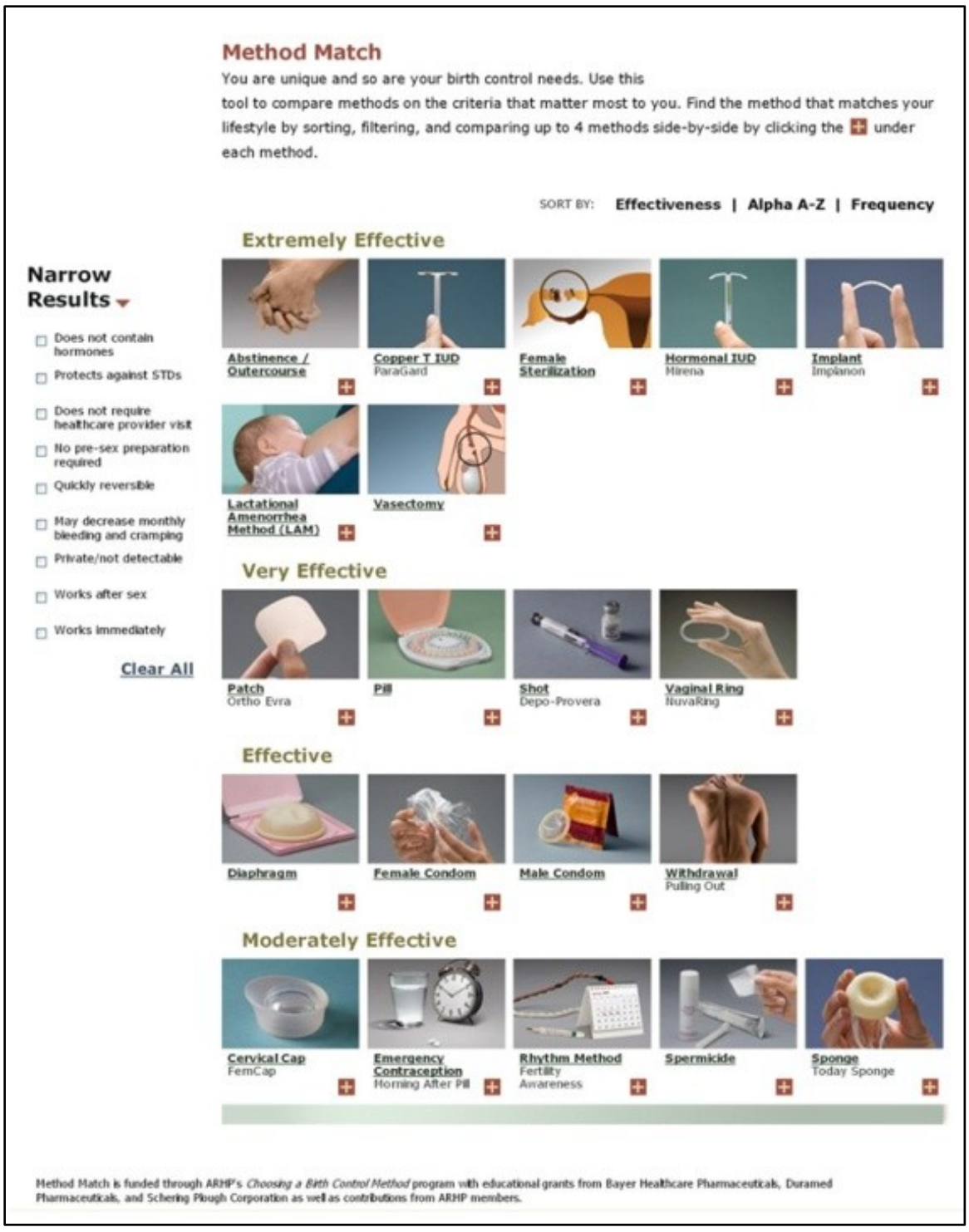
A quick search online uncovers countless forums where women ask each other for advice about the pill and its side effects. In one forum published in 2003 on *Women's Health* online[7], a woman began a discussion because she wanted to stop using the patch, and asked what pill other readers would suggest. There were a few who enthusiastically supported one brand or another, but many women seemed to take the question as an invitation to share their own horror stories with different pills. There were a variety of ways to express their negative experiences, but one commenter, after a particularly long diatribe about the truly awful side effects she experienced from Yaz (the same pill used by Isabelle, quoted above), summed it up thusly: "If you want to be a raging psycho b*tch with clear skin and lighter periods, this one's for you. I'd rather practice abstinence than take this wretched pill again" (Cornforth 2003). While few advertisements, printed materials, or even doctors' warnings seem to acknowledge this side of the birth control

[7] http://womenshealth.about.com/b/2003/07/29/which-birth-control-pill-is-best.htm (accessed 2011-2012).

pill, it is clear that its highly variable and personal side effects can have a significant (and sometimes appalling) impact on the women who take it. Ashton's (and many others') attempts to gloss over potentially serious side effects are just one more mechanism for attempting to normalize pill use, and to train women to rely on technological and medical treatment of their bodies.

There are few reliable resources for women who want to know exactly what they may be in for when they begin the use of a hormonal contraceptive (or an "oral hormone," as Ashton would have us describe it). Although there are currently more websites and online resources available on this subject than ever before, it is hard to know what is trustworthy. Some sites seem official but contain confusing or outright misleading information. For example, the website for the Association of Reproductive Health Professionals (ARHP) was founded by a branch of Planned Parenthood, and provides an online tool that it calls the "Method Match" – an interactive tool to help the user choose the most appropriate form of birth control for her needs (see next page).[8] With this tool, the user can compare up to four types of methods at once, filter out or include certain types (such as "hormonal"), and sort by fields such as "effectiveness" or "frequency" of use. I was initially impressed by this site, because it offers statistics on the failure rate of each type of contraceptive, provides an entire range of contraceptive devices (not simply "the pill or the condom"), and its format is easy to understand. But as I began to look more closely, it became apparent that the website (ironically yet another form of technology that purports to help women control their bodies) is not entirely accurate.

[8] http://www.arhp.org/methodmatch/ (accessed 2011-2012).


Method Match
You are unique and so are your birth control needs. Use this tool to compare methods on the criteria that matter most to you. Find the method that matches your lifestyle by sorting, filtering, and comparing up to 4 methods side-by-side by clicking the + under each method.
SORT BY: Effectiveness | Alpha A-Z | Frequency
Narrow Results
Does not contain hormones
Protects against STDs
Does not require healthcare provider visit
No pre-sex preparation required
Quickly reversible
May decrease monthly bleeding and cramping
Private/not detectable
Works after sex
Works immediately
Clear All
Extremely Effective
Abstinence / Outercourse
Copper T IUD ParaGard
Female Sterilization
Hormonal IUD Mirena
Implant Implanon
Lactational Amenorrhea Method (LAM)
Vasectomy
Very Effective
Patch Ortho Evra
Pill
Shot Depo-Provera
Vaginal Ring NuvaRing
Effective
Diaphragm
Female Condom
Male Condom
Withdrawal Pulling Out
Moderately Effective
Cervical Cap FemCap
Emergency Contraception Morning After Pill
Rhythm Method Fertility Awareness
Spermicide
Sponge Today Sponge
Method Match is funded through ARHP's Choosing a Birth Control Method program with educational grants from Bayer Healthcare Pharmaceuticals, Duramed Pharmaceuticals, and Schering Plough Corporation as well as contributions from ARHP members.

One example of the site's inaccuracy is in the way that "Fertility Awareness" and the "Rhythm Method" had been lumped together under a single entry in the "Moderately Effective" category. Briefly, the rhythm method is based on the assumption that a woman has a 28-day cycle, and relies primarily on counting days to avoid unprotected sex during the period when she is assumed to be most fertile. The Fertility Awareness Method, on the other hand, involves charting basal body temperatures and cervical fluid on a daily basis, and keeping a calendar of each cycle (for more details, see the discussion of Fertility Awareness in Chapter 3 of this thesis). Although the two methods are similar, the credibility of the site was immediately diminished by the fact that no distinction had been made between them.

Other aspects of the "Method Match" tool were similarly misleading. For instance, the tool rates the "Lactational Amenorrhea Method" as "extremely effective"; the 9th edition of *Our Bodies, Ourselves*, on the other hand, states that "you should never assume that you are infertile simply because you are breastfeeding. …This method must be very strictly followed to be effective. Even then, its success is contingent upon such frequent nursing that it is often difficult for women in Western societies to rely on completely" (2011:249). Also on the "Method Match," the female condom is listed as "effective" while FAM is listed as only "moderately effective"; a chart of contraceptive methods (printed by sexualityandu.ca and distributed by McGill's Shag Shop, no date) shows that the effectiveness of these two methods are actually extremely similar. According to the chart, the female condom is considered 79% effective with typical use and 95% with perfect use, while FAM is 80% effective with typical use and 91-99% effective with perfect use. "Method Match" also lists "Emergency

Contraception/Morning After Pill" as a "moderately effective" method of birth control, even though according to the sexualityandu.ca chart it is in fact "intended for occasional use, when primary means of contraception have failed" – and not as a regular contraceptive method. These are just a few of the methods that I examined in considerable detail; I'm sure closer inspection would uncover further questionable statistics and claims of effectiveness.

It is important to note that the tiny fine print at the bottom of the tool states, "Method Match is funded through ARHP's *Choosing a Birth Control Method* program with educational grants from Bayer Healthcare Pharmaceuticals, Duramed Pharmaceuticals, and Schering Plough Corporation as well as contributions from ARHP members." Although this tool appears to provide information that would allow a woman to make an informed choice regarding her contraception, the fact that it is funded by major manufacturers of prescription contraceptives calls into question the objectivity of the information it presents. Once again, something presented as an educational resource for women contains filtered information that contributes to the continued management of women's reproductive decisions, and manages and "technologizes" their views of their bodies (and women's bodies in general), thereby undermining any real chance of empowerment through it.

Selling a Lifestyle

> Oh my God, that first one for Nuva Ring, I absolutely hated [it]. They sang a song, all the people in the pool [in yellow bikinis]… I just thought that was *so* annoying. It objectified women and it turned them into Barbies who need to take contraception. I just *really* did not like that one. And I don't like the ones where there are supposed to be two friends talking, and one girl is just spewing all of the drug facts, like 'you might get an extra headache...' It's just so superficial. And [it's] trying to hide or, I feel, to be dishonest about the product itself. –*Nadia*

Every industrialized country except for the US and New Zealand prohibits direct-to-consumer advertising (DTCA), but in the United States the advertisement of birth control pills on television is standard practice. These ads often feature bright, colorful videos full of smiling women and upbeat music, and proclaim the many benefits of the birth control pill (Skip your period! Don't have cramps! Feel confident!), while rarely acknowledging that other main feature of the pill: birth control. Contraception is rarely mentioned in these ads, a selective advertising trick akin to Dr. Ashton's prescription for "oral hormones." Nor are there always clear admissions of the many potential negative side effects that may come along with the pill. There are, however, many implications that the pill can solve the troubling monthly grievances associated with PMS, those side effects we repeatedly revisit in Emily Martin's table of menstrual symptoms.

Officially, Canada prohibits DTCA. However, "although the Food and Drugs Act in Canada prohibits advertising of prescription drugs, with the exception of name, price and quantity, the pharmaceutical industry has been flouting the law for several years with two types of ads: 'reminder' ads and 'help-seeking' ads" (Women's Health Policy Brief 2005:1). These TV ads may include misleading or incomplete information, and "cannot provide the type of impartial, comparative information that patients and the public need to make fully informed treatment choices" (Women's Health Policy Brief 2005:1). While Canada's laws are much stricter than those in the US, there is nevertheless enough legal wiggle room that pharmaceutical companies can still get their brands (and benefits) up on the screen, and into consumers' minds. Also, because of increased access to US programming, even TV viewers in Canada may be subject to American commercials for

birth control, and therefore susceptible to the same presentation of benefits (without necessarily hearing all the risks).

In recent years, some pill manufacturers have come under fire for their misleading advertisements in this regard. Bayer, the pharmaceutical company that manufactures the pills Yaz and Yasmin (and funder of the "Method Match" tool above), got into some serious trouble for its 2008 Yaz advertising campaign. An article in the New York Times explained: "aimed primarily at women in their 20s, Yaz has been known for its slogan — "Beyond Birth Control" — which promotes it not only for pregnancy prevention but as a lifestyle drug" (Singer 2009:3). A recent post on a website dedicated to reporting on litigation against Bayer announced, "In 2008, the company was cited by the FDA for airing television commercials that overstated the birth control pill's approved indications… Currently, more than 7,000 Yaz and Yasmin lawsuits await trial in US courts, with nearly all involving allegations that drugmaker Bayer Corporation failed to adequately warn users about the risk of side effects" (Carlisle 2011).

The lawsuits against Bayer have coincided with many emerging reports that link various birth control pills to significant health risks for the women who take them. There is increasing evidence that "Yaz and similar birth control pills such as Yasmin, Ocella,

Zarah, and Gianvi put women, including teenage girls, at a significant risk of developing side effects such as blood clots, pulmonary embolism and gallbladder problems," which is particularly frightening given that in a recent study, "Yaz was named 'by far' the most popular oral contraceptive for US women aged 13-18" (Carlisle 2011). Two studies, reported in April 2011, found that "pills [namely Yaz and Yasmin] containing a new type of hormone called drospirenone triple the risk of blood clots compared to an older generation of pills that contain a hormone called levonorgestrel" (Appleyard 2011:1).

Even more recently, The Globe and Mail reported that major pharmaceutical company Pfizer Inc. recalled around one million packets of Lo/Ovral-28 Norgestrel and Ethinyl Estradiol birth control tablets because "some blister packs of the oral contraceptive might contain an inexact count of inert or active ingredients in the tablets." In short, the pills "may not contain enough contraceptive to prevent pregnancy. Pfizer said the birth control pills posed no health threat to women but it urged consumers affected by the recall to 'begin using a non-hormonal form of contraception immediately'" (Altaffer 2012). Perhaps the pills don't constitute a "health threat to women," but the potential (substantial) consequences of unwanted pregnancy on a woman's life should not be underemphasized. Several sites around the internet are already discussing the likelihood of lawsuits that Pfizer may face, once women begin to find out whether their faulty pill packs have resulted in the "side effect" of an unplanned pregnancy.

In general, these days there seem to be regular announcements of drug recalls and higher-than-anticipated side effects, just as there are new versions of hormonal contraceptives released to the public on an ongoing basis. Yet despite the significant

potential health risks, corporate chastisements, and periodic recalls, the pill continues to be a lucrative product for pharmaceutical companies. In 2008, Americans spent more than $3.5 billion on the 40 brands of birth control pills on the market, which were used by nearly a third of women who wanted to avoid unplanned pregnancy (Johnson 2010:1). After its reprimand for misleading advertising, the FDA ordered Bayer to air commercials which corrected its previous marketing in order to clarify the approved benefits of Yaz, but by the time the corrective commercials aired, the 2008 "sales of Yaz in the United States [had] increased to about $616 million, from about $262 million the year before" (Singer 2009:1,4). It is too early to tell what the impact of Pfizer's 2012 pill recall will be, but if history is any indication I doubt they will go out of business anytime soon because of it.

Like the sales of birth control, advertisements for contraception remain prolific in North America, although the format of these ads has changed slightly in the last several years. Commercials from just a few years ago tended to focus almost exclusively on the nearly miraculous treatment of period symptoms (like those that Yaz once claimed), while they avoided most discussion of dangerous side effects and also rarely acknowledged the contraceptive's primary function (preventing pregnancy). Perhaps because of the regulatory backlash against such ads, current commercials for birth control tend to spend around half of their airtime selling the product, and the other half explaining the side effects and risks associated with it. Although it would be impossible to adequately summarize every birth control advertisement that has aired, it is worth examining a few to get an idea of the way pharmaceutical companies are currently selling contraception.

While these ads may refrain from the grandiose claims of "curing periods" for which the older Yaz commercials were censured, most can't help listing at least a few benefits, and manage to wink at the acknowledgement of their role in pregnancy prevention. The most striking aspect of current advertising, however, is the clear message they send about women's lifestyles. One after another suggests that a woman's choice of birth control has something to do with what "type" of woman she is (highly educated, career-oriented, etc.). Moreover, these ads suggest that consuming their particular contraceptive will lead a woman to become her ideal "type" – to consume a contraceptive is to consume a lifestyle. This is an approach Bayer *hasn't* shied away from: remember that Yaz's slogan was "Beyond Birth Control." In selling the pill, Bayer was selling a lifestyle.

In a 2011 advertisement for Beyaz, another birth control pill manufactured by Bayer, women are explicitly portrayed as literal consumers of life choices.[9] The ad follows four women, aged in their 20s to early 30s, as they enter what looks like a shopping mall. They walk in as a group, but branch off immediately as each woman

meanders through a different aisle. A voice-over states, "You know what you want today.

[9] Beyaz Birth Control [Video]. 2011. http://www.youtube.com/watch?v= NdSmXKRqFHM&feature=related (accessed 2012).

But you never know what you might want tomorrow. It's good to have choices. It's good to have Beyaz, from Bayer." The women pass and investigate several shelves, labeled with little signs that say things like "Grad School," "Significant Other," "Picnic by a waterfall," "Trip to Paris," and "Buy a house." As the women continue to browse, the narration continues, "Like all birth control pills, Beyaz is effective at preventing pregnancy and may give you lighter periods. And if you choose Beyaz for birth control, it may help treat moderate acne and premenstrual dysphoric disorder (PMDD, not PMS). And also contains folate! Folate is a B-vitamin recommended for all women in their reproductive years." At this point in the commercial, one of the women walks past a stork carrying a bundle wrapped in purple satin (which represents a baby). The woman keeps

walking, but the stork climbs off his shelf and follows her. She looks back over her shoulder, puts her hand up in a kind of "stop" or "no thank you" gesture, and walks away from the disappointed stork (wings drooping), toward a display labeled "Trip to Paris." Another woman is shown considering dollhouse-sized houses, and eventually she chooses one and puts it in her basket, while the narrator spends around 30 seconds listing side effects and health problems that can result from using Beyaz:

> With folate, Beyaz reduces the risk of rare neural-tube birth defects during use, and shortly after stopping. Beyaz is a different type of hormone that for some may increase potassium too much. So don't take Beyaz if you have kidney, liver, or adrenal disease, because this could cause serious heart and health problems.

> Tell your doctor if you're on daily long-term treatment for chronic conditions like cardiovascular or inflammatory diseases. Serious risks include blood clots, stroke, and heart attack. Smoking increases these risks, especially if you're over 35, so don't smoke on Beyaz. Don't take the pill if you've had any of these conditions, certain cancers, or could be pregnant. The pill does not protect against HIV or STD's.

The commercial concludes with the four women in a car, purchases in hand and a five-foot-long Eiffel Tower strapped atop the vehicle, laughing and smiling as the narrator concludes, "Ask your health care provider about Beyaz – because it's good to have choices."

This is the most literal representation of "women as consumers of birth control as lifestyle" that I have seen in an advertisement. It is worth noting that, like most contraceptive ads, the actresses are all female, and any representation of sexual intercourse is nonexistent – surprising, given that one must have sex in order to get pregnant, thus predicating the need for birth control in the first place. This ad is unusual in that men *are* technically present, although they only function here as pure objects – miniature, unmoving, two dimensional and encased in plastic, and fought over by multiple women vying to put their preferred "significant other" into their shopping basket first. (Note the two female hands reaching for the same "man" in the image above.) The ad shows life goals as things a woman can achieve (purchase), ostensibly through her use of Beyaz, and implies that perhaps these accomplishments (products) would be unattainable without this particular pill.

Like older pill ads, there is reference to the treatment of period symptoms (acne and PMDD), although the list appears substantially shorter than in previous Bayer advertisements. However, if Bayer had listed all the sub-symptoms of PMDD, the list of treatable symptoms would have been just as long as those originally claimed by Yaz.

(The 2008 ad featured the caption "Yaz treats PMDD" above the many floating "symptom balloons" featured in the screenshot from the Yaz commercial, above.) Interestingly, Beyaz also boasts the inclusion of folate within the pill, a rather confusing addition given that folate is generally touted as an important supplement for pregnant women (and not for women hoping to avoid pregnancy). Another change is the laundry list of negative symptoms – literally half of the commercial is a narration of side effects and risks of this pill. Yet during this long recitation, the video displayed is full of bright colors, smiling faces, and the portrayal of exciting possibilities. Although each woman follows her own path toward different goals throughout the commercial, by the end of the ad all the women have regrouped into a laughing, smiling bunch. This is typical of many ads, which often feature groups of women going through ordinary motions while laughing and smiling disproportionately to the tasks at hand. Kinsey described the women in these ads to me as follows: "They're just happy, smiling women, and they're just… life is *amazing*, and they're being who they want to be. 'Oh, well, it's because I take the pill!' I just think it's awful. I think it's so cheesy."

Advertisements for the many brands of birth control pills are far more common than for other types of contraception, but a few of these other methods have memorable ads as well. Several of the women I interviewed mentioned a prominent ad for the Nuva Ring in particular.[10] Although Nadia (quoted above) and Lensa were the only two women who remembered the specific contraceptive that was advertised (several actually thought it was for a birth control pill), everyone who mentioned the ad could describe its plot and

[10] Nuva Ring Commercial [Video]. 2008. http://www.youtube.com/watch?v=mb49mo5uvE0&feature=related (accessed 2012).

imagery in fairly specific detail. The ad begins with a screen that reads, “Tired of your old birth control routine?” and then breaks into a very catchy song wherein a chorus of women sing, “Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday, Every Day! And repeat! Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,

Sunday, Every Day! Again!” The song is accompanied by images of synchronized swimmers dressed in bright yellow and pink 1950’s style swimsuits, jumping in turns into a pool. Each woman represents a day of the week in a 28-day birth control pill pack, which has 21 yellow “active” pills and 7 pink placebo pills. The tagline for the ad reads, “Break free from the pack,” as one by one a few of the swimmers walk away from the swimming routine, strip off the middle of their swimsuits to reveal a (modern) two-piece bikini, take a drink from a nearby bartender and walk into a much smaller (ring-shaped) pool.

Like the Beyaz ad, the Nuva Ring commercial features a narrator who describes the product’s benefits (“It’s a small, comfortable, once-monthly vaginal ring that delivers a continuous low dose of hormones. It’s as effective as the pill, but you don’t have to take it every day”), followed by a familiar list of side effects and warnings. Also similar to the previous ad, this one features no hint of sex, and only one man: the bartender who brings drinks after the women have left their “routine,” and who gets only a few seconds of

screen time. One major difference between this ad and the one for Beyaz is that the Nuva Ring doesn't make any claims about treating symptoms associated with periods. Rather, its entire platform is based on the idea that women are tired of the outdated once-a-day routine of the birth control pill, and can be liberated through the use of the new (modern) Nuva Ring. As Lensa described it, "the way they present the pill is in terms of being the most boring possible thing you could do with your life… and taking the pill is just the most boring, mundane drudgery. …Taking Nuva Ring [on the other hand] is just going to open your life up to color and excitement and fun!"

The Nuva Ring actually had a follow-up advertisement around 2010, a couple of years after the first one aired.[11] Although she didn't say so explicitly, I'm fairly certain that Nadia, in her quote at the start of this section, was describing this ad in the second part of her diatribe against contraceptive advertisements. The newer commercial featured three women sitting in a living room who start talking about the Nuva Ring when its (older) commercial comes on the TV they are watching. Woman 1 says, "Ooh, I love this commercial!" and proceeds to sing along with the synchronized swimmers ("Monday, Tuesday, Wednesday, Thursday, Friday…"). This prompts the following discussion among the women:

Woman 2: Would you guys try Nuva Ring?
Woman 3: I'm not even sure what it is.
Woman 2: It is a monthly vaginal birth control ring that delivers a low dose of hormones.
Woman 1: Don't you have to… put it in?

[11] Swim Along Nuva Ring [Video]. 2009. http://www.youtube.com/watch?v= nY3MfNWHGvk (accessed 2012).

Woman 2: For me it's easy! You put Nuva Ring in for three weeks, you take it out, and then you put a new one in seven days later.
Woman 3: I could handle that.
Woman 2: It's small and comfortable. Plus you don't even have to take it every day.
Woman 1: That's nice.
Woman 3: But I'm already on the…
Woman 2: …The pill… (rolls eyes as everyone says "the pill" simultaneously) I know. [all smiling]
Woman 3: (sheepishly) I know, right?
Woman 2: So was I, until I talked to my doctor about switching. Nuva Ring is just as effective.
Woman 3: Really?
Woman 1: Here are the risks.
(All three women watch the old commercial on the TV while the narrator explains the risks and potentially harmful side effects)
Woman 3: So you'd recommend it?
Woman 2: I would.
Woman 3: Maybe it's time I asked my doctor about it.
Woman 2: You should! (touching Woman 3's shoulder)
Narrator: Talk to your doctor about trying Nuva Ring today.

Like its predecessor, this Nuva Ring ad attacks the pill directly, but is a bit more explicit in its explanation of what the Ring is and how it works. It touches on the assumed discomfort of women to touch their genitals, as Woman 1 reveals when she asks (squeamishly) whether or not the user has to insert the Ring, but then the ad attempts to counter that expectation through Woman 2's casual and relaxed response. This ad also addresses the assumption that all women are on the pill, when Woman 2 rolls her eyes and *all three* women chime in when Woman 3 starts to say that she's already on the pill. Their behavior feels like a mild rebuke, belittling her use of the pill as something obvious (they all already know she's on it and the implication is that they've all talked about it before) and embarrassing (as Woman 3's sheepish "I know…" indicates). In addition to reclassifying the pill as outdated and conservative, this ad tries to emphasize that Nuva Ring is at once new and modern but also already popular, as the caption beneath the

video reveals ("9 out of 10 women who used Nuva Ring in a clinical trial would recommend it to others").

The Nuva Ring commercials portray the women who choose it as consumers of a modern lifestyle; not held back by the constraints of 1950s birth control, they choose to "break free from the pack" both literally and figuratively as they move forward into modernity. Because Nuva Ring is significantly less popular than the pill, its ads work harder to create a sense of normalcy around its use as a contraceptive. By emphasizing that 90% of users would recommend Nuva Ring, the ad creates a sense that "everybody does it," despite implying only moments before that "everyone's on the pill" (and not in a good way).

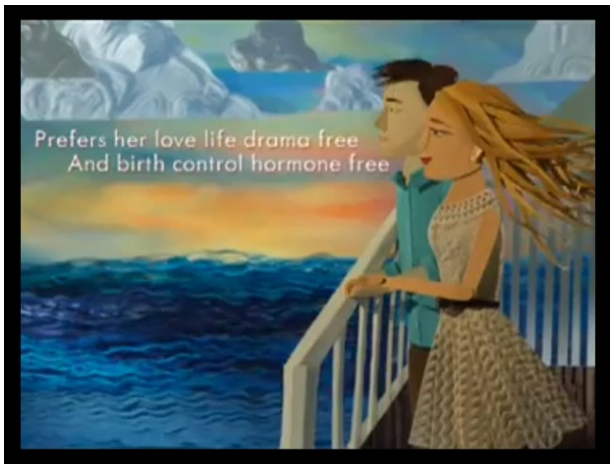
One last advertisement that I would like to mention here is a brand new commercial for ParaGard, a hormone-free copper IUD.[12] Intrauterine Devices seem to be even less popular than Nuva Ring, at least based on my interviews with women and health professionals, but ParaGard's 2012 advertisement seems to be selling to a particular crowd. It features stop-motion paper animation (rather than live actors) and presents a series of (types of) women who are described by the narrator thusly: "Prefers her coffee caffeine free. Prefers her paint fume free. Prefers her birth control hormone free." As the video follows a series of paper cut-out women going through various activities (drinking coffee, painting a wall, riding a moped, gardening, jogging, sitting on a swing beneath a tree, walking through an autumn forest with a young child, and finally standing beside a man at a waterfront), the narrator informs the viewer that "ParaGard

[12] Paragard Fits Your Life by Curious Pictures – Hayley Morris [Video]. 2011. http://www.youtube.com /watch?v=NqM3nvbra44 (accessed 2012).

intrauterine contraceptive is the only reversible birth control that's both highly effective and hormone free. And because it's free of hormones, ParaGard doesn't interfere with your natural cycle." Like the other advertisements I've discussed, there is a rather

alarming set of warnings and health risks, such as, "in rare cases, ParaGard may attach to or go through the uterine wall and cause other problems. Although uncommon, pregnancy while using ParaGard can be life-threatening and may result in loss of pregnancy or fertility." Finally the ad concludes with a description of ParaGard and the woman who uses it: "Prefers her love life drama free, and birth control hormone free. ParaGard: birth control that fits your life, naturally."

Clearly this ad is attempting to connect with women who are reluctant to use the more popular forms of hormonal contraception, and ParaGard may be hoping to reach and/or create a market of women who desire a form of "natural" birth control. There is a question of just how "natural" anything can be that must be prescribed and inserted by a medical professional (whether it is hormonal or not), but nevertheless this ad is attempting to distinguish itself from the likes of Beyaz and Nuva



Ring. Again, the ad wants to convince the viewers that there is a type of woman who wants "natural" products – a woman who always appears outdoors, surrounded by grass, trees, flowers and water, and who (again) appears only once in the presence of a man – although as always, sex is not explicitly mentioned, although it is politely suggested by the term "love life." Curious Pictures, the company that was hired to create this ad for ParaGard, describes their approach to the commercial as follows:

> Paragard hired Curious Pictures to deliver work that not only reflected the brand's message but offered a sensory experience that would be associated with the natural feel of the brand. …It was decided to use hand-cut paper for a stop-motion piece that would convey a natural and physical sense of movement and lighting. The goal was to produce an upbeat and stylish commercial where each character would have a distinct personality seen through their appearance, movement, and even facial expressions. By creating unique characters, the work heightens the sense of identification, emphasizing Paragard's message and steering away from generic perceptions.[13]

Through its careful choice of language and style, ParaGard offers a new type of birth control (and a "natural" lifestyle) to yet another type of woman consumer.

Conclusion

> I guess those stupid commercials are right. I mean, [the pill] really does let me live how I want to live. Because I'm guessing if I hadn't been taking it for so long… I would have fallen pregnant earlier. So, yeah, it has given me more, I guess, more of a freedom to live the kind of life that I want to live. –*Kinsey*

The abundance of ads for birth control pills as opposed to ads for other forms of contraception might be one reason that many women are unaware of potential alternatives. A recent national study on the contraceptive practices of Canadian women found that only "three currently used methods predominated among 15-19 and 20-29 year-olds who had intercourse in the last six months. These were the male condom, oral contraceptives (i.e., the birth control pill) and withdrawal (pulling the penis out of the

[13] From the description posted to the video uploaded to YouTube by Curious Pictures, http://www.youtube.com/watch?v=NqM3 nvbra44 (accessed 2012).

vagina before ejaculation); see Table 1, from sexualityandu.ca. All other 17 methods (e.g., patch, ring, IUD, injection, diaphragm, sponge) were each used by less than 5% (0% - 4.4%)" (SIECCAN 2010:1). Despite the high number of hormonal and non-hormonal alternatives to the pill (some of which are considered equally effective and with fewer side effects), 67% of teenagers continue to use the pill. There are many reasons why young women are not taking advantage of alternate contraceptive options, a scenario I explore further in the course of this thesis.

Table 1: Contraceptive methods currently used by young Canadian women

	15-19	20-29
Male Condom	74.3%	55.5%
Oral Contraceptives	66.6%	58.3%
Withdrawl	17.3%	12.0%

Source: Black, et al. (2009).

Advertisements like those listed above certainly work to make contraceptives somewhat invisible – that women will use birth control is taken for granted, and the ubiquitous pill in particular has become extremely normalized. By selling types of womanhood, advertisements convey a message that women can consume a lifestyle, while downplaying risks or alternatives. The focus on "consumption" and the normalization of these contraceptives has diminished the sense that a woman needs to know anything else about her body; if she knows which birth control to use, and therefore will theoretically avoid pregnancy when she wants to, why should she need to look up how her reproductive cycle works?

The Boston Women's Health Book Collective published the renowned *Our Bodies, Ourselves* in the early 1970s, and in 2011 the BWHBC released a fully revised, 40th Anniversary edition of the book. 2011 also marked the 50th anniversary of the birth control pill. Although many companies and websites took it as an opportunity to celebrate

five decades of "women's liberation" (touted as increased sexual freedom and reproductive control), this milestone also offers a moment for scientists, scholars, and consumers alike to thoroughly consider the complex influence of contraception on women's reproduction. As the *OBOS* editors state in the introduction to the new edition:

> Much has changed in the United States since the first edition, when abortion was illegal, birth control was not widely available, and the few available texts on women's health and sexuality—almost all written by men—discounted women's experiences and perspectives. Today, information is abundant, but it is still difficult to find reliable information that encompasses the diversity of women's experiences and teases apart the conflicts of interest inherent in many issues that affect women's health. Far too often, corporate and pharmaceutical interests influence medical research, information, and care, and contribute to the unnecessary medicalization of women's bodies and lives. This not only wastes money and poses avoidable risks but also can discourage women from questioning the assumptions underlying the care they receive and from valuing and sharing their own insights and experiences" (2011:xiii)

In the following chapter I will explore some of the programs, organizations, and sites of knowledge that could provide information to women about sexual health and reproduction, as well as examine further the "medicalization of women's bodies" and the pharmaceutical and corporate interests that continue to influence women's lives.

> I would say I feel fortunate that we have choices. I guess to a certain extent, which one to choose is not really confusing to me, simply because the main ones that are touted are the condom if you are concerned about STDs and reproduction, and the pill if you are in something long-term and monogamous. So I guess the **other options aren't even on that many people's radar**… I guess it bothers me that, you know, it's that way with a lot of drugs in general as well; whoever has the biggest advertising budget, who markets and whatever company brings the coolest gadgets to the doctors, **that's what they push on us**. So I guess there's something upsetting about that whole system of 'we're choosing this simply because it's what's being most effectively marketed to us'; not [because] it's necessarily the most effective thing, or even the perfect thing for our own lifestyle. So I guess on some level that bothers me, but **the bottom line is I want to be protected. So I'll do what I have to do**. *–Melanie*

Chapter 5: Empowering Ignorance

> They know about the pill, they feel secure about the pill, they've read about the pill, everybody around them's got the pill, so the pill's what they want because **they feel *safe* with it**.
>
> My attitude is if [you're prescribed the contraceptive] you want, you're more **likely to be compliant**. Because you feel that that's what all your girlfriends have, you feel you already have a positive perception [of] that contraceptive method, because you've gotten influenced by your friends, and so you're more likely to continue. **Ultimately my goal is not to prescribe a contraceptive for the sake of prescribing a contraceptive – ultimately it's to prevent a pregnancy.** And if they're going to take that contraceptive and not become pregnant, then that's what I want. *–Dr. T*

In Chapter 4, I showed how messages in the cultural sphere encourage women to act as consumers of birth control (and of lifestyles). Marketing contraception as a treatment for perceived negative side effects of womanhood, along with the normalized prescription of hormonal contraceptives (and the pill in particular) to young and adult women, contributes to the regular use of particular forms of birth control. But to some degree, women are tacitly aware of the constructed nature of many cultural messages about hormonal contraceptives. As some of the women I interviewed made clear, the implications about birth control in these contexts can be misleading and, at times, laughable to the target audience; such resources are not to be relied upon as dependable sites of information. Knowing this, where can a woman turn to find impartial information about contraception and reproductive health?

Sexual education classes, university health clinics, and medical health professionals are potential sources of information, with teachers, staff, and doctors who can serve as authority figures with regard to sexual health and birth control. Their knowledge could theoretically empower women to make informed choices, and each individual's perspective is generally assumed to be, if not unbiased, at least more

objective than ads created by pharmaceutical companies. However, certain assumptions, expectations, and prerogatives of medical professionals (with regard to birth control and the nature of young women) can lead them to filter the information they provide. The imperative to avoid pregnancy at all costs can manifest as a manipulation of information, resulting in selective education that implicitly manages women's reproductive choices.

Teaching "Sex Ed"

For many women, sexual education begins before or around puberty. Some have memories of childhood discussions with parents or elder siblings, while others remember elementary school health classes and the proverbial videos about "Your Changing Body." In Chapter 6 I will discuss the memories of the women I interviewed about this topic, and their perceptions regarding how those early experiences shaped their later understanding of fertility and reproduction. While most of these women did not attend elementary or high school in Quebec, sex education in local high schools is nevertheless relevant to understanding the broader umbrella of medical perspectives on sexual health (perspectives that directly affect both teenagers and adult women).

Currently in Quebec, sexual education classes are not mandatory in high schools. There are a few websites that offer suggestions to would-be instructors of the topic, including a large segment on the Canadian Federation for Sexual Health website as well as on www.sexualityandu.ca. But for the most part it is up to each individual teacher to decide if she (or he) wishes to teach sex ed to her classes, and to educate herself accordingly in order to do so. There are no guarantees that individual teachers will choose to teach sexual education at all, much less that they will do it well. As Dr. Pierre-Paul Tellier, Director of Health Services at McGill and known as "Dr. T" to staff and

students, informed me, "that's what we're relying on right now in Quebec. Which is unfortunate, but that's what's been decided. And not everybody's equipped to teach this. … It's 'mandatory' to some extent in that they're *supposed* to teach it, but *will* they teach it and how well [will they] do it, I don't know."

For university students in undergraduate Education programs who expect to become high school teachers, the prospect of eventually teaching sex education may be daunting. But one way future instructors can receive guidance on how to teach the subject is by attending a training session led by Marcie Jacobs and Dina Montgomery. (I have assigned pseudonyms to Dina and Marcie, in order to help protect their identities.) Marcie works for Dr. T as the Health Promotion Coordinator at the McGill University Student Health Clinic, and she is also currently the coordinator of the Shag Shop (which I discuss in greater detail below). She has a background in sexuality studies, and for several years has been a teaching assistant for an upper-level undergraduate sexuality class taught by Dina Montgomery. Dina teaches classes at McGill and Concordia University, and is the president of a company that provides what she calls "Sex Education Training and Consulting Services" as well as "Smart Sex Educational Materials." Dina also claims to be "the only Certified Sexuality Educator in Montreal." Marcie and Dina are both members of the Sexual Health Network of Quebec, and through Dina's company they provide periodic training sessions for individuals who intend to teach sexual education in high schools.

On November 4, 2011 I was able to participate in one of these sessions, entitled "Best of the Classroom Experience: The Power of Sex Education Activities." The session offered "practical tools to teach this subject to grade levels 5 to 11," and covered topics

such as puberty, anatomy, contraception, sexually transmitted infections, and condom and barrier use. The session took place at 6 p.m. in a large classroom on the 2nd floor of McGill's Education Building, and I went in a few minutes early hoping to find an inconspicuous seat in the back of the room. However, when I arrived I found Marcie setting up for the presentation, and she immediately engaged me in conversation. Marcie and I had met some months before when I contacted her about volunteering with the Shag Shop, and I had participated in several SHAG events already by this time; consequently I was not surprised when she asked me to sit in the front of the room to encourage other participants to do the same. She also warned me that I would be participating in small-group activities, something I was not expecting but which ultimately turned out to be very informative.

Gradually students filtered in, and by the time Marcie began her presentation there were over 30 participants (only 4 were men) in attendance, plus Marcie and Dina. Most of the group was comprised of Education students, although a few were volunteers who worked with Marcie at SHAG. Marcie began the session with a PowerPoint presentation that covered the main topics for the evening, but she quickly had us break into groups of three or four in preparation for a series of training activities. I was grouped with two young women who were both undergraduates, one in a Physical Education program and the other in a TESL (Teaching English as a Second Language) program. In the course of the training session, and particularly when we broke into small groups, I realized two very important and surprising things: first, that I had begun to see myself as a sort of expert on several sexual health topics, and second, that Marcie had begun to see me this way as well.

As I briefly explained in Chapter 2, this realization of authority crystallized for me when Marcie asked two of the small groups (including mine) to come up with a detailed description of the menstrual cycle. One of my teammates left the room for a bathroom break (telling us, "I have no idea how it works, anyway"), and the other was clearly confused and immediately stopped talking, as she folded her arms across her chest and leaned far back in her seat. She was not defensive or angry, just embarrassed and unwilling to venture a guess. Reluctantly I sketched out my understanding of how the process worked, to her eager nods and smiles (and regular refrain of "I can't remember, but that sounds right"). When Marcie called out that it was time for one team to give their answer, by chance the other team had already given an answer to a different question, so by default it was "our turn." Since my single remaining teammate was steadfastly refusing to make eye contact (Marcie's eyes, meanwhile, were boring into my own), it fell on me to provide my description. Initially I was disappointed by this turn of events, not because I had to speak publicly (which was surprisingly comfortable for me), but because I had hoped to listen to what *other* participants said and then to take copious notes. But in that moment I realized that I *did* possess a substantial amount of knowledge, and that Marcie was to some extent relying on me (as a co-authority figure) to help carry the group activity. That sense was strengthened when she visibly relaxed as I gave my explanation, then proclaimed my summary "very succinct" and had little to add to it.

This particular moment clarified yet another important insight for me, which was that most of the people in the room were treating the session as a sort of sexual health refresher course. Rather than asking questions about how to teach this information to high school students, many people in the room raised their hands and asked Marcie for more

detailed clarification of how the various stages of the reproductive cycle actually worked. This pattern held true throughout the session – over and over, although people participated in the group activities, these were frequently interrupted with requests for more review and more explanation of reproductive processes, basic anatomy, and forms of contraception. At the end of the session, Marcie asked the room broadly what we had learned during the session, and the very first person to respond (a woman) said, "Well, I guess I realized today that my Grade 7 'Anatomy of the Sexual Organs' needs to be touched up a little bit if I'm going to be teaching this!" The room erupted into appreciative laughter, and a second woman added, "I think I learned that *I* need to be more informed about all of these things before *I* start teaching it; maybe just taking a sex education course, like a whole thing, and teaching *myself* more before I start teaching kids." A few moments later another woman explained, "I think I came here [thinking] 'Oh yeah, it's going to be like a refresher,' and you're like, 'Oh my goodness, I really *did not know* some of these things!' You can't know everything." Marcie concluded the evening by reassuring everyone that they were not, in fact, expected to know everything, but that it would be good to have a broad understanding at a certain level in order to be able to "answer basic questions" at least.

After the session, I lingered for a few minutes to chat with Marcie and Dina. I had a question about luteal phases (the period of time between ovulation and the onset of a period): Dina and Marcie were confident that this period of time is exactly 14 days for every woman, but I asserted that for me it's always 12 days long. This led to a fascinating exchange where Dina asked how I knew when I ovulated, and was visibly startled when I explained my 5-year use of FAM (charting temperatures, cervical position and cervical

fluid), and that I was therefore clearly aware of my monthly ovulation patterns. She repeatedly told me what an exception I was, that usually when she asked people about this kind of thing they had "no idea what I'm talking about," and that virtually everyone she has ever encountered who used FAM was trying to achieve a pregnancy. (She could hardly believe that I was not, in fact, charting in order to try to conceive.)

Eventually our discussion turned to the question of teaching FAM in high schools, and when I asked whether it was worthwhile to do so, Dina gave me a qualified yes: "I am selective in my teaching," she told me, adding that "I answer questions from my students when I'm asked," but she is careful of just *how* she answers them and what information she provides. As she put it, she doesn't "want them to twist the information," to put themselves at risk by making "assumptions about their fertile phases." Because it was the end of a very long evening on a weeknight, I was unable to continue this discussion with Dina. On another occasion, however, I had the chance to talk to Marcie about the topic of teaching FAM to teens, and she took a similar stance. As she put it, "You can't trust teens to be aware of what's normal for their cycle. They aren't as interested, maybe, in keeping track" of their cycles as older women, or women trying to conceive, might be.

These brief statements relate to a larger pattern of the way medical authorities think about and discuss women (particularly young women) as unwilling or unable to understand all facets of their reproductive health. It had seemingly never occurred to Dina or Marcie that a method like FAM could be taught to young women in the context of their daily lives (rather than strictly as a method to try to conceive). Instead, both instructors resorted to stereotypes that established young women as untrustworthy and

disinterested, which in their eyes justified an avoidance of teaching fertility awareness in high schools. Dina and Marcie's comments also echo some of the attitudes that Dr. T presented to me, in an extended interview that I discuss later in this chapter.

McGill's Sexual Health Awareness Group (SHAG)

As Dr. T informed me, when he began his work as the Director of Health Services at McGill a big part of his job was "to develop health education material [and] to make people aware of their options." One result of this initiative was that Student Health Promotion developed Peer Health Educator groups, which consist mainly of volunteers along with a few student staff members. These groups "target unhealthy or risky behaviour practices prevalent in McGill's student body and encourage self-efficacy and the adoption of healthier habits".[14] Student Health Promotion supports four distinct groups, namely SHAG (short for Sexual Health Awareness Group, and also a play on the British term for sex), Fit@McGill, Safer Partying, and Mental Health & Well-Being. In 2005, Student Health Promotion opened the "Shagalicious Shop" (later shortened to "Shag Shop"), which became a hub for SHAG volunteering as well as a location for the sale of sexual health products through SHAG. (Later in this chapter I discuss the shop in much greater detail.)

Marcie Jacobs began volunteering with SHAG in 2008, and has been the Coordinator of the Shag Shop since 2010. She is also responsible for hiring and training all Shag Shop employees, developing resources and publications, managing web content for SHAG websites, and working with Dr. T to coordinate all of SHAG's events and initiatives. I came across SHAG in the summer of 2011 when I was searching for

[14] Excerpted from the home page for McGill's Peer Health Educator Website, viewable only by invitation, for active volunteers (accessed 2011).

organizations that provided sexual health information to teens, undergraduates, or graduate students. Originally I applied to be a volunteer, but as I described in Chapter 2, after meeting with Marcie I was invited to tag along to a number of SHAG events without becoming an official volunteer.

In the Orientation for new volunteers in late August, 2011, I learned that SHAG (like all of the groups in Student Health Promotion) pursues a "harm reduction" approach: while certain behaviors are acknowledged as unhealthy, SHAG also recognizes that people can choose whether to participate in those behaviors. Rather than attempting to force people to stop certain behaviors, or to try to enable others, SHAG essentially encourages people to find a safer way to do the things it's assumed they would do anyway. The staff members of the Health Promotion Groups (including SHAG) intensively train the volunteers who sign up each year; in addition to an orientation session, volunteers are required to attend a thorough, well-planned training event that takes place across two entire days, held during a weekend in September. For SHAG, the goal is to give each volunteer a comprehensive background in reproductive processes and anatomy, all forms of contraception, and sexually transmitted infections (STIs), as well as to provide them with broad training in workshops that explore "values assessment," "consent," and "leadership." The idea is that in future SHAG events, these volunteers will be able to speak as authority figures on a variety of topics that they may encounter from the student population with which they engage.

In addition to providing volunteers with extensive training, SHAG spends a great deal of its energy trying to find new ways to reach students with information about sexual health and safety. Marcie mentioned to me the challenge of "trying to get information to

students who may not care," which SHAG combats by employing a variety of strategies aimed at reaching the highest possible population of students. These can include events such as "tabling" days, where SHAG sets up a table or booth in a populated area of campus and distributes materials (like free condoms and pamphlets) to students who pass by; "Rez Hall visits," where SHAG volunteers go to McGill undergraduate residence halls and invite students to participate in games for prizes; visits that involve distributing SHAG pamphlets and free condoms to students around campus at special events, such as at the Halloween party hosted by McGill's graduate student association at Thomson House; and contraceptive information sessions, in which students are invited to drop in to learn more about the various methods of birth control.

Although these endeavors were often laboriously planned, many of the ones I observed fell short of their goal to reach students. For instance, when I talked to a volunteer who had staffed a table in the Engineering building one day, she told me that she was surprised that more students weren't excited to get free condoms; she had finally taken to wandering through the crowd and distributing them to students who walked by, since so few people were willing to approach the SHAG table. At the Thomson House Halloween party in 2011, literally hundreds of the condoms that had been so carefully handed out by volunteers at the front door had been torn open, played with, and discarded by the end of the evening. Even at the contraceptive information session, which Marcie decided to offer after she and I had discussed contraception several times, exactly one person showed up to participate – and it happened to be someone that I had invited.

The failed contraceptive information session clearly illustrated that either SHAG is unable to reach individuals who might be interested in sexual health information, or

else there is a particularly small population of such individuals around the McGill campus. This session also revealed a few previously unexamined expectations of my own with regard to SHAG. Marcie had asked me to join her as an educator at this event, once again positioning me as a sort of honorary authority figure. I suspect this was in large part because I had asked on more than one occasion about natural methods of birth control, and perhaps recognizing that SHAG didn't have a lot to offer on that subject, Marcie incorporated me into the session to act as a resource. I helped set up the condoms, phalluses, and contraceptive devices that I fully expected to demonstrate to masses of students, and I carefully arrayed a spread of promotional materials and explanatory pamphlets on the display table.

When no one attended (save the lone woman who I had invited), I was surprisingly disappointed. I felt frustrated, and found myself brainstorming ways to help SHAG reach more people and improve attendance at events like these. It took me a little time to get to a point where I could analyze the situation from a slight distance, and to draw conclusions from it. I also eventually realized that although Marcie was willing to try new approaches, such as offering this contraceptive information session, she was unsurprised by the poor turnout. She came across as slightly jaded, and expressed to me

that her "sympathy for people who come in and don't know this stuff goes out the window when I throw an event like this and no one comes."

For volunteers and staff who spend hours and days preparing for SHAG events, low turnouts are tremendously disappointing. Even in the residence halls, where volunteers assumed that undergraduate residents would be a kind of captive audience, the crowd at the event I attended was much smaller than expected. On that particular evening, two teams of volunteers were prepared to lead sessions in different areas of the residence hall, but upon realizing the low number of students who stopped and were interested (compared to the dozens who walked past in a seemingly endless flow), the volunteers consolidated the "groups" into a single unit. Once everyone had assembled, fourteen students were present (four of them men) – out of a building with a capacity of nearly 750 male and female students.

The session featured a "Jeopardy-style" game where the students were split into two teams and chose team names ("Hanky Panky" vs. "The Sex Machines"), then took turns choosing questions from a set of categories: McGill Health Services, STIs, Shag Shop, Sexy and Safe, and Contraception. The most popular category was easily "STIs," while "Shag Shop" generated the least excitement (and the fewest accurate responses). Correct answers earned points and sometimes prizes (such as a sample pack of lubricants or condoms), and for the most part the teams engaged in friendly competition. There was a lot of joking and laughing, particularly among the few men who were present, most of all when they discovered a small flip-book that advertised condom use through a cartoon illustration of two people having sex (and putting on a condom in the process). Although there was some juvenile giggling for the duration of the event, several people in the group

(particularly one former medical school student) took the game fairly seriously, and showed an impressive level of interest and aptitude across all of the categories.

Once again I had attended this event expecting to act as an observer, or possibly as a volunteer, so when I arrived at the residence hall I spoke with the volunteers and helped them arrange the chairs and materials for the session. But as in the sexual education training session, I inadvertently found myself surrounded by participants. Despite my efforts to remain quiet and let the game play out, at one point a male student sitting next to me literally reached over, touched my arm, and said he thought it was my turn to choose the next question for "our team." At that point I took a more active role as a student participant, although I did my best to try and let my teammates answer questions as much as possible. After all, I had already seen the questions and answers at previous volunteer training sessions! Although I was dragged into providing a few answers for several of the questions about contraception and the Shag Shop, perhaps I was too neutral; in the end our team lost the game.

Although the overall turnout was less than expected, the students who participated enjoyed themselves and eagerly participated in the game and discussions. A few times I overheard exclamations like "This is so interesting! I'm learning so much!" or, "That's disgusting. I would never use that." There were also a surprisingly high number of questions about diaphragms. The students helped themselves to the pamphlets and promotional materials that had been set out (including the condoms and cartoon sex flip-book), and everyone seemed generally enthusiastic by the end of the session. Yet one of the volunteers later confided in me that the session I had attended was "different than usual" in its small size and what she described as a low level of energy, and she seemed

slightly disappointed. This feeling was compounded when the volunteers realized that an undergraduate student who was expected to participate was unfortunately passed out (drunk) in an adjacent room. Still, compared to the contraceptive information session that had zero participants, this residence hall visit was perhaps a qualified success.

Ask Dr. T

Sometimes women may desire more information than what they receive from things like sex education classes and the SHAG sessions described above. Although these events can provide an introduction to large amounts of material, if a woman has additional questions or wants to know something in greater detail she will have to find alternate means of getting information. One option is to go to the web. A 2011 study of teens in Ontario found that 40% of the teens surveyed said that the internet was more useful to them than their parents when it came to sexual knowledge, and 25% rated sources on the internet as more useful than their high school sexual education classes (Tobin 2011). For teenagers or adults who seek information about potentially sensitive topics related to sexuality, the web is an accessible site of knowledge that can be privately explored at any pace.

As I discussed in Chapter 4, there are many websites that feature comprehensive information about sexual health, reproduction, and contraception. These websites can come from many sources, including: professional health organizations (for example, The Society of Obstetricians and Gynaecologists of Canada, which administers the sexualityandu.ca website); non-profit foundations (like Planned Parenthood, Plan Canada's "Because I am a Girl," The Canadian Federation for Sexual Health [formerly Planned Parenthood Federation of Canada], and The Association of Reproductive Health

Professionals [ARHP]); magazines and books (such as tcoyf.com, based on *Taking Charge of your Fertility* by Toni Weschler, or The Nest magazine online); discussion boards and blogs (for instance, the substantial section of the About.com website that is dedicated to contraception); and private and university clinics (including those for Concordia University and McGill University). As I have already shown, some of these sites are more reliable than others; recall the Method Match tool presented on the ARHP website that looks official but is influenced by a major pharmaceutical company and contains biased information. In the course of my research I came across dozens of websites that provide sexual health information, and I have listed only a very few here; a quick Google search will bring up hundreds of thousands of potential online resources.

I bring up websites again because, as it turns out, SHAG also has an online presence. Dr. T personally designed, wrote, edited, and/or reviewed all the content on the AskDrT website.[15] The site is a part of SHAG, and is geared toward providing information about sexual health to university students. The website features a cartoon persona (a kind of mascot) that represents Dr. T, who addresses sexual matters in a frank but playful way. As the welcome page for the site explains:

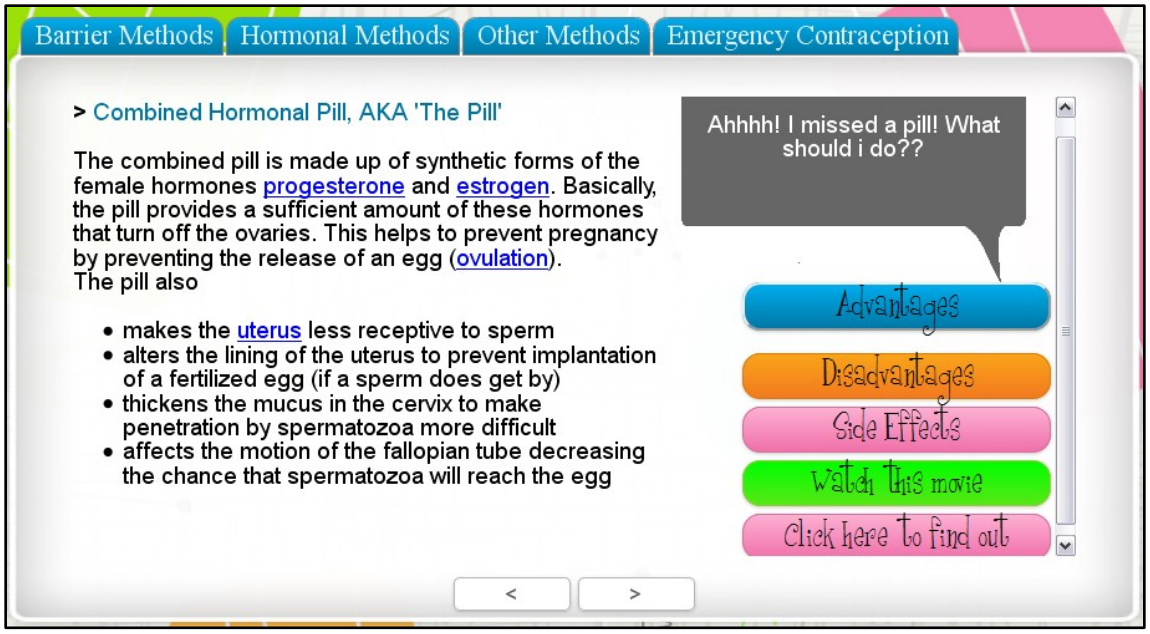
> This isn't your average gym class or science lecture. We know...health schmealth. The last thing you need is another person telling you to eat your vegetables. But AskDrT is here to give you the kind of health info that really matters to YOU. We're talking SEX and RELATIONSHIPS and a whole lot of other stuff that comes along with becoming an adult. This is where you can find answers to your most intimate questions about your own body (and about your partner's). Whether it's swelling, sweating or secreting, we're not shy. And if your questions aren't answered on the site, you can always send an anonymous question to the man himself, Dr. T. So let's get sexy! (In a healthy kinda way...)

The site is divided into several categories, including "Sex & Relationships," "Contraception," "Pregnant?," "At the Doctor's," "STI and Other Infections," and "Ask

[15] www.askdrt.mcgill.ca (accessed 2011-2012).

Dr. T." The tone of each section is light, but there is a lot of content and explanations are generally very thorough.

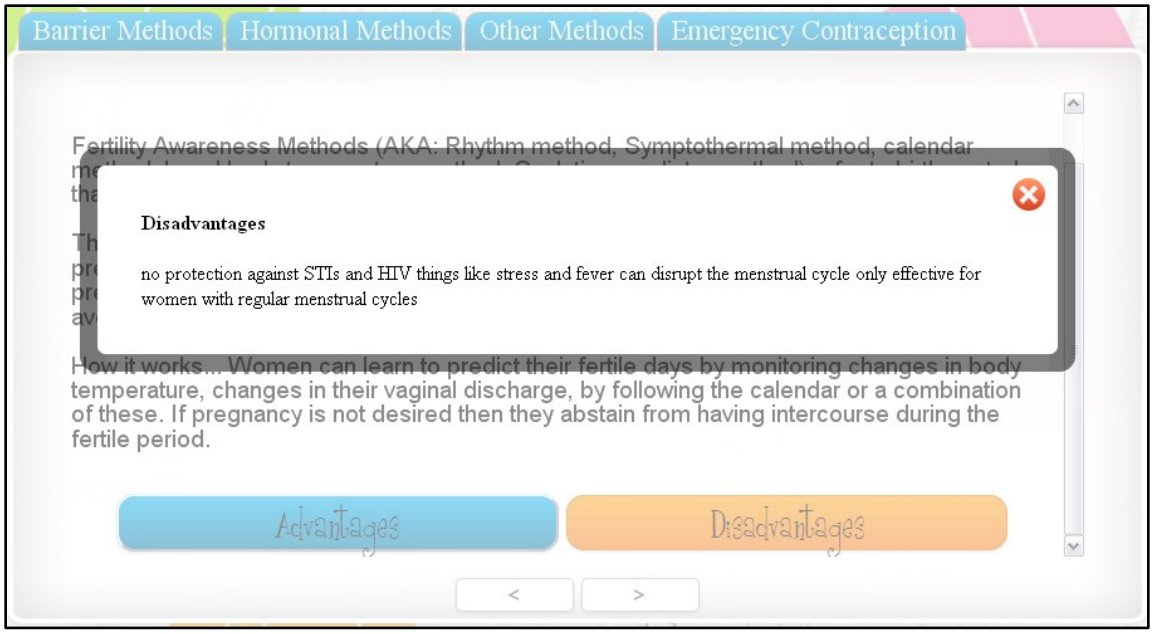
As with many online resources for sexual health, certain elements in the "contraception" category are presented in greater detail than others. The birth control pill is the first item listed under "hormonal methods" in the "Contraceptives" section, and an incredible amount of information is available for it. There are four in-text links you can click for definitions of terms, as well as buttons on the right-hand side that offer additional information. There are links that describe advantages, disadvantages, and side effects of the pill, there's an animated video, and finally a pop-up window full of further information (like what to do if you miss a pill).



Most of the hormonal methods on the site feature a comparable amount of information, and nine of the methods listed (around half of them) also have corresponding animated videos (for the pill, internal condom, external condom, diaphragm, cervical cap, sponge, patch, ring, and injection). The methods without videos are spermicides, hormonal and non-hormonal IUDs, the progestin-only pill, and the

"other" methods (a category that includes vasectomy, tubal litigation, abstinence, withdrawal, and finally the fertility awareness method).

FAM does appear on the site, but it is the last-listed method and is described in fairly vague terms. A range of natural methods are all lumped together under the heading "Fertility Awareness Methods," when (to take just one example) the Rhythm Method and Symptothermal Method are different techniques with dissimilar rates of effectiveness (a distinction which is sometimes overlooked). The entry for FAM also seems to have received less thought and attention than many of the other methods. Unlike the site's resources on its entry about the pill, when you click the buttons for advantages and disadvantages of the Fertility Awareness Method, it is obvious that the content was added with very little consideration. The pop-up for "Advantages" simply reads, "can be an effective form of birth control inexpensive encourages body-awareness" – with no elaboration or even punctuation.



Like many websites (including the ARHP site with the Method Match tool), AskDrT presents a comprehensive list of contraceptives, but not all methods are

represented equally. Recognizing this type of pattern enables one to note the subtle biases for and against particular methods of birth control, which can implicitly guide the choices (and awareness) of women who visit the site looking for information. The website also makes it hard to find percentages that state the effectiveness of each method; such a feature is commonly offered by many sexual health resources online (such as sexualityandu.ca) and can be a major factor for women who are trying to choose a form of contraception. In the case of AskDrT, it is worth reiterating that the site was designed by Dr. T himself, the Director of Health Services at McGill, and not by a pharmaceutical company with a vested interest in the sales of a particular product. The impact that Dr. T's perspective has on SHAG, AskDrT, and even the patients he sees at the clinic, is a subject to which I shall return shortly.

One unique element of the AskDrT website is the feature for which it is named – the ability to ask Dr. T a question. Anyone can follow the links on the site and electronically submit a question about any subject (not only topics related to sexual health). No name is required and every submission is anonymous, although you must enter an email address in order to receive a response. All questions are reviewed, and all questions (excluding those that are spam or unintelligible) are passed on to Dr. T, who sends a personal response to every single question that he receives. Topics which are deemed useful to the larger population, particularly those related to sexual health, may be posted on the AskDrT website; these can include questions that Dr. T has been asked repeatedly, or that he considers particularly relevant to undergraduate students. The ability to seek medical authority in this way is a powerful one. This feature provides an unusual way to seek information – it is at once anonymous and can feel safe (like

browsing the web) while still offering the security of a one-on-one interaction with an authority figure.

It's important to note that some information may never make it to the AskDrT website as a result of Dr. T's judgment. For example, I have come across only two questions on the site that relate to non-hormonal methods of birth control. In one, a young woman asked if it was safe to have sex without condoms (because the risk of pregnancy was not something that worried her), or if there was a place to get free condoms in Omaha, Nebraska because ultimately she was strongly opposed to using hormonal contraceptives. Dr T responded as follows:

> Having vaginal intercourse without protection is risky. …I would suggest that since making a baby takes two that you discuss this with your partner. Does he want a child? Is he ready to make this commitment? Have you thought of the implication this may have for your future? It will affect your ability to finish school, get an education, earn a reasonable salary. In the USA young women who get pregnant as teens earn less money then [sic] their peers. It is very normal to crave sex but there are consequences. Unfortunately, I don't know where to find cheap condoms in Omaha but you may want to think about getting a diaphragm fitted [sic] it is much cheaper in the long run and doesn't involve hormones.[16]

Dr. T took the question as an opportunity to write about what he sees as the negative consequences of an accidental pregnancy on her life, while scarcely addressing her actual question about condoms. And rather than suggesting any number of non-hormonal or natural methods of birth control, he mentions only the diaphragm (a method that I examine in a bit more detail below).

The second question on the site, featuring a similar topic, came from a young man who asked the following question:

> My gf [girlfriend] has regular periods. Last time - on the day that she had her period, and the night after - we had sex without condoms and I ejaculated inside of her. Is this generally a safe practice with respect to pregnancy (not considering

[16] http://www.mcgill.ca/studenthealth/ask/sexhealth/contraception #NEBRASKA (accessed 2012).

> STI/STD)? (Mind you - my gf insisted, but I didn't feel very comfortable with the idea). I was hoping that this method could be an alternative to going on the pill.

Dr. T replied:

> If her cycles are regular and greater than 21 days, then it should be relatively safe. The sperm lives 72 hours inside the vagina and can fertilize an egg until then. If her cycle is short and her period is long, then the last day of her period may be close to ovulation which may not be safe. A better alternative is for your girlfriend to learn how to know when she is ovulating. Then you can have unprotected sex from 3 days after ovulation until her period starts. You did, however, say that you don't feel comfortable ejaculating inside of her. It is important to remember that you should respect her wishes but that you also have a right to discuss the issue. You can also come to the Shag Shop in Student Health Services to talk about alternative options for contraception.[17]

Here, Dr. T actually suggests that the girlfriend should learn to keep track of her ovulation, but neglects to explain just how she could go about doing so (for instance, by charting her cycles with FAM). These answers, and the site overall, reflect Dr. T's genuine interest in helping students and sharing information, but also reveal his avoidance of certain topics, much like the tactics used by Marcie and Dina with regard to educating teens.

The Shag Shop

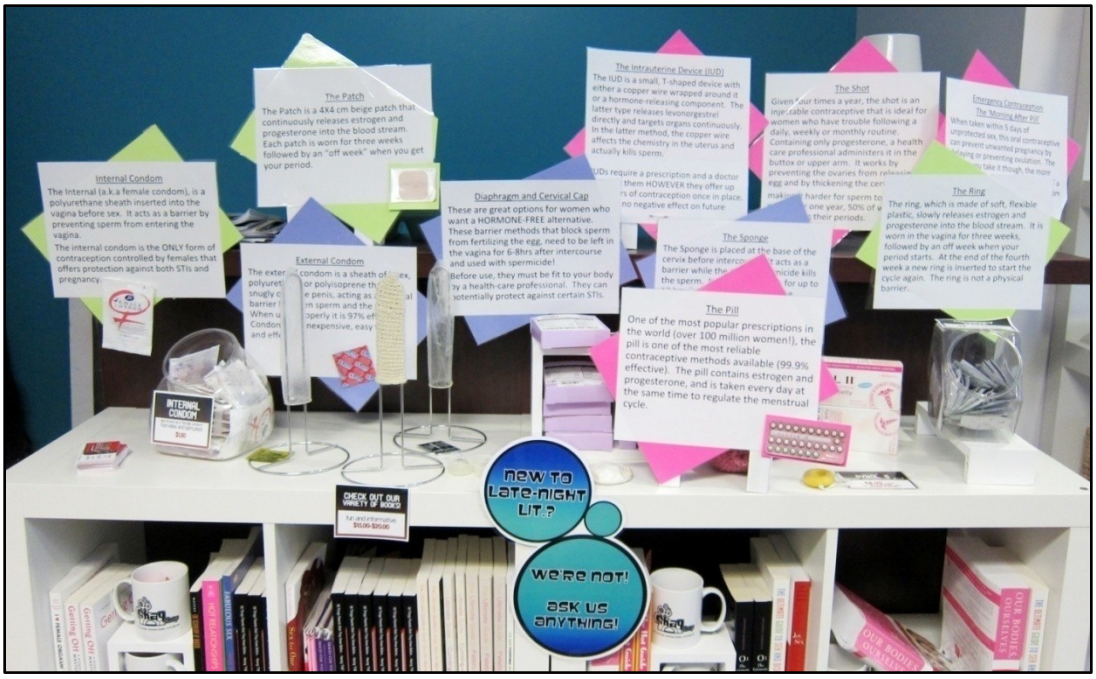
For those who want more of a face-to-face encounter (and not just a virtual one), in 2005 SHAG opened a physical location that people can visit. The Shag Shop is a very small room that's located in the same building as McGill's Health Clinic, around the corner from the clinic's waiting area. The hallway walls on the way to the shop are plastered with bright posters and big blue signs, with blue "footprints" pasted to the floor that lead the way to the shop. The boutique offers a number of sexual health products at-cost (meaning SHAG makes no money from their sale), in the hope that students will take advantage of the low prices to buy these materials and consequently engage in safer sex.

[17] http://www.mcgill.ca/studenthealth/ask/sexhealth (accessed 2012).

The shop sells more than 30 different types and brands of external condoms (starting at $0.25 each), as well as a selection of internal condoms, lubricants, massage oils, lotions, menstrual products, pregnancy tests, contraceptive jelly, dental dams, sponges, diaphragms, and around two dozen books (including three copies of an older edition of *Our Bodies, Ourselves*). I once asked Marcie if she would be interested in adding *Taking Charge of Your Fertility* to the shelves, since I had found it so personally informative; although she was visibly uncomfortable with the idea, she did tell me that if I would send her the information about it, she would "at least look into it."

Although the shop sold condoms and lubricants from its inception, it was consumer demand for diaphragms that led to the sales of multiple contraceptive products in the shop. As Dr. T explained to me, several years ago a few students complained that they could no longer find diaphragms in Quebec: "Some of the students want[ed] the options that are not particularly popular options in general… and it was really then very difficult for them to get it. So we just wanted to do it to facilitate availability to students. That was more a realization of the need, and saying, well, we could do that." Once it became clear that the shop could supply diaphragms to a select group of student consumers, it wasn't long until a variety of contraceptives were for sale.

In addition to selling an assortment of products, one goal of the Shag Shop is to provide sexual health information to students. The shelves outside the entrance to the shop are lined with pamphlets, brochures, posters, and charts, and the walls inside feature large, attention-grabbing displays. The first time I entered the Shag Shop, the bookshelf immediately opposite the door was covered with a series of signs explaining some of the major forms of hormonal and non-hormonal contraception, along with a few demonstration items. These demo objects were the same ones that SHAG volunteers used



during residence hall visits, tabling demonstrations, and the contraceptive information session. The Shag Shop offers a rare opportunity to see and handle things like the internal condom, Nuva Ring, and even an IUD, without buying one first. SHAG volunteers staff the Shag Shop, and encourage dialogue with visitors (and customers). The hope is that students who come in to buy condoms will also come in with questions that the volunteers can answer, thereby making the shop another site from which SHAG can offer

reproductive information. In an interview published by the *McGill Reporter* in 2009, Dr. T explained the shop this way:

> In a nutshell, we wanted to make health education more acceptable to students, and to create a place where they would feel comfortable. It used to be that students had to purchase condoms at Health Services. We wanted a place that was a little different, funkier – a place where students could have peer-to-peer education and health educators on hand. Everything is sold at cost. The Shag Shop provides opportunity to disseminate information about safe sexual practices and contraception. When we put the shop together people were very receptive. To me, it was, and remains, an opportunity to educate. (Lee 2009)

However, when I asked Marcie if many people had come in and asked about the contraceptive display, I was told that mostly they just came in to buy condoms.

The shop also has its own virtual presence, distinct from the AskDrT website. "TheShagShop" has a channel on YouTube where fourteen videos are posted; these feature individuals (often SHAG volunteers) who present information related to sexual health and SHAG. Several of the videos show potential visitors how to find the Shag Shop; after all, it is tucked away deep inside the Brown Building and is hard to find, despite the posters and "footprints" that meander past the health clinic and delineate the path to the shop. One of the videos is entitled "Sperm Run," and it follows volunteers who are dressed up as sperm (wearing white plastic caps and tunics with long white "tails" trailing behind), running across campus and through the Brown Building until they reach the shop's front door. Other videos explain birth control methods (such as the internal condom, the diaphragm, and the pill, among others). The remaining videos provide an overview of male and female reproductive systems, and demonstrate alternative menstrual products (like the Diva Cup, a reusable menstrual cup made of silicone).

The first Shag Shop video was uploaded to YouTube in December 2011. The shop also has a profile page on Facebook (the "McGill Shag Shop"), and each YouTube video has been posted on that page as well. It's clear that SHAG is working hard to increase its presence online and to reach greater numbers of people through the internet, although it's difficult to know the extent to which they have been successful. As of February 2012, the YouTube videos had been viewed a total of 908 times, and the Facebook page was "liked" by only 375 people (up from 321 in September 2011). Given that the McGill campus is comprised of over 30,000 students, it is apparent that despite its combined online and on-campus activities, SHAG is reaching only a small percentage of its target population through these efforts.

McGill's Director of Health Services

One person who *does* reach many students at McGill is Dr. T. In addition to his presence online, Dr. T is currently the Director of Health Services at McGill, he works part-time as a physician at Head and Hands (a community health clinic in N.D.G.), and at least two days per week he works as a physician in the McGill student health clinic. He has a background in family medicine, and his interests at McGill focus on adolescent health; particularly, as he says, "the issues that are pertinent to this age group, which include contraception and STIs." After I had spent some months participating in SHAG events, Marcie introduced me to Dr. T and made it possible for me to set up a one-on-one interview with him. Dr. T graciously sat with me for well over an hour, late one rainy afternoon after he had finished his other work for the day. He was very patient with me as I questioned him about his role at McGill and with SHAG, asked for his opinions about women and birth control, and even as I requested clarification about the health care

system in Quebec (after all, he said, "it is quite confusing to everybody!"). Dr. T's open and genial manner made it easy to talk with him, and I appreciated his time and input (and his sense of humor) very much.

In his work at McGill, Dr. T has endeavored to create new and improved initiatives to bring sexual health awareness to the students on campus. As he told me, he is a family physician with interests in adolescent health, and he works mainly with young people. As a gay man, his personal interests include queer and transgender studies; as he explained in the McGill interview, "being gay has taught me a lot about empathy" (Lee 2009). Although he doesn't devote much of his work to contraception, he does consider himself to be sensitive to some of the needs of women: some 10 or 15 years ago, he initiated a movement to use "patient teachers" in the teaching of pelvic exams to medical students. As he explained:

> The patient teachers are essentially a collective, which for lack of a better word we call a feminist collective. …They are there primarily not only to teach to students, but to teach an approach which is more sensitive to the woman as a person, and some of the issues she might have and some of the anxieties she might have. So in essence the exam becomes less about inserting a speculum, and more about explaining things, more about making the woman understand, and really being respectful of the woman as a patient.

The "patient teachers" echo the style of the volunteers and staff at SHAG – they act as experts, disseminating information while remaining more accessible than official authority figures (like doctors). Like the AskDrT website, this type of approach attempts to bridge a perceived gap between medical personnel and patients.

For all his hard work, however, there are still some problems at the student health clinic at McGill. According to Dr. T, one of these stems from the provincial health care system, which constrains the number and type of physicians that the clinic can hire. For

Dr. T, this is a problem because it means he can't bring in as many doctors (particularly family physicians) as he would like, and the ones who *are* hired can only work on a part-time basis. A major consequence of this situation is that there is little communication among doctors who work at the clinic, which also means that none of the doctors receive training from Dr. T:

> We do try to train our physicians to make them more aware; for example, [when] new contraceptive techniques… come in. Or very recently, the [government has] changed the pap recommendations. But our physicians are notoriously not interested in coming to training sessions. Actually I've given up, so I don't do [them] any more. I've sent the recommendations by email, but I know half of them don't read it.

While he concedes that this can be frustrating, Dr. T explains that it's really just a question of "having to live with the system as it exists."

Another issue at the health center is that nurses are paid on a daily basis, while doctors get paid per patient that they see. Along with the shortage of family physicians in the clinic, this leads to a pretty standard routine of doctors hurrying through patients at a rapid pace. It's for this reason that Dr. T and Marcie have suggested that a woman who is interested in starting a new form of contraception should make an appointment with a nurse whenever possible; this way she can spend up to half an hour discussing her options (as opposed to 15 minutes with Dr. T), and at the end the nurse can provide a prescription if necessary. Although a doctor can and will sit down for contraceptive consultations, Dr. T comically described his subjective experience of that situation thusly: "As a physician, when you come in and see somebody who says, 'Talk to me about birth control,' you say [to yourself], 'Oh my God, I don't have that much time! In my life!'" This problem of time is not unique to McGill's health clinic; many of the health centers in the province work under similar circumstances. But Dr. T's work is

unique in that his efforts with SHAG and the Peer Health Educators offer ways to help overcome the difficulties resulting from the health care system.

In addition to constraints imposed on them by government forces, sometimes medical authority figures can also be subject to personal biases that may influence their approach to health care. From time to time in our discussion, Dr. T expressed subjective opinions about particular forms of contraception, side effects of various methods, and perceptions of women (of all ages). Like Marcie and Dina, he clearly holds a low opinion of natural methods of birth control; when I asked him directly about FAM, he replied,

> I don't necessarily encourage it, so therefore **it's something that I avoid mentioning**. **Because it's not reliable**. … It is a combination of techniques that you use, and part of it has to do with being very regular, and **most women are not necessarily very regular**. And so that makes counting your days difficult. Part of it involves being comfortable with your body and checking for cervical mucus, and that's also… that's something that you need to teach people. … And the other part is taking temperature, and that's **kind of difficult to do unless somebody's able to find an electronic thermometer**. By the time that you get comfortable with recognizing the dip and rise [in temperature], that usually takes two to three months, and **most people get fed up** with that before they get to the two-three months of getting a regular pattern. There are some people who are committed to it and who use it, but **most of the time they're not interested** in that.

There are several things to say about Dr. T's opinions of FAM. His argument that the method is not reliable is debatable at best. On the Contraceptive Comparison Chart from sexualityandu.ca (described in Chapter 4), the sympto-thermal method is listed as 80% effective with typical use, and 91-99% effective with perfect use. Compare that to the diaphragm, the surprising (and arguably outdated) form of contraception that catapulted the Shag Shop to its status as a "safer sex boutique," and the method suggested to the querent from Nebraska on the AskDrT website who sought a hormone-free option for contraception: the Contraceptive Comparison Chart rates the diaphragm as 84% effective

with typical use, and 94% effective with perfect use – not drastically different from FAM after all, and hardly foolproof in its own right. Also, Dr. T's claim that most women's monthly cycles are not regular echoes medical language from nearly 30 years ago; as Emily Martin noted, in 1982 one Dr. Lever estimated that "'more than three quarters of all women suffer from symptoms of PMT [another way to say PMS].' In other words, according to Lever, a clear majority of all women are afflicted with a physically abnormal hormonal cycle" (Martin 1988:162). Dr. T seems to hold a similar opinion, reflecting a stance that resonates with decades of medical perspectives toward the treatment of women's bodies (as I discussed in Chapter 1). Dr. T also makes several implicit assumptions about women in the course of his statement. He alludes to FAM's requirement that a woman who charts must check the quality and consistency of her cervical mucus, and implies that many women will not have the necessary level of comfort with their bodies to do so. Yet he repeatedly recommends the diaphragm, which is a barrier method that requires a woman to fold and insert a large latex or silicone device high up inside her vagina before sex, and to retrieve and clean it afterwards – hardly less "messy" than FAM (and no better suited for "squeamish" women).

Dr. T is also concerned about the high degree of difficulty he associates with teaching FAM, particularly to young women. In addition to assuming that they would be unable to find a digital thermometer (available in any drugstore), he asserts that most women will not have the patience or the interest to keep up with FAM as a method of contraception. He also implies that they may not be able to understand the process. As he told me later in our conversation,

> You need to go through **the whole reproductive cycle**, you need to explain the reproductive cycle, what's happening in the reproductive cycle, why you're

> looking for certain things in terms of signs, and why certain things are occurring at certain times. And that takes a lot of time. So in itself, it's like a course by itself. … Sometimes they need to see [their own] eggwhite stuff to really understand what you mean… You explain what it is, and say, 'Do you notice what your mucus is like now, what it feels like? Well this is what it is like when you ovulate,' and then it becomes concrete. [But for high school or undergraduate students] it's **just too difficult**.

His discussion of the arduous task of teaching the reproductive system (never mind a method like FAM) reveals an assumption that women can't be thoroughly knowledgeable about reproduction. His claim that women need to see real-life, in-person samples of fertile-quality cervical fluids in order to make their understanding "concrete" (evidently photos will not suffice), along with his series of concluding questions for the supposed student, lend a patronizing tone to his argument. His concluding sentence seems to place the blame on women themselves for not being able to understand these matters, rather than on doctors and educators who are unwilling or unable to take the time and effort to comprehensively teach this information. Granted, this type of education might take more time to teach women, but as he put it, "they just don't understand it because it's a complicated process; they're not going to remember it." If women aren't expected to understand the reproductive cycle, then doctors and health professionals are evidently not expected to try to teach it.

Several of Dr. T's comments reflected a similarly dismissive attitude toward women's ability to learn. For instance, when he offhandedly remarked that "it becomes a little too complicated" to explain how the pill works to a woman who is receiving a prescription for oral hormones. Or when he bemusedly described women who come to the clinic and "smell like dead fish down there" (without realizing they have an infection), and are "just totally oblivious to what their body is, [and] don't really question

what's going on down there." Perhaps one of the clearest examples of this attitude comes from Dr. T's argument for why he doesn't advocate teaching FAM to undergraduate students:

> It's really not a reliable method from the point of view of this population. It requires such an amount of discipline that **it is not the nature of this age group** (from the point of view of their developmental stage) to use this method and to control that amount of things. What happens is that, first of all, the young people that we deal with are at a stage where yes, they're slightly beyond adolescence, but they're still quite young. And they still, **many of them still do not have a concept of 'futurality'** [sic] **and a concept that what their actions might bring is some sort of problems later on**. And therefore to practice fertility awareness you have to be aware of that, and you have to be able to delay gratification.

At this point, the problem is not whether FAM is a reliable method for contraception, or even if it is a valuable tool for gaining insight and connection to one's body. Rather, Dr. T declares that undergraduate women (aged anywhere from 18 into their mid-twenties) are *by nature* too immature, too unaware of consequences, and too impetuous to be relied upon to use a method like FAM correctly. Dr. T evidently does not consider the possibility that teaching young women to use FAM could foster valuable skills and habits, thereby developing the maturity and self-awareness that he believes they lack. Note that during our entire conversation, only women were discussed in such terms; Dr. T only mentioned men once in an anecdote about purchasing condoms in the Shag Shop.[18]

In all of my interviews with medical professionals, there was a strong implication that without contraception (and hormonal methods in particular) young women would almost necessarily become pregnant. Accidental pregnancy was presented by Dr. T and

[18] In future research I would like to add male perspectives on reproduction and decision-making with regard to contraception; unfortunately it was beyond the scope of this thesis to directly seek men's viewpoints on the matter. Furthermore, since the only discussion of men by medical professionals was with regard to condom sales, I unfortunately had little ethnographic data to draw from in order to incorporate any significant aspect of men's experiences with birth control.

others as a worst possible outcome, one that absolutely must be avoided. Whether this conceptualization of young women as magnets for unintended (and unwelcome) pregnancy is limited to health professionals or is part of a broader cultural view of young womanhood is a valuable question, and it would be illuminating to explore the related cultural imperative to avoid pregnancy among young women at all costs; unfortunately such an investigation is beyond the scope of this thesis. However, in my interviews with medical professionals and with women it became clear that for almost everyone, an unplanned pregnancy is considered a destructive event with dire repercussions for the woman, as well as a nearly inevitable outcome for any woman who is not using birth control.

Medical authorities may decide not to teach some kinds of information after assuming that women cannot, will not, and ultimately *should* not utilize certain forms of knowledge (such as FAM). In their attempts to prevent unintended pregnancy resulting from the misuse of "confusing" information, health professionals intentionally withhold information from women, and thereby encourage degrees of selective *ignorance* in women. Dr. T, Marcie, and Dina each expressed assumptions about women (of various ages) to justify this approach: women can't understand or remember "complicated" processes like the reproductive cycle; they "just aren't interested" in basic biology and their reproductive patterns; they require "concrete" visual evidence in order to understand fertility symptoms; and young women "can't be trusted" because they have no sense of "futurality" (consequences).

It is not only information about fertility that is filtered before it is communicated to women. The mandate to keep them from getting pregnant is also used to justify

selective discussion of the potential side effects of various methods of birth control. As Dr. T told me, "what you want to do is to prevent pregnancies. In part because the effect of a pregnancy on a young woman can be very devastating and can have [a] heavy-duty economic impact as well as psychological and physical impact. And young women are much more likely to have medical issues from a pregnancy than they are from taking any form of hormonal contraceptive." This statement reflects the dominant medical perspective that regards pregnancy as an illness full of "medical issues" (rather than as a natural process), and calls to mind the pregnancy "symptoms" that I discussed in Chapter 4. Dr. T made it clear in our interview that his main concern is finding a contraceptive that a woman will take consistently and successfully, in order that she not conceive by accident. To ensure this outcome, however, he must manipulate the information he provides:

> They need to take it well, and the biggest reason that people stop is side effects. … And they don't tell us when they stop. They just stop. So it's important for us to explain to them the side effects, the bothersome side effects. But **part of the side effects**.
>
> Part of **overcoming some of the impact that these bothersome side effects will have** is if they've already had a positive attitude towards it, and they feel comfortable with it already. If they have side effects and [one of their girl friends] says, 'Oh yeah, sure, when I started I had bleeding a couple of days during the month, no big deal,' then it's no big deal! Whereas if they're sort of by themselves and they really don't know, then they don't know what that means, and they become very anxious and just stop [taking it].
>
> **I cover the side effects which I think are *relevant***. Sometimes you scare people by giving them information, and *how* you give them information. And though you may want to scare people at times, it's not really a good approach. …The likelihood of serious complications (for example with the pill) in a young woman is extremely low, **whereas the likelihood of stopping the pill because of bothersome side effects and getting pregnant,** and the complications that you can get from pregnancy**, is much more frequent and much higher than the [risk of] blood clots**.

For Dr. T, side effects and the choice of specific hormonal or non-hormonal contraceptives are practically irrelevant; for him, it's all about the need to avert pregnancy. He also assumes a kind of "female contraceptive culture," which Gutmann described in *Fixing Men* as the way that "women worldwide are overwhelmingly responsible for birth control" (2007:40). Dr. T suggests that women communicate with one another about contraception, forming a kind of "contraceptive culture" wherein they can reassure one another about their choice of birth control. For Dr. T, the idea is that medical professionals should empower women with just enough information that they can use a given contraceptive correctly, talk to one another about it, and not get spooked by a few side effects, while simultaneously ensuring that they remain just ignorant enough of *all* side effects or alternative contraceptive methods that they can't mess it up and get pregnant.

Conclusion

With regard to contraception, a lack of clear and accessible information about all forms of birth control, coupled with incomplete education regarding reproductive processes, cultivates women's dependency on medicine and technology. Without a full understanding of how the female body works, and particularly without an awareness of alternate forms of contraception, many women may rely strictly on contraceptives (and usually, therefore, on prescriptions) in order to avoid unwanted pregnancy. Although some organizations endeavor to provide additional information about sexual health, the content of these sites of knowledge is often filtered, just as doctors can choose to filter what they tell patients about risks and side effects.

As a result of these interconnected processes, a particular type of female ignorance is manifested, based on medical (and cultural) assumptions that women don't want or need to understand the basic tenets of reproduction. Consequently, women themselves may feel that they don't want or need to cultivate their own reproductive awareness, thus reinforcing their dependency on birth control if they don't want to conceive by accident. When social structures not only fail to educate women, but also propagate a dependency on the same few forms of contraception, the result hardly seems empowering for women.

> I don't prefer any [method]. I prefer what the person wants. The "best one" is what's best for them, because **that's what they will comply with.** And ultimately **the compliance is what's important**. *–Dr. T*

Chapter 6: Birth Controlled

In Chapters 4 and 5 I explored the many external forces that can inform, influence, and manage women's decision-making with regard to contraception. Young women are viewed as neither competent nor interested in understanding their reproductive cycles, and there is a consequent lack of effort to teach them about their bodies and fertility. Cultural and medical sites of knowledge (such as websites, advertisements, and medical professionals) encourage women to remain at least partially ignorant of basic biology. These factors contribute to a self-fulfilling prophecy that in effect distances women from their fertility. By not teaching young women to be interested in, or to take responsibility for, their reproductive cycles, there is instead a sense fostered among many women that they *don't need to know* about their fertility. Despite this gap between bodily knowledge and practice, women nevertheless actively make choices about contraception and reproduction. In this chapter I recount women's memories of sexual education, use of contraception, and lifestyle choices in order to explore their lived experiences of birth control.

Sex Education: "How Babies are Made"

Most of the women I interviewed were not raised in Quebec, but many shared remarkably similar memories of sexual education in their youth. It would seem that whether you go to school in Winnipeg, Manitoba or Fayetteville, Arkansas, sex education is fairly consistent. And it's important. As the Boston Women's Health Book Collective asserted in *Our Bodies, Ourselves,*

> Access to education has a powerful effect on a woman's ability to exert more control over personal choices, including whether and when to have children. Better-educated women are more likely to delay childbearing, and literate mothers are better able to care for their children. Policies that promote the education of

> girls and women therefore lead to reductions in the birth and infant mortality rates, as well as improved health for women and for the community as a whole (2011:779).

For the women I interviewed, sexual health education usually began in pre-pubescence, when a racy scene in a movie or a term heard in the schoolyard often prompted a discussion with a parent or sibling. Isabelle told me that when she was eight or nine years old,

> …my sister refused to tell me what a blowjob was, and I told her if she didn't, I would ask my dad – so I did. [He reacted] very clinically. I didn't really care what he was talking about; I just looked back at [my sister], who was mortified, and laughed.

Melanie first learned about sexual intercourse at a similar age during a slumber party from a "girl who knew a lot." A few months later she recalled reading aloud (at her mother's urging) from a book about sexuality with her mother: "I remember not wanting to read it out loud, because I was embarrassed saying "penis" and "vagina," or whatever. Those were words of course I knew, but never really said out loud." Melanie suggested that her mother wasn't comfortable with the topic, and she figured it was easier for her to ask Melanie to read through a book than to try and explain it herself.

A few years later, in Grade 5 and around age 10-11 for almost everyone, there was usually a special day when the boys were taken to one room and the girls to another for a lecture on sex ed. Typically girls learned about menstruation and boys learned about nocturnal emissions; as Chloe said, "they separated the boys and girls for some of the classes, and for the girls we definitely talked about pregnancy and having our period, and all those kind of things. I'm not sure what the guys talked about." Hilary, who attended school in Montreal, actually attended a weekly health class that started in Grade 5. Lensa (and Hilary as well) described the classes as teaching the "mechanics of sex and biology,

but not specific to any real actions or outcomes. It was really basic, obviously – it wasn't like, 'this is how you put a condom on' to a bunch of eight year olds." All the women remembered receiving information about periods and body parts, even Nadia, who attended a Catholic elementary school: "Instead of calling it 'Health,' they called it 'Family Life,' beginning with how families get created… it was the first time I was aware of the fact that 'I will have sex with a man, and that is how I will get pregnant, and I will be a birthing mother.'"

By the time the women were in middle or high school, sex education had usually been incorporated as a part of "Health Class." Some of the women remembered specific lectures about reproductive systems, menstruation, and basic biology, but there seemed to be little connection made between female reproduction and the act of sex. Melanie said that her teachers "talked about the period and they talked about the uterus being the place where the baby grows. But I always remember there being a kind of disconnect between the mechanics of the period versus the connection to pregnancy and getting pregnant." Josephine explained that "I never had any sociological classes on it, it was all science – 'this is how it works, period.' And always some awkward teacher teaching it." As Penny further explained,

> The thing I notice from sex ed is that it taught me how babies are made, but that's really kind of *it*. The part about healthy sexual practices, or your own menstrual cycle, or knowing what's weird, what's not weird – that [was missing]. People still don't seem to understand how STI's are transmitted and what prevents them, even very educated people. And in terms of birth control, people also don't seem to understand how your menstrual cycle ties in. And those are two pretty basic things.

No one mentioned learning about fertility awareness in their health classes. Most remembered sex ed in high school as focused on the dangers of unprotected sex (namely, the transmission of STD's and STI's, and the risk of accidental pregnancy), and very

rarely on the relation between fertility, sexuality, and the multiple methods of birth control. Even though contraception was sometimes discussed, it was typically presented in the context of preventing sexually transmitted diseases:

> In middle school it was like every year you had a health class, and one of the huge sections for like a quarter of the year wasn't even about learning reproduction… it was about STD's, and I was memorizing lists of symptoms for these tests. That was my major impetus for [feeling like] "I don't really care so much about a kid," because as horrible as it sounds there's a solution for that. But if you catch some sort of virus, that's never going away. *–Isabelle*

These classes had a strong impact on several of the women's future contraceptive choices. For Isabelle, sex ed classes instilled the idea that STD's were the largest risk to her health, and she acted more carefully to prevent contracting a virus than to avoid a pregnancy. Ironically, this behavior is in stark contrast to Dr. T's declaration in our interview that young women have no awareness "that what their actions might bring is some sort of problems later on." As a young woman Isabelle was successfully taught about the long-term risks of contracting sexually transmitted diseases, and she made subsequent contraceptive choices to protect herself accordingly.

Few of the women listed any one source as the main place they could go for information about sexual health after high school. Sarah, a former McGill graduate student, actually mentioned the Shag Shop once, although she initially called it the "Stag Shop" and, as she said, she "never ventured over there. But it sounds like the Shag Shop has all kinds of goodies." Sarah also noticed the same "fishbowl of condoms" placed by SHAG in the women's bathroom at McGill's graduate student house that I had also inadvertently encountered. In terms of alternative sites of information, a few women mentioned that they might browse the internet, although no one named any particular websites or organizations other than Google. Isabelle said, "I'll ask my sister if I have

questions; she's a doctor. If it's really embarrassing I'll look on the internet first, and if I find out it's not a big deal then I'll ask her."

Health clinics were a potential resource for a couple of the women I interviewed. Penny was lucky enough to have had a good doctor in her undergraduate clinic; it was a woman she was able to visit consistently for around 4 years and whose advice she trusted. Not everyone considered doctors and nurses a reliable source of information, however. Kinsey, for instance, told me that if she had a particular question she would first check on Google, but "if I was really curious I'd probably go to the clinic and ask. But I just don't trust them, so… I would probably ask, and still doubt what they say. But [I'd go] just to hear their opinion." And as Chloe pointed out, "especially at the university clinics, they just want to get through as many people as possible." Even Penny said that since moving from her undergraduate university, she has adjusted her approach for how to get the most out of a clinical visit:

> Now I'm more assertive. If I go to a doctor that I haven't seen before, I try to go really prepared, with "these are the questions that I need to ask, and this is the information that I need to get from this person." Because I find sometimes if you don't straight up ask, they just want you out the door fast.

The women I interviewed all agreed that doctors in health clinics often make them feel hurried (and unheard). This is not surprising given Dr. T's explanation of the small amount of time a doctor has available to spend with his patients, as well as the financial incentives for doctors to see as many patients as possible each day. Consequently, women felt the need to carefully prepare for appointments, to find alternate resources for information beyond the clinic, or even to avoid certain doctors in particular. During our first group interview, Chloe told us of her experience with a doctor at a university clinic she visited:

> He seems like he wants it to be kind of fun, and tries to make it low key, but to me it seems really unprofessional. With [a friend of mine, this same doctor] was talking on the phone as her legs were already up in the stirrups, ready to have the exam, and he was like, "Oh you want another pap? I'm really papped out today."
>
> And once he tried to convince me that, "You know, you don't really need to do this every year anymore. Why don't we just do this another day?" And I said "No, I've been waiting six weeks for this, I want my appointment." And he was like, "*fiiiiine*" [exasperatedly].
>
> During the whole process, I have never felt so… I felt like I was being finger-raped, basically. It was completely uncomfortable. I had tears streaming down my face, and afterward he said, "We have to have a little chat now" [in an irritated tone]. He said I acted like I had been sexually assaulted, and he asked me if my boyfriend is rough with me because he's never seen anything like it before. And I wanted to say to him, well, you should really re-evaluate how you do these procedures, because it's completely uncalled for! I've never had these issues before. And he replied, "No, I think you're just being a little squirmer."
>
> I was shocked. [But] who do you complain to? The more people I've talked to who've had him for that procedure [agreed that] he was rough and didn't know what he was doing, and he just made them feel completely uncomfortable. I've gone back [to the clinic since then], and when they ask me if I prefer a male or a female [doctor] I tell them it doesn't matter, but I will not take Dr. X."

This doctor's seeming reluctance to provide pelvic exams to Chloe and to her friend, as well as his casual dismissal of Chloe's extreme distress during her pap smear illustrates just how distanced doctors can be from the women in the bodies they examine.

The distance between medical professionals and women is further illustrated by their typical expectation that young women are disinterested in learning the specifics of the reproductive cycle. Several of the women I interviewed emphasized that they considered themselves to have been well-informed about their bodies at the time that they were taking health classes in high school, often around the same time that they started using the pill. As Chloe recalled, "when I first went on [the pill] I definitely knew everything. I learned all the chemicals [laughs] and what was going on." Many women echoed Josephine, who simply said, "I think I generally know how things work."

However, when I asked each woman to describe the female reproductive cycle in her own words, an immediate anxiety was palpable. A few asked me to clarify whether I meant "the menstrual cycle" (when in fact by asking about "reproduction" I had hoped that I might elicit an explanation of the entire monthly process, and not just the 5-10 days that involve bleeding). Invariably there was a 10-second pause while I gave each woman time to think, at which point I realized her discomfort and began to feel awkward myself. Sometimes this moment wasn't subtle; Lensa, for instance, exclaimed, "How would I describe it? Like biologically? Holy cow!" At this point in every interview, I almost always offered quick reassurance that the question wasn't "a test," and I asserted that "there are no right or wrong answers! I just want to understand your impression of the process." After a few moments of silence, nervous giggling, or occasional fidgeting, each woman eventually offered her description of the reproductive cycle.

Lensa told me that "it's something you learn the basics of and the biology when you're in elementary school, and then when you get to high school it's kind of about your actual actions. So by the time we're this age, now, I'm like… I don't even remember how it works." Some women's explanations reverted to basic terminology and simple summaries. Kinsey explained that every month, "your body prepares itself to carry a child. It starts getting ready, padding it up… Your body releases an egg, and [if] it's not fertilized then your body gets rid of all that stuff that it's prepared, which is your period. And then it happens again!" A few used technical terms and medical phrases; Sarah, for example, knew that ovulation occurred around days 12-14 of a woman's cycle. Grayson offered the most "medical" description:

> The lining of the uterus builds up and eventually you get a spike in LH, I think it is. In your ovaries are follicles for eggs, and they gradually get bigger, and then an

> egg is released. It goes through the fallopian tube, passes down; at some point it either gets fertilized (at which point it's an embryo, and embeds in the wall) or it doesn't, and then the lining of the uterus comes out, which is your menstrual cycle, more or less, right?

This was probably the most "accurate" description, and no one else offered any explanation of the reproductive process that was quite as comprehensive. Most of the women focused primarily on the events surrounding menstruation, along the lines of Melanie's explanation:

> So, you have a finite number of eggs that grow in your ovaries (you have two ovaries). And when it's time for your period, well… Basically, the process that happens is every month, or approximately 28 days, an egg goes down the fallopian tube and lands in the uterus. When the egg comes down it releases certain hormones, and that causes blood and tissue to accumulate in the uterine lining so that if you do get a pregnancy, that would nourish the baby eventually. But if the egg is not fertilized, then the blood and the tissue and the egg are expelled from the uterus, and that's when you have your period.

Melanie's account covers most of "the basics," although it omits some of the details provided in Grayson's account. Most of the explanations I received were of a similar type, although some had a bit more trouble; Hilary, for example, could only describe the process as "your body getting rid of excess blood, and it's also a mark of fertility. I don't know how that's related, how getting your period means you can have children."

After each woman had finished her explanation, I asked how it made her feel to describe her reproductive cycle. I was dismayed to find that most of them seemed to feel acutely embarrassed. Even Grayson, who provided a very thorough explanation, said "it's a little embarrassing, at my age, to have to try [to explain it]… It would be one thing if I was a teenager, but [now] I felt like, 'if I get it wrong, that's going to be totally humiliating.'" My question also caused several women to pause and evaluate how strong their knowledge of their bodies and cycles really was:

> I'm not actually so confident about how it works. I'm not really aware of my cycle. …I think I knew more about how the physiology of how the body works when I was younger, when I had those sexuality classes and they taught it to me, but those just stopped as I got older. So I never got a stronger sense of how my body works. [And most of the time] I don't think about it at all. *–Hilary*

The near-universal discomfort that my simple question elicited was something that I did not anticipate, but that I encountered in every interview. Each woman was initially unnerved to be asked to speak as an authority on female reproduction, and some seemed to feel guilty for not being an expert on the topic by virtue of *being* a woman. These women had high expectations of themselves and, as graduate students, seemed especially sensitive to being seen as ignorant. They valued the idea of expertise, and upon recognizing that their knowledge was lacking they felt ashamed; they seemed embarrassed that they hadn't studied, or at least been better prepared, for our interview.

Yet, they had a relatively basic level of sexual education; they came from high schools that seem to have omitted certain information in the same way that Dr. T described for Quebec schools, where little emphasis was placed on teaching biological information about fertility. They had no source of mandatory instruction in sexual health in the years after high school. None of them had intensively studied reproduction or anatomy, and it had been years since any of them had taken a health class. Evidently higher education, first at undergraduate and then graduate levels, had done nothing to increase their knowledge of the subject. As Lensa told me, "no one has asked me to actually talk about this in fifteen years!" Josephine remarked that her grasp of the topic "was probably a lot better when I was actually taking the classes, and studying them; I feel like I had a really good understanding, but there are probably some huge chunks I've forgotten just because I haven't studied it in a while." Upon being asked to describe the reproductive process they experience every month, these women seemed to suddenly feel

that they *should* possess some higher level of bodily self-awareness, and some of them felt that they had failed to adequately demonstrate it. Hilary, for instance, told me repeatedly that "I really don't feel smart. I should know this. I should know how my body works, and why." Lensa likewise worried if she really knew enough:

> I feel like I have an understanding of the basics, but I feel like if something was ever wrong with my fertility, or not quite right with my cycle, I either maybe wouldn't know, or wouldn't know what the problem is. We kind of know how the basics work, but what if you have issues? Do we know what they are? Do we know when to go see someone about it? But for the most part, I'd say I have a basic understanding that I'm happy with.

Using Contraception: "Quelling the Bloody Warfare that was my Period"

In addition to being somewhat unfamiliar with the detailed processes of the female reproductive cycle, many of the women I interviewed revealed that they had a limited knowledge of birth control options as well. As Josephine explained, "I think most of what I learned about contraceptives was through my friends, and I guess to an extent through the media. We talked about it a little in school, but now there are so many different types, and back then there weren't that many types." A huge variety of potential hormonal, non-hormonal, and natural methods of birth control are now available to women: Chapter 3 of this thesis lists the 15 methods that are presented on www.sexualityandu.ca; the ARHP "Method Match" tool online lists 20; and the contraceptive chart made by sexualityandu.ca (and distributed by SHAG) lists 21 forms of birth control. (This does not take into account the dozens of branded and generic varieties of each type of contraception.)

Most of the women I interviewed could remember the existence of an average of only 4-7 methods, most commonly the pill, the external condom, the shot, the patch, the ring, and the sponge. Every so often someone was able to list more than the standard few

contraceptives, and in the group discussion the women together listed withdrawal, condoms, the rhythm method, diaphragms, IUD, spermicide, and of course the pill. Although several seemed to feel the same as Penny, who said she didn't "know the fancy names for things," occasionally specific brands of birth control were named. Most were aware of the Ortho Tri-Cyclen brand of the pill, and a few were familiar with Yaz and Alesse (both pills), as well as the Nuva Ring. Melanie was able to list quite a few specific brands by name, including Norplant (the implant), Depo-Provera (the injection), and Seasonale (the pill that gives you 4 periods a year).

To find out which methods were commonly in use (and not just which contraceptives each woman was aware of), I asked ten of the women I interviewed to fill out a brief questionnaire before we talked (see Appendix 3). The results of the questionnaire helped me gain a basic understanding of their sexual activity and preferred methods of birth control. Of the ten women, nine had (ever) had sex, seven were having sex at least once a month, and six were currently using some form of contraception. I asked them to list all forms of contraception that they had ever used, or were currently using, and to write down their personal estimate of each method's effectiveness at preventing pregnancy. Only one woman out of ten had never used contraception; for the other nine women, the results were as follows:

- Eight women listed the birth control pill, and rated its effectiveness between 85-99%. (For reference, the sexualityandu.ca contraceptive chart lists the pill's effectiveness as 92% with typical use, and 99.7% with perfect use.)[19]
- Seven women listed the external condom, and rated its effectiveness between 80-95%. (The contraceptive chart lists its effectiveness as 85% with typical use, and 98% with perfect use.)

[19] One woman did not fill out a questionnaire, but she was sexually active and was using the birth control pill and the external condom. As a result, 10 out of the 11 women I interviewed had ever used a contraceptive; of those, 9 had used the pill, and 8 had used condoms.

- Two women listed Plan B, and rated its effectiveness from 98-100%.
- One woman listed the mini-pill, and rated its effectiveness at 90%. (The contraceptive chart lists its effectiveness as 92% with typical use, and 99.7% with perfect use.)
- One woman listed fertility awareness, and rated its effectiveness at 90%. (The contraceptive chart lists its effectiveness as 80% with typical use, and 91-99% with perfect use.)
- One woman listed spermicide, and rated its effectiveness at 80%. (The contraceptive chart lists its effectiveness as 71% with typical use, and 82% with perfect use.)
- One woman listed the dual method of the pill and condoms, rated its effectiveness at 85%.

Among the ten women who filled out the questionnaire, only seven types of methods had been used by anyone, a total that accounted for approximately 30% of the available forms of birth control. The average is less for individual women; the most any single person said she had ever used was four methods. Interestingly, the women's estimations of the effectiveness of the contraceptives they have used were for the most part very accurate. However, even though only one person listed it in the questionnaire, in the one-on-one interviews several women mentioned their reliance on dual methods. Penny explained that even though she was on the pill, "I would almost always also use a condom, but several times I didn't, and that stressed me out. I don't think I was always perfect about taking [the pill]." When Sarah was on the pill but dating casually at university, she said she "always used condoms anyway," and occasionally lied to her partners, telling them she wasn't on the pill so that they would have no question about using a condom. When I asked her if she was more confident about using the pill or using condoms, a big part of her confidence depended upon whether or not the withdrawal method was incorporated as well:

> With the condom and withdrawal, I would say [I'd be] 99% confident. Without withdrawal, 80-95%. If I had to pick [between the pill and the condom], I would

> trust the condom with withdrawal – I feel like the pill with withdrawal is kind of iffy. –*Sarah*

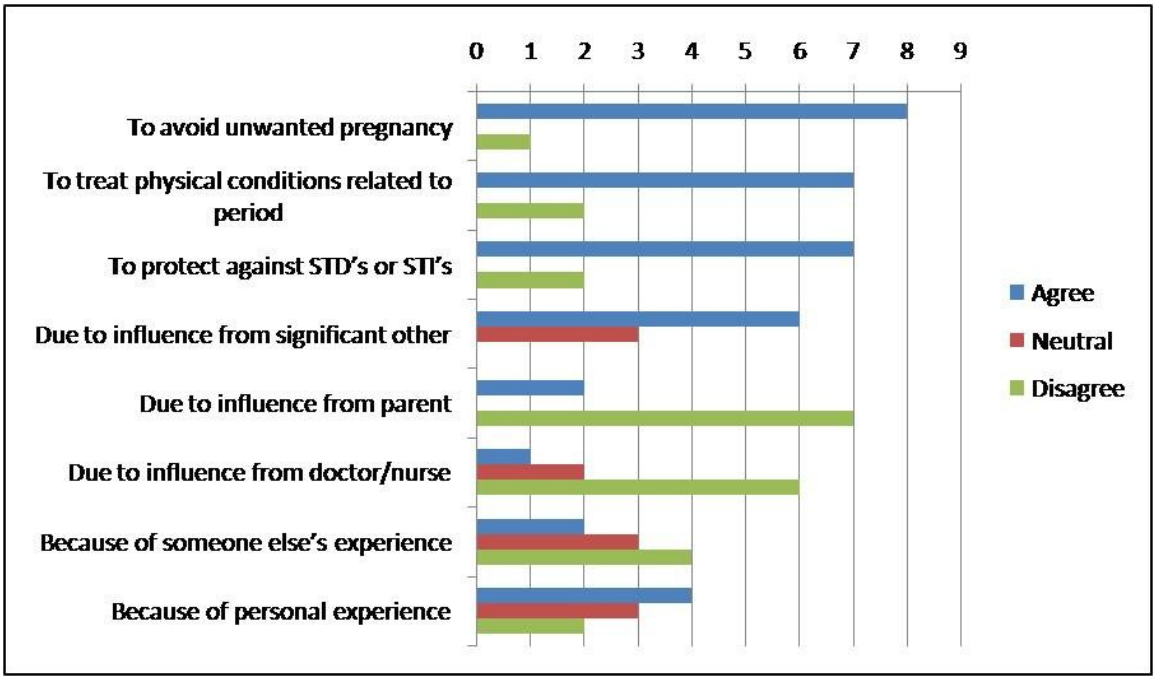
Sarah and Penny may have chosen to use condoms in part because of fears of STIs from short-term partners, but their concern was broader than that. Even women in long-term relationships (and on the pill) sometimes employed dual methods:

> Normally he does not ejaculate inside of me. That's part of the fun; it's now not only because we're trying to avoid getting pregnant, but it's part of our routine. … [If he does ejaculate inside me, some anxiety] is definitely more noticeable and it is on my mind, and then I think we're a little bit more wary about how regular I have been with my pill. But it really is very rare, so most of the time we don't have any worry that I'm going to get pregnant, at all. It's like a blip on the radar. –*Chloe*

Some women distrusted the pill, despite clearly knowing that it is a highly effective method. They therefore hedged their bets by incorporating a condom or the withdrawal method *along with* their use of the hormonal contraceptive.

The overwhelming majority of the women I interviewed had some experience using the pill, and most relied on it for contraception. Hilary, however, had never had sex, but had used the pill for a few years in her youth to ease heavy menstrual bleeding. Isabelle also used the pill for heavy periods, but despite being sexually active she no longer considered it her primary method of birth control. Like Sarah, Penny, and Chloe, Isabelle didn't want to depend exclusively on the pill: "I only recently went back on a different pill, and I don't use it or even think of it as being contraception, probably because I spent five years without it just trusting condoms. [Now I use the pill] only to quell the bloody warfare that was my period every month."

To establish a few reasons why women might use certain methods of birth control, the final section of the questionnaire asked each one to rate her agreement with a series of explanatory statements. To indicate "disagree" generally meant that she had never used any form of contraception in the way described. The nine interviewees who had ever used contraception were asked to rate how strongly they agreed that "I choose to use contraception…" for each reason, and their responses are summarized in the chart below.[20]



Perhaps as expected, most of the women used contraception to avoid pregnancy. Seven out of nine of them also used the pill to "treat" their periods, which seems to fit with the medical and cultural messages about "appropriate" uses for the pill that I have discussed in previous chapters. Interestingly, very few of the women agreed that their reproductive choices were affected by outside influences - not by parents, partners, or even medical authorities. Sarah told me that the influence a partner has on her choice of contraception

[20] This chart is intended primarily to visually organize the data from the questionnaire, and not to imply statistical significance.

"fluctuates by the relationship and by the person; there's not a lot of influence. I'm a fairly educated person, I know my risks, and I know the reality of the situations. Really it's mostly my decision." Sarah was aware that unprotected sex could result in severe consequences for her – namely, STIs or a pregnancy (which in turn could necessitate the use of emergency contraception or even an abortion). She felt that she was the person who would be most affected by these risks, especially since she was not in a long-term relationship. In order to maintain her lifestyle, she had decided that the right to choose contraception was almost entirely hers.

Because so many women had experience using the pill, I asked them to describe the way the pill works to prevent pregnancy. For most of the women, their discomfort was at least as acute as when I asked them to describe the reproductive cycle. A couple of women flatly told me they really didn't know what it did:

> To be honest I have really never looked into it that much. As I was taking my pill the other day, I was honestly wondering what does this pill do in my body? What does it do to my body that makes me not get pregnant? And shouldn't I know these things if I'm taking it? And I honestly don't know. *–Lensa*

Several women remembered carefully reading the literature they received the first time they were prescribed the pill (like Hilary, who said, "I do remember reading the insert"), but many of them apologized for having forgotten it since then. Still, most of the women ventured at least some explanation. Kinsey, who has been on the pill for 12 years, explained, "I probably just know the basics of what happens. It tells your body that you're pregnant… and then you're not, and you have a period." Several women's explanations were similar to Sarah's, who said, "The hormone in the pill tricks your body into thinking that you're pregnant, and that's why the egg can't attach to the wall. Once you stop taking the pill for the seven [placebo] days, that's when your body is allowed to

shed the lining." Chloe said that "basically I know the bad thing about it is that it's making my body think that I'm pregnant." Melanie again provided a little bit more information than most in her explanation, but still didn't feel entirely confident about her answer:

> I guess from what I understand, the pill suppresses one of the hormones that are necessary to allow a pregnancy to happen. It suppresses one (I don't know if it's progesterone, or estrogen, or something else), but it's supposedly one of them, and [the pill] prevents your body from making it. Therefore, you can't become pregnant because of that. But I'm not really sure, to be honest!

In fact, most pills suppress the hormones that would cause a woman to ovulate; as Marcie explained to SHAG volunteers, "I usually tell women that the pill puts your ovaries to sleep." During each month that a woman properly takes the pill, no egg is released into the uterus, meaning that there is no egg present to meet up with sperm and cause a pregnancy. And just in case an egg *is* released, most pills also cause the lining of the uterus to be thinner (so that it wouldn't support the implantation of an embryo), and decrease the quality and quantity of the woman's cervical fluid (making it harder for sperm to swim up and survive in the uterus). None of the women could really describe how the pill worked using this kind of specificity, yet just as with the reproductive cycle, most conveyed that they (again) knew "the basics" of what was going on in their bodies:

> I'm pretty comfortable, I guess; I know more or less the basics. I know some of the [possible] complications, but I don't know the details very scientifically. For now, for what's going on with me, I'm comfortable with what I know. *–Sarah*

Lifestyle Choices: "If It Ain't Broke, Don't Fix It"

For the most part, the women I interviewed were primarily aware of only those methods that they had used personally or that they had discussed with close friends and family. The majority of these women started the pill when they were between 13 and 18 years old. Women in Hilary's family had a history of anemia with very heavy menstrual

flows, and she said that at age 13 she started the pill because she "had no choice but to take it – I nearly had to have a transfusion because I lost so much blood." Several women (including Isabelle) went to their mothers when they were young about discomfort related to their periods; their mothers took them to a doctor and the doctor prescribed the pill. A few women told me that their mothers told them they *had* to use the pill. As Kinsey reported, when she was 16 years old and had a steady boyfriend, one day "my mother told me that I had to go on birth control. …I didn't talk to her about it. But she knew I had been in this relationship for about a year already, and we were teenagers. For my mom it was just like, 'You're going to do this.'" And Kinsey got a prescription for the pill. Sarah, meanwhile, experienced a kind of intervention:

> I went on the pill [in grade 8] because I had extreme periods. My cramps [put me] out of commission for three days; every month it would get to the point where I would throw up, and my periods would last 6-9 days, easily.[Once, in grade 10]I got sent home from work. [My boss was an old friend of the family, and] she called my mom and said, "Listen, this is not normal. You need to take your kid to a doctor!" So a few months before I turned 18, I went to see a doctor, and they prescribed the pill (Alesse), and he gave me a muscle relaxant for the cramps. [My mom] saw everything I was going through, but only once did I actually call her to pick me up from school because I couldn't take it anymore. She knew how heavy my flow had been, but wasn't concerned enough, I guess, to push me [to go on the pill sooner]. –*Sarah*

Sarah's mother had experienced similar menstrual discomfort during her life, and perhaps expected that this kind of pain was more of a "womanly" problem than a "medical" one. However, Sarah also said that most of the time she tried to be "a trooper" about it, and rarely complained to her mom. It was only when someone else commented on the abnormality of the situation that mother and daughter decided to seek "treatment."

Only a few women told me that they reached a point where they independently realized they were ready to become sexually active and wanted to be "safe" about it. After using condoms, they eventually took steps to get on hormonal birth control, at

which time they invariably went on the pill. Chloe said she "went on [the pill] when I was 18, because I was getting pretty serious with my boyfriend and I wanted to be safe and be responsible. But I told my parents it was because I had really bad cramps and wanted to get rid of my acne. I asked my doctor for it, I made the appointment, I did it all on my own." Lensa had a similar experience when she was 17, and entered into a serious relationship. Eventually she went to a doctor and asked specifically for the pill:

> By that point I think I was the last one of my friends to go on the pill, and that's just what we did. We didn't see any other options besides going on the pill and using condoms. I wanted to go on the pill for pregnancy protection, but I also knew, from my friends and through reading about it, that it made your period regular and treated symptoms. That was something that I needed too, so I talked about it in terms of both things. *–Lensa*

For many women, then, the pill's capacity to "treat side effects" was conflated with its role as a contraceptive. As Sarah explained, "I think for a lot of people it's sort of a convenient excuse. It's like, 'I don't have to ask my mom to put me on birth control because I want to have sex,' instead it's 'oh, I have this issue, so now I'm on birth control, and if a year from now I'm ready to have sex or I'm in a relationship, then I'm ready to go!'"

A lot of the women I interviewed stayed on the pill for anywhere from 3-12 consecutive years after first starting it. Unless there was some major complication or an unbearable side effect (and there rarely was), in general these women were content to stay on the same method, and sometimes even on the same brand of the pill. As Kinsey said, "I can't be bothered to mess around. Maybe I try another one, and it affects me some other way. I know it's normal to have cramps anyway, so I'm not going try to take another one to get rid of that. Because it's pretty normal to feel like that." The feeling that discomfort is a part of menstruation is something that a few women mentioned to me, and

echoes the experience of Sarah and her mother (above). Kinsey's approach to the pill also resonates with the perspective of the medical professionals I spoke to, who felt that once a woman found a method that worked for her, she would be best served to stick with it. As Dr. T said, "part of overcoming some of the impact that these bothersome side effects will have [on a woman] is if [she's] already had a positive attitude towards it, and [she feels] comfortable with it already."

Despite their inclination to stay on a given method (usually the pill) for as long as possible, most women are likely to reevaluate their contraceptive choices at some point later in their lives. For instance, a change in relationship status can cause the need for more (or less) reliable methods of birth control. Isabelle was 20 years old and in college when she had her first serious boyfriend and decided to start taking the pill, although the side effects were so unpleasant that she eventually went off it entirely. Melanie didn't start the pill until she was married at age 28, and she stopped taking it three years later when she got a divorce. The adjustment from high school to university living can cause a similar shift, as changing environments and lifestyles may necessitate different forms of protection. As Isabelle told me, when you go away for university "you have your own house/room, your parents aren't around… You start to think about having to deal with everything yourself, [contraception] included."

Sometimes reaching a certain age and discussing contraception with friends and family can prompt reconsideration as well. As Chloe told me,

> [Around the time I finished my master's thesis] a lot of people were trying different contraceptive methods. I had one friend who went on a different birth control pill, one friend got the IUD, and another friend got the IUD plus hormones. So we were all switching! It was really weird because we'd all been the same for so long. When we all first were on the pill, we all thought we were kind of experiencing the same thing. But then at this point we realized how

> differently we were reacting to it, and how different our lifestyles were. How we wanted different things.

Isabelle, similarly, recently learned about Nuva Ring when her sister switched to it after years on the birth control pill. Interestingly, neither Chloe nor Isabelle switched from the pill after learning that someone they knew had used another method. This kind of communication among women about their experiences with birth control seems to fit Gutmann's model of the "female contraceptive culture" (2007:40), and also reflects the kind of girl-chat about birth control that Dr. T assumed takes place among the patients he encounters. But interactions among slightly older women, like graduate students, are clearly different from those of girls in high school (and perhaps even undergraduates, if Dr. T is correct in his expectations of them). The fact that Chloe and Isabelle were not swayed to change their method of birth control runs counter to Dr. T's assertion that conversations among girlfriends will necessarily provide reassurance, and give a woman "a positive perception [of] that contraceptive method, because [she's] gotten influenced by [her] friends." Younger women may look to their peers to help find a sense of security in what is "normal," but by the time these same women have been on birth control for a number of years it would seem that their contraceptive motivations are significantly more inwardly driven.

In all my interviews, not a single person told me she changed her birth control because she heard about a different method from someone else. In fact, the opposite sometimes occurred. Chloe gained a negative perspective of IUDs when one caused hemorrhaging and necessitated emergency surgery for one of her friends. Isabelle developed an aversion to the Ring when she realized you have to store each week's supply in the fridge until you're ready to use it. Women may talk to one another about

their birth control, but these conversations seem as likely to warn women away from less common methods as they are to convince a woman to try one. And even if her friends had good experiences, as Sarah stated, "I'm not curious enough about it to research it further. They're happy about it, it's easier for them, but the pill works for me. I don't forget [to take] it, it's become part of my life, and I'm comfortable with that. If it ain't broke, don't fix it." The women I interviewed were rarely motivated even to research other birth control options based on the experiences of others; rather, a shift in personal circumstances was required in order for a woman to consider making a change.

Interestingly, Dr. T explained that women who choose to switch their contraceptive method (and particularly those who want something that is non-hormonal) are typically more familiar with the range of birth control that is available:

> I think the ones who want a non-hormonal method are a lot more aware than the ones who want hormonal methods. The ones who want the pill, you know, what they've done is they've talked to their girlfriends, and so they're like, 'oh this is the easiest method,' or 'this is what I've seen in magazines' – they don't really research it. People who make the decision to use a barrier method or even to use an IUD have researched it a whole lot more.

Because such women have to break the norm and work hard to self-educate, they end up with greater knowledge of their bodies and of all their potential contraceptive options. There also seems to be a connection between a woman's age (and sexual experience) and her comfort level toward seeking new information and asking questions of medical professionals. As Chloe told me,

> …for a long time I was waiting for the doctor to ask me questions; I didn't actually know that I could be the one who was directing [the conversation], with 'These are my issues, these are the things that I'm experiencing.' I think everyone figures that out on their own at some point, but I could probably be better about it.

Lensa stated that when she went to a clinic to get a prescription to go back on the pill (after a few years off), "I guess since I was older they didn't question me as much. I just went in and said that I wanted to go back on the pill, and they were like 'ok, great.'"

Graduate students face a number of potential reasons to explore alternative forms of birth control. Those who are near to completion of an advanced degree may be more determined than ever to avoid pregnancy, especially as they seek employment and career opportunities. But just as there is an assumption that younger women must not get pregnant, there is a parallel expectation that as women get older they will eventually decide to bear children. For Lensa, "when I was younger it was something that I assumed, that one day I'll have kids." And for several women it seemed that a change had taken place in their mindset, from a desire to avoid pregnancy to a gradual acceptance of the possibility of having children:

> Probably until fairly recently, until three or four years ago, if I had gotten pregnant I would have considered not wanting to see that through. But there's a transition point, a point at which that shifts. … Some of these issues have been coming up more because of friends having babies, or getting married. I am hearing more about people's choices than I have in a while. Now there's a phase of people actually reproducing; it's a different stage. *–Penny*

A few of the women I spoke to were in long-term relationships and marriages themselves, and were contemplating how to balance career and a future family life. But even among those who weren't necessarily in a committed relationship, there was a sense that by a certain age, pregnancy would no longer be the worst thing in the world:

> I guess I'm sort of at that point in my life now that I don't fear having children, necessarily. I want to bring children into the world in the right environment: so a healthy relationship, myself being financially stable, that sort of thing. But I'm at that point in my life where having children won't ruin my life, it just might not be the optimal situation. *–Sarah*

Chloe and Melanie both expressed fears that getting older might make it harder to have an easy pregnancy, but around half of the women told me that they still did not necessarily want to get pregnant at the current time. Most expected that they would want to have children at some point in the future, though.

Although she wasn't thinking about pregnancy, Penny at one point found herself single and wondering why she was still using the pill. She had initially used the pill to ease discomfort from periods, and had been in a long-term relationship. "Then I was single for quite a bit of time, and I realized that I didn't know how I felt off of [the pill], and I kind of wasn't sure if I wanted to be taking a daily thing. So I went off it, and I felt great. I've gone back on [it] a couple of times for reasons of trying to control my period, with very limited success, and I gave up." Of all the women that I spoke to, only Grayson had actually stopped taking birth control in order to try to conceive. She said she "went off the pill shortly after we got married, so we could have a child." She used fertility awareness to avoid getting pregnant for the first few months, and later used it to help track her cycles to make it easier to conceive. With the exception of Grayson and Penny, though, none of the other women I interviewed had attempted to even learn about the majority of birth control methods in any great detail. As Lensa said, "I could, but I guess I'm not that curious." They all had a general awareness of the existence of most methods (and a few in particular), but for the most part they had not been self-motivated enough to extensively research any alternative options.

Similarly, very few of the women had ever charted their reproductive cycles or tracked their fertility in any comprehensive way. Some even seemed distrustful of methods that would allow a woman to do so; as Melanie explained, "I recently saw two

colleagues get pregnant on [what I call] the 'oops method'… where they weren't on anything, but were kind of counting days, or doing the rhythm method, or whatever." A few women told me that they kept some kind of track of their cycles: Penny tried to be aware of her approximate ovulation times, while Melanie said she marks only the first day of her period each month on a calendar. She said, "I kind of keep track of my period because I want to know when I need to have pads in my bag. But that's the only reason why I do it. I want to know when it's going to fall, if I'm going to be on vacation, [and] if it's going to be inconvenient." Grayson was the only woman who was personally familiar with FAM, and that was because she was actively trying to conceive. She taught herself "things like the Billings Method, which I didn't even know existed until two or three years ago. I've actually read scientific studies on the rhythm method, natural method, and Billings, and it's really outstanding how effective it is. I was really surprised. I use it now as a result of that knowledge. I took what was initially a birth control method, and flipped it backwards." Grayson considered FAM to be a form of birth control that *she* had discovered and adapted to use for getting pregnant; ironically, this is exactly opposite to the perspectives of the medical professionals I interviewed, who had only ever considered FAM to be a recourse for women who were trying to conceive.

The majority of the women I interviewed were not intimately familiar with the chemical and biological processes that take place in their cycles every month, yet most seemed confident that when they were ready to get pregnant, they would have no trouble doing so. Most had little doubt that once they stopped taking the pill they would be quickly and easily able to get pregnant, without the need to chart their cycles or practice

FAM. Chloe, who had been on the pill for ten years, once asked her family doctor if she would have any trouble getting pregnant when she finally went off it. She said he told her she "didn't have to worry about it. Some people say you should wait a year to really get your cycle back up and running, but then my friend got pregnant the next month after going off the pill." So Chloe felt very reassured. Similarly, Sarah had been using the pill for 9 years, and seemed more or less to trust that it wouldn't affect her fertility:

> [Although I] remembered learning in high school that taking the pill can have side effects on your fertility in the long run… it's been working very well for me, and I'm not planning on getting pregnant anytime soon. So it's a good thing for me right now, and I don't want to mess with it. I'm hoping that, being a low dose pill, maybe [Alesse] won't be as bad when it comes to that time [when I want to have children]. On a scale of 100%, I'm maybe 10% concerned, but for now, not enough to change anything.

Although a couple of the women hinted that they worried about the long-term effects of taking hormonal birth control, none seemed overly anxious about it. Lensa went so far as to say, without any real distress, that "when I decide to have children, I am fully prepared that it might not be the easiest process in the world, that the decision to have kids is not the final decision that might come along." Also, none indicated an awareness that surprisingly, even in contraceptive-free conditions, "the chances of a typical couple of proven fertility conceiving in any one menstrual cycle is thought to be no higher than about 25%" (Weschler 2002:143). The only person to have made any realization along these lines was Grayson:

> [After I went off the pill] we used the rhythm method for [the first] three months, because I was told that conceiving immediately after you go off the pill is dangerous, and there's a high risk of miscarriage. [Two years ago] we were successful, but my child didn't survive; I had a miscarriage in my 2nd trimester. We've been trying [to conceive again] for 15 months now. We're actually going to a fertility clinic.

After her heartbreaking miscarriage and a year and a half trying to conceive, Grayson was left wondering if she would ever be able to get pregnant again, and if the birth control pill had been to blame.

At some point in our interview, I asked each woman if, hypothetically, she thought she was capable of preventing unwanted pregnancy. The answer was a universal and resounding yes. But what if she was unable to use any form of hormonal contraception? Most women immediately responded that they would use condoms, and since a few had already used condoms as their sole form of contraception already at some point, this wasn't too much of a stretch. Sarah, for instance, said that she was 99% confident she could prevent a pregnancy with a condom if she could use the withdrawal method as well. For 3-4 years, Lensa had relied only on condoms and didn't get pregnant (although she said that approach made her feel "significantly less confident" than when she was using the pill). And Nadia, who had only *ever* used condoms, quipped, "If you use it right, you can sleep at night!" Finally I pushed further, and asked what each woman would do if she couldn't use any hormonal contraceptives *or* any barrier methods. Could she prevent a pregnancy? Pretty much all of the women were discomfited by the question, and were hesitant to say that they could or couldn't avoid pregnancy with certainty:

> With no contraception and no withdrawal, my confidence in not getting pregnant would probably be 5-10%. With withdrawal, probably 50%, because it's pretty much a 50/50 thing. We'd have to figure something else out – it's not a risk I'm interested in taking. –*Sarah*

Melanie told me, "I would not want to get pregnant with someone who I was just dating. I couldn't do it. I think there's a good chance that if I couldn't use the pill or condoms, I might just choose to abstain."In the end, most women said that they didn't think they

could do it. Nadia believed that without any method, her confidence would be "like zero percent," and Lensa said that she simply "would not feel confident *at all*. That would be a really scary world to live in."

Conclusion – Choosing a Paradox

Despite the overall sense that they know "the basics" about reproduction and birth control, through the course of my interviews it became apparent that women's knowledge about their bodies and their contraceptive choices is far from comprehensive. The complicated interplay of medical, cultural, and sometimes chemical influences led many women to feel dissociated from their bodies and fertility. Penny explained that she stopped using hormonal contraceptives because they made her feel "more out of touch with my body, and I preferred to be more *in* touch with it. And I like the idea of knowing that if something is going on, I will notice, I will *know*, because I'm not masking it with something." Birth control is a paradox: using hormonal contraceptives allows women to control their fertility (and prevent births), yet information about contraceptives is controlled such that women may not always have full knowledge of their options (and those options' consequences). Hormonal contraceptives can mask women's connection to their bodies, and without understanding their fertility on an intimate, personal level, women can become dependent on contraceptives in order to continue to avoid pregnancy. In this context, not only women's choices, but women themselves are, to some extent, controlled.

When I asked each woman directly how she felt about using (or not using) the pill and other methods of birth control, I received a wide range of answers. Some indicated

that they felt they should know more, or appreciated being given an opportunity to reconsider topics to which they hadn't recently given much thought:

> I know that probably if I wasn't taking [the pill], it would be better… but I don't know why, specifically. But I'm pretty sure [it would be good] if I wasn't taking it! But I don't want to get pregnant. So I'm going to keep taking it. *–Kinsey*

> There is definite confusion as to how it all works. Some women do take the pill, so what does it really do? You should know what it does to your body, and understand the cycle. And I only understand it vaguely. *–Hilary*

> For the longest time I haven't thought about fertility. It's just been sort of routine, out of my normal thinking. So it's kind of interesting to just think about my body again, and to think about what's happening. It's good to be aware. *–Chloe*

> [Our interview] made me think more in-depth about things that I realized I hadn't thought about for a long time, decisions that I had made at one point and hadn't revisited, either because there really wasn't a need or because it just wasn't really at the front of my consciousness, or on the radar. It made me think of everything again, and I realized I was basically happy with my decisions. *–Penny*

Others reflected that contraception (and specifically the pill) served a need for them. Although they conceded that it might not be completely ideal, they had decided that for a number of reasons it was appropriate for this time in their lives:

> I like it [that I take the pill]. I'm a very Type A, obsessive, organized sort of person. I like that I know when my period's going to come, and roughly how long it's going to last. It's convenient. The risk of infertility is sort of somewhere in the back of my mind, but it's not concerning me enough to stop. I think my ultimate motivation is consistency, regularity, not having pain, not having the annoyance – that's definitely number one. *–Sarah*

> For me, I haven't found any cons with the way it fits into my life as it is right now. I started taking the pill because I was terrified of getting pregnant at the age of 18, and I went off the pill because it kind of wasn't convenient in my life anymore, and I kind of wanted to see, "Do we really need to take this?" I decided, after three or four years, that for me the benefits outweighed the disadvantages. I feel that it's interesting because it's something that I take every day, so it's something that enters my mind when I'm taking it. Just briefly [I think], "Why am I taking this? What kind of choices am I making in my life?" It does play an important role in terms of how I see my life right now, and in terms of how I want it to play out, and what kind of options I want to have. *–Lensa*

Only Grayson had undergone an extreme hardship that she believed to be a result of taking the pill, and for her, the consequence of her miscarriage was absolute:

> I'm actually trying to stay away from the hormonal options now. I used to think they were perfectly safe. I read this Christian propaganda about how the pill causes miscarriages, and I thought it was a load of crap. And then I had a doctor when I was in the emergency room [during my miscarriage], and he asked me, "How long have you been off the pill before you got pregnant?" I said three months, and he said, "You should really go six months. I don't know why doctors say three, but I see a high rate of miscarriages for people who have only been off for a three month period. …I really hate that a lot of these church groups use this research, because people don't take it seriously, but it is legitimate scientific research. The pill messes up your hormone levels." At that point, I began to look into the more scientific journals about this, and I realized there is a high rate of miscarriages associated with it. So I'm never going on the pill again. I was really, really heartbroken about this, so I said, "Never again." I still feel partly responsible for everything. I'm not taking the pill, not touching any hormones, ever again.

Toward the end of every interview, I asked each woman if she would theoretically consider the use of a "male pill." Analogous to the pill for women, this hypothetical contraceptive would allow a man to take a pill and not impregnate the woman (or women) he has sex with. Although a few of the women initially seemed enthusiastic about the idea, most were wary:

> If there was a pill for guys, that would be fantastic! If it was proven to be as effective as birth control for girls, I would trust it. But I would have to know how the pill itself would be designed for guys – would the guy just not ejaculate? I don't know how that would necessarily be functional for a guy. But I feel like it would even it out a little bit more. [Culturally I don't think it would go over well, because] I don't know of any guy that would be like, "I'm gonna take a pill to regulate my sperm!" *–Nadia*

> The act of taking a pill to prevent pregnancy has become such a female mode of thinking (or way of thinking, action, or practice) that for some reason if men started taking it I would find it a little funny. There's nothing wrong with it, and I would actually encourage it if I had a serious partner. But there would be something about it that at first would be a little funny to me. *–Lensa*

> *Penny*: [I think] there's a male pill.
> *Shannon*: Would you trust that?

Penny: No. …Well, maybe. But I'd only trust it as much as I trusted the pill for myself (which I still doubled with a condom all the time). I don't think that's a much better solution.

A pill for men may one day become a reality, but in the meantime some surprising new potential alternatives have been making their way into headlines. A very recent article by Zosia Bielski described an experimental treatment using ultrasound that "could one day be used to shut down sperm production, handy for men who want something more fool-proof than withdrawal or condoms, but less permanent than a vasectomy" (2012:NP). The treatment is not yet being tested on humans, but as Dr. Tsuruta (interviewed by Bielski) explained, it has already proved effective for rats and could offer temporary sterilization for up to six months at a time. In theory, the procedure would involve "men poaching their boys": as Bielski describes it, men would briefly submerge their testes in a "cup of saline solution or water. From underneath, you would turn on the ultrasound, which travels through the liquid and gets to the testes." In addition to the possibility of this form of contraception, Bielski commented on the current state of birth control options for men:

> Even as parental responsibility equalizes between the genders, options for men who want to wield control over their fertility remain scant. With attempts to create a "male Pill" now spanning three decades, scientists are still experimenting with a wide range of options, including hormones in the form of gels, implants and shots; plant-based pills being tested in Indonesia as well as "accidental discovery" oral drugs that block sperm production or even hinder ejaculation during orgasm. "Male contraception has always sort of been the little brother to female contraception," Dr. Tsuruta said. "The success of the Pill - that's just stupendous. But there are women who have bad side effects from hormonal contraception. Men need to be aware that sometimes they have to step up" (2012:NP).

Although I only discussed a "male pill" with the women I interviewed, I imagine that their misgivings about it would likely translate to *any* form of contraception that would take the responsibility for avoiding pregnancy out of their hands (and bodies). Penny was

bothered by her perception that "it's still seen as a woman's responsibility, exclusively by some people, to not get pregnant. I don't think that's a fair expectation." And as Bielski notes, "a 2005 United Nations survey found that 75 per cent of Canadian men don't use any form of contraception - not condoms (often shirked by committed partners), or permanent vasectomies, or the dubious withdrawal method."

Yet most of the women I spoke to seemed very uncomfortable with the idea of handing over the reins of contraception to a male counterpart. Should his birth control fail, it is the woman who would bear the resulting burden; no pill is going to cause men to gestate babies. Paradoxically, a "male pill" might ease the "contraceptive burden" that Penny and others felt, and which Matthew Gutmann described (2007:41), but it could also theoretically return women to a state of dependence on a method that is literally out of their hands. The desire to retain control of their fertility seemed to outweigh the theoretical benefits of male contraception, and revealed an impression that women sense themselves to be the most qualified for the job. As Melanie said, "Ok, let's say there's a man-pill, and if he took it every day, it's a 100% chance I would not get pregnant. I still would not trust him. How do I know he would take it?" For the women I interviewed, having personal choices allowed them to maintain their preferred lifestyle, a kind of sovereignty that was largely based on their ability to directly control their fertility. As the Boston Women's Health Book Collective affirms,

> Our ability to prevent or delay pregnancy is fundamental to our ability to choose how we live our lives. The advent of the Pill and other birth control methods has enabled women around the world to complete our educations, pursue our dreams, and create more egalitarian relationships. Most of us want contraceptives that are effective and safe, are simple and unobtrusive to use, protect us against sexually transmitted infections – including HIV/AIDS – and can be used before having sex. Unfortunately, the perfect method does not exist. But advances in birth control technology have created more choices than ever before, making it more

likely that a woman can find an option that meets her individual needs (2011:201).

Epilogue

In 2011, the United States government classified birth control as "preventive health care, and President Barack Obama's health care law requires health plans to cover prevention free of charge" (Alonso-Zaldivar 2012). The opposition by conservative politicians was swift, launching what Arizona's President of Planned Parenthood, Bryan Howard, has since called "the assault on women's health care across the country" (Betancourt 2012).[21] Initially the conservatives framed their response as a question of religious freedom; churches and religious institutions argued that because any use of contraception ran counter to their faith, it was unconstitutional for the government to mandate that they provide birth control to their employees. In February 2012, a House Oversight and Government Reform hearing on religious liberty and the birth control rule took place, featuring a panel of ten male religious leaders (shown to the right). When Democrats proposed that a student named Sandra Fluke be allowed to testify, she was denied entry by Chairman Darryl Issa. As an article in the Huffington Post by Laura Bassett and Amanda Terkel explained,

A photo of the panel, courtesy of Planned Parenthood

> Issa said at the hearing that he rejected the Democrats' female witness, Sandra Fluke, because, as a Georgetown University law student who "appears to have become energized over this issue," she was "not appropriate or qualified." …

[21] This type of political conflict is not limited to the United States; in April 2012, Canadian conservative politicians will reopen abortion debates by setting up "a parliamentary committee to examine Canada's 400-year-old definition of a human being in subsection 223 (1) of the Criminal Code" (Gyapong 2012).

> Issa's staff told Democrats that the chair had decided, "As the hearing is not about reproductive rights and contraception but instead about the Administration's actions as they relate to freedom of religion and conscience, he believes that Ms. Fluke is not an appropriate witness" (2012:NP).

Fluke was eventually permitted to speak at "a Democratic hearing, and talked about the need for birth control for both reproductive and broader medical reasons. She mentioned in particular a friend of hers who needed contraception to prevent the growth of cysts" (Mirkinson 2012). Eventually it was decided that contraceptive coverage would remain covered under the health care plan:

> Women will still get guaranteed access to birth control without co-pays or premiums no matter where they work, a provision of Obama's health care law that he insisted must remain. But religious universities and hospitals that see contraception as an unconscionable violation of their faith can refuse to cover it, and insurance companies will then have to step in to do so (Feller 2012).

Although the terms changed slightly, women were nevertheless guaranteed contraception as preventative health care. But shortly after this incident, TV personality Rush Limbaugh, voice of a controversial conservative radio talk show, attacked Ms. Fluke personally about the content of her testimony. As Amy Davidson reported, Limbaugh claimed that Ms. Fluke's statements revealed her to be a "prostitute":

> What does it say about the college coed Susan [sic] Fluke, who goes before a congressional committee and essentially says that she must be paid to have sex? What does that make her? It makes her a slut, right? It makes her a prostitute. She wants to be paid to have sex. She's having so much sex she can't afford the contraception. She wants you and me and the taxpayers to pay her to have sex. What does that make us? We're the pimps. The johns, that's right. We would be the johns—no! We're not the johns. Well—yeah, that's right. Pimp's not the right word.

A few days later, Limbaugh added,

> So, Ms. Fluke and the rest of you feminazis, here's the deal: If we are going to pay for your contraceptives and thus pay for you to have sex, we want something for it. And I'll tell you what it is. We want you to post the videos online so we can all watch (2012:NP).

Not only do Limbaugh's statements reveal a shocking level of antiquated sexism, but he also completely disregards the fact that a woman can use contraception for reasons other than sex (among many other things). It also seems that Limbaugh was giving voice to broader sentiments held by conservatives toward women and contraception, an attitude Davidson described as:

> …drawing upon the social-conservative point of view on reproductive issues and sex—and they're doing so for the cheap appeal of a certain idea of what a woman should do and be. That's putting it politely. To put it impolitely, here, again, is Rush Limbaugh, responding to criticism from Senator Maria Cantwell, who had been asked, in an interview, if Limbaugh should have questioned Fluke's "virtue."
>
> Limbaugh:
> "I'm not questioning her virtue. I know what her virtue is. She's having so much sex that she's going broke! There's no question about her virtue" (2012:NP).

Moreover, such conservative backlash against contraception and women's health has manifested among politicians not only in word but also in deed. A number of bills have been proposed by Republican lawmakers in an attempt to control women's access both to reproductive health care as well as to birth control. In March 2012, the Arizona Senate endorsed a contraceptive bill that would not only allow companies to refuse insurance coverage for contraception if it conflicted with their religious beliefs, but also to "permit employers to ask their employees for proof of medical prescription if they seek contraceptives for non-reproductive purposes, such as hormone control or acne treatment" (Betancourt:NP). In short, if a woman could not provide documented proof that she was using contraception for purposes other than birth control (that is, for *non-sexual reasons*), her employers could refuse her insurance claim and therefore deny her access to paid contraception. And because Arizona is an at-will employment state, "bosses critical of their female employees' sex lives could fire them as a result" according

to Erin Ryan, in an article entitled "Law Will Allow Employers to Fire Women for Using Whore Pills" (2012:NP). The bill is unlikely to pass, given that it violates a number of privacy laws, but as Ryan stated, "that doesn't make it any less depressing" (2012:NP). The Arizona bill defines contraception as both birth control and medical treatment, but implies that only the latter is valid for coverage. It would also allow employers to enforce their religious beliefs on their female employees based on their own moral judgment against women's sexuality. This recalls the disparaging terminology used by Limbaugh against Sandra Fluke, revealing an outdated yet continuing belief that women who have sex (and don't want to get pregnant) are "sluts."

In addition to controlling access to contraception, there are also efforts to manage the education and health services that women can receive. According to Mark Memmott, a writer for the National Public Radio (NPR), Utah's state Senate recently approved a bill that would focus on abstinence-only instruction, and would explicitly "let schools skip teaching sex education and prohibit instruction in the use of contraception" (2012:NP). A Republican sponsor of the bill, Rep. Bill Wright, said it was largely "in response to what he viewed as inappropriate material being presented in classrooms, specifically materials produced by Planned Parenthood" (2012:NP). For some months, Planned Parenthood has been the target of much conservative ire; despite its work providing free and low-cost services to women around the country, Republicans are in general extremely opposed to the organization because some of its clinics also offer abortion services. Also in March 2012, an article in the Huffington Post by Laura Bassett explained how Texas Governor Rick Perry (who was also formerly a Republican presidential candidate) excluded Planned Parenthood from remaining a part of (and receiving funding from) the state's

Women's Health Program. This program is an initiative "which provides cancer screenings, contraceptives and basic health care to 130,000 low-income women each year" (2012:NP). Because the Women's Health Program is federally funded by Medicaid, Perry's refusal to provide funding to Planned Parenthood "broke federal Medicaid rules by discriminating against qualified family planning providers. …A state cannot restrict women's ability to choose a provider simply because that provider offers separate services—in this case, abortion—that aren't even paid for by the Medicaid program" (2012:NP). As a result, the Department of Health and Human Services announced that "it will cut off all Medicaid funding for family planning to the state," and thus Texas will lose all funding for the entire Women's Health Program (2012:NP). Perry's discrimination against Planned Parenthood was based on his (religious) belief that abortion is morally wrong, and as a consequence the entire state has lost nearly $40 million in funding for the Women's Health Program. This decision will undoubtedly have severe repercussions on the 130,000 women who rely on the program to meet their basic health care needs.

Abortion remains a highly contentious topic in the United States, and it's not only in Texas that politicians are proposing laws that adversely affect women as a result. In Virginia, another March 2012 bill was signed into law by Republican governor Bob McDonnell that requires that any pregnant woman who requests an abortion must first receive an ultrasound. Eight states in the U.S. require such a procedure, although some states have more strict requirements than others. As an article on ProCon.org explains, "Virginia's bill requires that women be given the opportunity to view the ultrasound image and hear the fetal heartbeat, while Texas's law, one of the most stringent in the

nation, mandates that the ultrasound image be placed in the woman's line of sight while the doctor describes it to her" (2012:NP). Although it is less exacting than the bill in Texas, Virginia's bill passed only after revisions to its controversial original form, which

> …mandated transvaginal ultrasounds be performed when fetal shape and heart tone could not be detected by the transabdominal method. McDonnell dropped his support for this requirement after it provoked a storm of protest, with [Charniele Herring, Virginia state House Democratic Whip, and Chair of the Reproductive Health Caucus] likening the proposed requirement to 'state-sponsored rape'" (2012:NP).

Although the Virginia law no longer requires transvaginal ultrasounds (which involve the use of a "wand" or "probe" that is inserted into a woman's vagina to monitor a fetus), women who want an abortion nevertheless have no choice but to undergo some form of ultrasound if they intend to carry out the procedure. Opponents of the bill, like Delegate Herring, "argue that the law forces women to undergo an unnecessary medical procedure without their consent, and that such laws are part of a thinly veiled campaign to erode women's reproductive rights" (2012:NP).

Amidst the complicated issues surrounding abortion, women's rights can be "eroded" in a number of ways. One such way involves not only considering the unborn fetus to be a person, but by placing concerns for the health and well-being of the fetus above those of the mother. For example, in February 2012 the Oklahoma Senate passed the "Personhood Bill," which would define a fertilized human egg or embryo as a "person." Several groups protested the bill, including the American Congress of Obstetricians and Gynecologists, who issued the following statement:

> The American Congress of Obstetricians and Gynecologists (ACOG) is unequivocally opposed to the so-called "personhood" laws or amendments being considered in several states. These measures erode women's basic rights to privacy and bodily integrity; deny women access to the full spectrum of preventive health care including contraception; and undermine the doctor-patient

relationship. ACOG firmly believes that science must be at the core of public health policies and medical decision-making that affect the health and life of women.

Like Mississippi's failed "Personhood Amendment" Proposition 26, these misleading and ambiguously worded "personhood" measures substitute ideology for science and represent a grave threat to women's health and reproductive rights that, if passed, would have long-term negative outcomes for our patients, their families, and society. Although the individual wording in these proposed measures varies from state to state, they all attempt to give full legal rights to a fertilized egg by defining "personhood" from the moment of fertilization, before conception (ie, pregnancy/ implantation) has occurred. This would have wide-reaching harmful implications for the practice of medicine and on women's access to contraception, fertility treatments, pregnancy termination, and other essential medical procedures.

These "personhood" proposals, as acknowledged by proponents, would make condoms, natural family planning, and spermicides the only legally allowed forms of birth control. Thus, some of the most effective and reliable forms of contraception, such as oral contraceptives, intrauterine devices (IUDs), and other forms of FDA-approved hormonal contraceptives could be banned in states that adopt "personhood" measures. Women's very lives would be jeopardized if physicians were prohibited from terminating life-threatening ectopic and molar pregnancies. Women who experience pregnancy loss or other negative pregnancy outcomes could be prosecuted in some cases.

So-called "personhood" measures would have a negative impact on fertility treatments, including in vitro fertilization (IVF), that allow otherwise infertile couples to achieve pregnancy and create their families. Such proposals would also invariably ban embryonic stem cell research, depriving all of society potential lifesaving therapies.

ACOG supports guaranteed access to the full array of clinical and reproductive services appropriate to each individual woman's needs throughout her life. These "personhood" measures must be defeated in the best interest of women's health (ACOG Statement on “Personhood” Measures, February 10, 2012).

Despite vehement opposition from groups like the ACOG, however, bills like Oklahoma’s “Personhood Bill” are regularly proposed and introduced in state legislature.

As if the consequences of this bill aren’t threatening enough to women, some go even further. In March 2012 the state senate of Arizona actually passed a “wrongful birth” bill, which “gives doctors a free pass to not inform pregnant women of prenatal problems because such information could lead to an abortion. In other words, doctors can

intentionally keep critical health information from pregnant women and can't be sued for it" (Foster 2012). Because prenatal care can reveal birth defects in a fetus that might lead a woman to choose an abortion, the bill would permit anti-abortion doctors the choice to not inform a woman of such conditions. But the article continues,

> [Prenatal care] is also for discovering life threatening issues such as an ectopic pregnancy which often requires an abortion to save the life of the mother. With rare exceptions, ectopic pregnancies are not viable anyway, but Republicans are allowing anti-abortion doctors to keep life threatening information from pregnant women all because they are obsessed with stopping any and all abortions. Women may not know they have a life threatening condition until they die on the emergency room table (Foster 2012).

This bill takes the control of women's bodies to an extreme, literally giving a doctor the power to let a woman die rather than sanction an abortion.

In recent months, a number of similar bills have arisen swiftly and in great numbers, but they are not without opponents. Female lawmakers in a few states have begun introducing bills of their own, aimed at calling attention to a double standard in the way conservative lawmakers appear to view healthcare. According to Diane Suchetka, a writer for The Plain Dealer, Ohio State Senator Nina Turner recently announced a bill that would require a man who wants to receive Viagra (an erectile dysfunction drug) "to provide his doctor with a notarized affidavit – from at least one sex partner – that says he's had symptoms in the previous 90 days" (2012:NP). Turner's bill is one among many that have recently been proposed by female lawmakers, including bills in Missouri and Georgia that would prohibit a man from getting a vasectomy unless "it is to save his life or prevent substantial and irreversible physical impairment" (Suchetka 2012). The point of such bills is ultimately not to keep either gender from gaining access to reproductive

health care; rather, Turner argues, it is part of an effort "to equalize the sexual health debate." The article continues:

> "The men in our lives, including members of the General Assembly, generously devote time to fundamental female reproductive issues. The least we can do is return the favor. … The sad part about that is when people introduce legislation that infringes on women's liberties, nobody bats an eye or thinks it's strange," [Turner] said. But take the same tack with men, she said, and the reaction is completely different.
>
> "It's an excellent way of answering some of the male-dominated individuals in the legislature who continuously think a woman's place is still in the home, in the kitchen with an apron on," state Rep. Bob Hagan of Youngstown said of her bill.
>
> "It's not a joke," Turner told The Plain Dealer this week. "I'm dead serious. I want to continue this strong dialogue about what is fair and what is equal" (Suchetka 2012).

In this thesis, I have shown how contraception is part of a system that not only provides reproductive power to women, but paradoxically contributes to ignorance of female biological processes, governs birth control choices, and manages women's fertility. The bills described above illustrate these matters, but on a larger, more public scale. While some topics, like FAM, are not currently required as part of sexual education in high schools, new legislation could actually prohibit schools from teaching *any* information about the various forms of contraception. By leaving young women (and men) doubly uninformed about the reproductive process as well as birth control, it stands to reason that women would be substantially more likely to accidentally become pregnant. Yet state laws against organizations like Planned Parenthood could leave such women with fewer resources to obtain information, and less access to affordable, judgment-free prenatal care. If a woman should choose to abort her pregnancy, which is her constitutional right in the United States, she could find herself facing invasive and medically unnecessary procedures before doing so. More frightening still, if she decides

to keep the baby but has severe complications from the pregnancy, she could literally die if her pro-life doctor decides not to disclose her condition, all in an attempt to keep her from having an abortion. These efforts to manage womanhood involve not only politicians making policy decisions for women with regard to their choices and bodies, but also allow the government to literally control women's lives. It is important that we continue to question the assumptions behind such management, and, as Nina Turner said, "to continue this strong dialogue about what is fair and what is equal" with regard to reproduction and contraception (Suchetka:NP). We must remain vigilant in our examinations of the ways that women's reproductive decisions appear to reflect private and individual choice, but are in fact linked to larger public forces that shape and manage reproductive options for women.

References

Alonso-Zaldivar, R. 2012. "Obama Birth Control Policy: Administration Lays Out Proposals For Carrying Out Compromise." *Huffington Post,* http://www.huffingtonpost.com/2012/03/16/obama-birth-control-policy-options_n_1354590.html (accessed 2012).

Altaffer, M. 2012. "Pfizer recalls birth control pills, says tablets may not prevent pregnancy." *The Globe and Mail*, http://www.theglobeandmail.com/life/health/new-health/health-news/pfizer-recalls-birth-control-pills-says-tablets-may-not-prevent-pregnancy/article2322276/ (accessed 2012).

Appleyard, F. 2011. "New birth control pill ramps up blood clot risk: Study." *Montreal Gazette*, http://www.montrealgazette.com/life/birth+control+pill+ramps+blood+clot+risk+study/4658446/story.html (accessed 2011-2012).

Ashton, J. 2009. *The Body Scoop for Girls: A Straight-Talk Guide to a Healthy, Beautiful You*. New York: Avery.

Bassett, L. 2012. "Texas Loses Entire Women's Health Program Over Planned Parenthood Law." *Huffington Post*, http://www.huffingtonpost.com/2012/03/15/texas-loses-entire-womens_n_1349431.html (accessed 2012).

Bassett, L. and A. Terkel. 2012. "House Democrats Walk Out Of One-Sided Hearing On Contraception, Calling It An 'Autocratic Regime.'" *Huffington Post*, http://www.huffingtonpost.com/2012/02/16/contraception-hearing-house-democrats-walk-out_n_1281730.html (accessed 2012).

Betancourt, T. 2012. "Senate judiciary committee endorses controversial contraceptive bill." *ASU News*, http://www.statepress.com/2012/03/12/senate-judiciary-committee-endorses-controversial-contraceptive-bill/ (accessed 2012).

Bielski, Z. 2012. "One Step Closer to a Pill for Men?" *The Globe and Mail,* http://www.theglobeandmail.com/life/health/new-health/health-news/one-step-closer-to-a-pill-for-men/article2324692/page1/ (accessed 2012).

Birke, L. and K. Gardner. 1982. *Why Suffer? Periods and their problems.* London: Virago.

Bleier, R. 1984. *Science and gender: A critique of biology and its theories on women.* Elmsford, N.Y.: Pergamon.

Bobel, C. 2010. *New Blood: Third-Wave Feminism and the Politics of Menstruation.* New Brunswick, New Jersey, and London: Rutgers University Press.

Bordo, S. 1993. *Unbearable weight: Feminism, Western culture, and the body*. Berkeley and Los Angeles: University of California Press.

Boston Women's Health Book Collective. 2011. *Our Bodies, Ourselves*. New York: Simon and Schuster.

Browner, C.H. 2000. Situating Women's Reproductive Activities. *American Anthropologist* 102(4): 773-788.

Buckley, T. 1982. Menstruation and the power of Yurok women: Methods in cultural reconstruction. *American Ethnologist* 9:47-60.

Buckley, T. and A. Gottlieb. 1988. *Blood Magic: The Anthropology of Menstruation*. Berkeley and Los Angeles: University of California Press.

Carlisle, C. 2011. "Yaz Birth Control Pill Most Popular Among Young Women." *Yaz Lawsuit News,* http://yazlawsuit-info.com/2011/04/yaz-birth-control-pill-popular-among-young-women (accessed 2011-2012).

Coleman, C. 2002. Assisted Reproductive Technologies and the Constitution. *Fordham Urban Law Journal* 30:57-70.

Comparative Chart. (ND). "Choosing a contraceptive that's right for u." Printed by sexualityandu.ca and The Foundation for the Promotion of Sexual and Reproductive Health. Distributed by the SHAG Shop at McGill University, 2011.

Cornforth, T. 2003. "Which Birth Control Pill is Best?" *Women's Health*, http://womenshealth.about.com/b/2003/07/29/which-birth-control-pill-is-best.htm (accessed 2011-2012).

Davidson, A. 2012. "Has Limbaugh Identified the G.O.P.'s Woman Problem?" *The New Yorker*, http://www.newyorker.com/online/blogs/closeread/2012/03/has-limbaugh-identified-the-gops-woman-problem.html (accessed 2012).

Davis, K. 2007. *The Making of Our Bodies, Ourselves: How Feminism Travels Across Borders*. Durham and London: Duke University Press.

de Beauvoir, S. 1952. *The second sex*, trans. and ed. H.M. Parshley. New York: Knopf. (Original publication: *Le deuxième sexe*, 2 vols. Paris: Gallimard, 1949.)

Delaney, J., M. Lupton, and E. Toth. 1976. *The curse: A cultural history of menstruation*. New York: Dutton.

Erikson, S. 2011. "Global Ethnography: Problems of Theory and Method," pp. 23-37. In *Reproduction, Globalization, and the State: New Theoretical and Ethnographic Perspectives,* C. Browner and C. Sargent (eds.). Durham and London: Duke University Press.

Feller, B. 2012. "AP sources: Obama revamping birth control policy." *Yahoo! News*, http://news.yahoo.com/ap-sources-obama-revamping-birth-control-policy-150350760.html (accessed 2012).

Foster, S. 2012. "Arizona Senate Passes Bill Allowing Doctors To Not Inform Women Of Prenatal Issues To Prevent Abortions." *Addictinginfo.org*, http://www.addictinginfo.org/2012/03/07/arizona-senate-passes-bill-allowingdoctors-to-not-inform-women-of-prenatal-issues-to-prevent-abortions/ (accessed 2012).

Foucault, M. 1978. *The History of Sexuality, Vol. 1: An Introduction.* New York: Vintage Books.
---. 1979. *Discipline and Punish: The Birth of the Prison*. New York: Random House.
---. 1980. *Power/Knowledge: Select Interviews and Other Writings*, 1972-1977, ed. C. Gordon. Brighton, UK: Harvester Press.

Ginsburg, F. and R. Rapp. 1991. The politics of reproduction. *Annual Review of Anthropology* 20: 311-343.

Ginsburg, F. and R. Rapp. 1995. Conceiving the New World Order: the Global Politics of Reproduction. Berkeley: University of California Press.

Gottlieb, A. 1982. Sex, fertility, and menstruation among the Beng of the Ivory Coast: A symbolic analysis. *Africa* 52(4):34-47.
---. 1988. "Menstrual Cosmology among the Beng of Ivory Coast," pp. 55-74. In *Blood Magic: The Anthropology of Menstruation,* Thomas Buckley and Alma Gottlieb (eds.). Berkeley and Los Angeles: University of California Press.
---. 1995. The Anthropologist as Mother: Reflections on Childbirth Observed and Childbirth Experienced. *Anthropology Today* 11(3): 10-14.

Gutmann, M. 2007. *Fixing Men: Sex, Birth Control, and AIDS in Mexico*. Berkeley: University of California Press.

Gyapong, D. 2012. "Personhood to be debated on the Hill." *The B.C. Catholic*, http://bcc.rcav.org/component/content/article/1-latest-news/1475-personhood-to-be-debated-on-the-hill (accessed April 2012).

Haraway, D. 1997. The Virtual Speculum in the New World Order. *Feminist Review* 55: 22-72.

Inhorn, M. 2003. Global infertility and the globalization of new reproductive technologies: illustrations from Egypt. *Social Science and Medicine* 56: 1837-1851.

Inhorn, M. and Birenbaum-Carmeli, D. 2008. Assisted Reproductive Technologies and Culture Change. *Annual Review of Anthropology* 37: 177-196.

Ivry, Tsipy. 2010. *Embodying Culture: Pregnancy in Japan and Israel*. New Brunswick, New Jersey, and London: Rutgers University Press.

Johnson, C. 2010. "America's Favorite Birth Control Method Turns 50." *Huffington Post*, http://www.huffingtonpost.com/2010/05/07/americas-favorite-birth-c_n_567607.html (accessed 2011-2012).

Laws, S. 1990. *Issues of Blood: The Politics of Menstruation*. New York: Macmillan.

Lazarus, E. 1994. What Do Women Want?: Issues of Choice, Control and Class in Pregnancy and Childbirth. *Medical Anthropology Quarterly* 8(1): 25-46.

Lee, C. 2009. "Dr. Pierre-Paul Tellier, Director, Student Health Services." *McGill Reporter*, http://publications.mcgill.ca/reporter/2009/10/dr-pierre-paul-tellier-director-student-health-services/ (accessed 2011-2012).

Lock, M. 1993. Cultivating the Body: Anthropology and Epistemologies of Bodily Practice and Knowledge. *Annual Review of Anthropology* 22:133-155.

Lock, M. and V. Nguyen. 2010. *An Anthropology of Biomedicine.* West Sussex: Wiley-Blackwell.

Martin, E. 1988. "Premenstrual Syndrome: Discipline, Work, and Anger in Late Industrial Societies," pp. 161-181. In *Blood Magic: The Anthropology of Menstruation,* Thomas Buckley and Alma Gottlieb (eds.). Berkeley and Los Angeles: University of California Press.

Martin, E. 2001. *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon Press.

Mead, M. 1928. *Coming of Age in Samoa.* New York: William Morrow.

Memmott, M. 2012. "Utah Legislature Votes To Prohibit Schools From Teaching About Contraception." *The Two-Way: NPR's News Blog*, http://www.npr.org/blogs/thetwo-way/2012/03/07/148175378/utah-legislature-votes-to-prohibit-schools-fromteaching-about-contraception?ft=1&f=1001 (accessed 2012).

Mirkinson, J. 2012. "Rush Limbaugh: Sandra Fluke, Woman Denied Right To Speak At Contraception Hearing, A 'Slut.'" *Huffington Post,* http://www.huffingtonpost.com/2012/02/29/rush-limbaugh-sandra-fluke-slut_n_1311640.html (accessed 2012).

Neergard, L. 2012. "$100 or $1,000, birth control costs vary widely." *The Post and Courier*, http://www.postandcourier.com/news/2012/mar/10/100-or-1000-birth-control-costs-vary-widely/ (accessed 2012).

Rapp, R. 1999. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. New York: Routledge.

Rapp, R. 2001. Gender, Body, Biomedicine: How Some Feminist Concerns Dragged Reproduction to the Center of Social Theory. *Medical Anthropology Quarterly* 15(4): 466-477.

Ryan, E. 2012. "Law Will Allow Employers to Fire Women for Using Whore Pills." Jezebel, http://jezebel.com/5893011/law-will-allow-employers-to-fire-women-for-using-whore-pills (accessed 2012).

Singer, N. 2009. "A Birth Control Pill That Promised Too Much." http://www.yaz-birth-control.org/yaz-news/28-a-birth-control-pill-that-promised-too-much-.pdf (accessed 2011-2012).

Suchetka, D. 2012. "Ohio State Sen. Nina Turner joins women across country striking back, introducing bills to regulate sex lives of men." *The Plain Dealer*, http://mobile.cleveland.com/advcleve/db_/contentdetail.htm?contentguid=rUSxI5TI&full=true#display (accessed 2012).

Tobin, A. 2011. "Many teens say Internet better than parents for sex ed." *The Globe and Mail*, http://www.theglobeandmail.com/life/parenting/teens/sexuality/many-teens-say-internet-better-than-parents-for-sex-ed/article2064423/ (accessed 2012).

Ussher, J. 2006. *Managing the Monstrous Feminine: Regulating the Reproductive Body*. New York: Routledge.

Weschler, T. 2002. *Taking Charge of Your Fertility: The Definitive Guide to Natural Birth Control, Pregnancy Achievement, and Reproductive Health, Revised Edition*. New York: Quill.

Women's Health Policy Brief. 2005. "Direct-to-Consumer Advertising (DTCA): Not in the Best Interests of Women's Health." *Health Canada*, http://healthcoalition.ca/wp-content/uploads/2010/02/policyWHP.pdf (accessed 2011-2012).

Young, F. and A. Bacdayan. 1965. Menstrual taboos and social rigidity. *Ethnology* 4:225-240.

Web References

About.com Contraception, http://contraception.about.com/ (accessed 2011-2012).

American Congress of Obstetricians and Gynecologists. 2012. "ACOG Statement on Personhood Measures." *ACOG.org*, http://www.acog.org/About_ACOG/News_Room/News_Releases/2012/Personhood_Measures (accessed 2012).

American Pregnancy Association, "Pregnancy Symptoms: Early signs of pregnancy," http://www.americanpregnancy.org/gettingpregnant/earlypregnancysymptoms.html (accessed 2011-2012).

Ask Dr. T: Healthy Sexuality for University and College Students, http://askdrt.mcgill.ca/# (accessed 2011-2012).

Association of Reproductive Health Professionals, Method Match online tool, http://www.arhp.org/MethodMatch/ (accessed 2011-2012).

Beyaz Birth Control [Video]. 2011. http://www.youtube.com/watch?v=NdSmXKRqFHM&feature=related (accessed 2012).

Canadian Federation for Sexual Health, http://www.cfsh.ca/ (accessed 2011-2012).

Concordia University Health Services, http://www-health.concordia.ca/ (accessed 2011-2012).

Guttmacher Institute, http://www.guttmacher.org/index.html (accessed 2012).

McGill University Student Health Services, http://www.mcgill.ca/studenthealth/ (accessed 2011-2012).

Nuva Ring Commercial [Video]. 2008. http://www.youtube.com/watch?v=mb49mo5uvE0&feature=related (accessed 2012).

Paragard Fits Your Life by Curious Pictures – Hayley Morris [Video]. 2011. http://www.youtube.com/watch?v=NqM3nvbra44 (accessed 2012).

Plan Canada's "Because I am a Girl," http://becauseiamagirl.ca/ (accessed 2011-2012).

Planned Parenthood, "Birth Control," http://www.plannedparenthood.org/health-topics/birth-control-4211.htm (accessed 2011-2012).

ProCon.org. 2012. "Abortion Ultrasound Bill Signed in Virginia." *ProCon.org*, http://www.procon.org/headline.php?headlineID=005074 (accessed 2012).

Sexuality & U, presented by the Society of Obstetricians and Gynaecologists of Canada, http://www.sexualityandu.ca/en (accessed 2011-2012).

Swim Along Nuva Ring [Video]. 2009. http://www.youtube.com/watch?v=nY3MfNWHGvk (accessed 2012).

Taking Charge of Your Fertility, http://www.tcoyf.com/ (accessed 2007-2012).

The Nest, "Sex & Romance" Discussion Board, http://community.thenest.com/cs/ks/forums/thread/58148407.aspx (accessed 2012).

The Sex Information and Education Council of Canada (SIECCAN). 2010. "Contraception Use Among Young Women in Canada: What are the trends?" http://sexualityandu.ca/uploads/files/CTR_ContraceptionAmongYoungWomen.pdf (accessed 2011-2012).

The ShagShop's Channel on YouTube, http://www.youtube.com/user/TheShagShop (accessed 2012).

Appendix 1 – Interview Participants

Pseudonym	Age	Citizenship	Relationship Status	Student Status	Birth Control Methods Used	Feelings toward Pregnancy*	Date of Interview
Isabelle	25	USA	Long-Term, Unmarried	Former, MA	Pill, External Condom	TNTC	6/20/2011
Grayson	33	Canada	Married	Current, MA	Pill, Mini-Pill, External Condom, FAM	TTC	10/26/2011
Hilary	24	Canada	Single	Current, MA	Pill	UC	11/1/2011
Josephine	23	Canada	Dating	Current, MSc	N/A	UC	10/25/2011
Kinsey	29	Canada	Long-Term, Unmarried	N/A	Pill, External Condom	TNTC	3/26/2011
Lensa	25	Canada	Single	Current, MA	Pill, External Condom	TNTC	11/1/2011
Melanie	38	USA	Single	Current, PhD	Pill	UC	6/20/2011
Nadia	25	USA	Single	Current, MA	External Condom, Plan B, Spermicide	TNTC	10/18/2011
Penny	28	Canada	Dating	Current, PhD	Pill, External Condom, Plan B	TNTC	6/21/2011
Chloe	30	Canada	Long-Term, Engaged	Current, PhD	Pill, External Condom	TNTC	6/16/2011
Sarah	26	Canada	Dating	Former, MA	Pill, External Condom	TNTC	6/21/2011

*TTC = Trying to Conceive, TNTC = Trying Not to Conceive, UC = Unconcerned (neither attempting nor avoiding conception, and/or there is no current risk of pregnancy)

Appendix 2 – Interview questions

Understanding of Fertility:
-At what age and under what circumstances did you first start thinking about your own reproduction and fertility?
-What are the earliest things you can remember about it – conversations, purchases, experiences? (Related to periods, to side effects, to contraception…)
-What were you told about contraception, by whom, and in what circumstances?
-How would you describe the process of menstruation/the reproductive cycle?

Contraceptive Choices:
-How do you feel about your understanding of your fertility/body/contraceptive choices?
-What options do you have, and which do you use?
-Have you ever used the pill?
-if so, when did you start and for what reasons? How long did you (or do you) take it?
-How would you describe the way the pill works?
-Why do you (or do you not) use the pill?
-Have you ever gotten pregnant by accident? If yes, why do you think it happened? How did it affect your subsequent contraceptive decisions?
-How do you feel about other contraceptive options? Can you describe any, and how they work? Have you tried (or wanted to try) any besides the pill? Why or why not?

Feelings about reproduction, contraceptives, and the pill:
-How do you feel about using (or not using) the pill? About other contraceptive choices?
-How would you describe popular impressions of birth control? (women, men, doctors, ads…)
-Can you think of some pros and cons of using various contraceptive methods? Have you experienced any of these personally?
-How do you feel about your understanding of the way various contraceptives work?
-How do you choose your birth control options now? Do you ever change methods?
-How would you describe advertisements you've seen for contraceptive methods such as the pill or condoms? Who are these ads trying to sell to? How do the ads affect you and your contraceptive decisions?
-Do you expect to stay on/off the pill? For how long, and why?
-If you are currently in a relationship, how does your partner feel about your contraceptive choices? Does your partner have an influence on the contraceptives you use?
-How confident are you in your ability to avoid unwanted pregnancy? (Without the pill? Without any contraceptives?)

Appendix 3 – Personal Questionnaire

Have you ever had sex? Y N

Are you currently having sex at least once a month? Y N

Are you currently using any form of contraception? Y N

Please list any contraceptive method that you are using (or have *ever* used), and rate your degree of confidence in its effectiveness in preventing unwanted pregnancy from 0-100% (where 0=will not prevent pregnancy, and 100=will absolutely prevent pregnancy every time).

Additionally, if you currently use one form of contraception regularly (more than any other), and would consider it your primary method of birth control, please place a star beside it.

1) _____ Effectiveness: _____%

2) _____ Effectiveness: _____%

3) _____ Effectiveness: _____%

4) _____ Effectiveness: _____%

5) _____ Effectiveness: _____%

Please rate your agreement with the influence of each of the following reasons on your present or past choice of contraceptive methods. Also list the method(s) to which each reason applies.
1=Strongly disagree, 2=Disagree, 3=Neither disagree nor agree, 4=Agree, 5=Strongly agree

I choose to use contraception:	RATING	METHOD(S)
To avoid unwanted pregnancy.	1 2 3 4 5	_____
To treat physical condition(s) related to period.	1 2 3 4 5	_____
To protect against STD's or STI's.	1 2 3 4 5	_____
Due to influence from significant other.	1 2 3 4 5	_____
Due to influence from parent.	1 2 3 4 5	_____
Due to influence from doctor/nurse.	1 2 3 4 5	_____
Because of someone else's experience.	1 2 3 4 5	_____
Because of personal experience.	1 2 3 4 5	_____
Other (please list)_____	1 2 3 4 5	_____
Other (please list)_____	1 2 3 4 5	_____