

University of Warwick institutional repository: <http://go.warwick.ac.uk/wrap>

A Thesis Submitted for the Degree of PhD at the University of Warwick

<http://go.warwick.ac.uk/wrap/4396>

This thesis is made available online and is protected by original copyright.

Please scroll down to view the document itself.

Please refer to the repository record for this item for information to help you to cite it. Our policy information is available from the repository home page.

WOMEN, SEXUALITY AND CONTRACEPTION

Scarlet R. Pollock

Ph.D.

University of Warwick

Department of Sociology

January 1983

TABLE OF CONTENTS

	<u>Page</u>
<u>Chapter 1</u> <u>SURVEY OF THE LITERATURE</u>	1
Adequate methods	2
Inadequate users	5
Women 'at risk'	9
Population control	12
Family planning	15
Medical monitors	17
Women's liberation or coercion?	22
<u>Chapter 2</u> <u>METHODOLOGY</u>	26
Approaching the study	26
Research design	28
The interviews	29
The sample	35
Characteristics of the sample	42
<u>Chapter 3</u> <u>THEORETICAL FRAMEWORK</u>	45
The position of women	45
The dominance of men	46
Heterosexuality and the family	47
Biological theory	49
Functionalist theory	52
Marxist theory	56
Original cause	62
Key institutions	65
Sexuality	66
<u>Chapter 4</u> <u>SEXUALITY</u>	69
Sex - with whom?	70
a) Lesbianism	71
b) Masturbation	73
c) Promiscuity	76
Sex - what is it?	81
a) Sex drive	82
b) Foreplay	83
c) Orgasm	85
d) Changing sex	90

	<u>Page</u>
Sex - for what purpose?	94
a) Pleasure	94
b) Affection	96
c) Having children	100
<u>Chapter 5</u> <u>CONTRACEPTION</u>	107
The first contraceptive method	108
Changing fashion	111
Finding a suitable method	113
Reliability	121
Health risks	126
Interference with love-making	130
Control versus responsibility	133
Menstrual periods	137
Availability	139
Looking to the future	147
<u>Chapter 6</u> <u>SEX EDUCATION AT SCHOOL</u>	152
Femininity and promiscuity	153
Dire warnings	158
Female versus male teachers	160
The biological approach	164
Marriage and motherhood	167
Contraception	170
<u>Chapter 7</u> <u>SOURCES OF INFORMATION</u>	173
At home	175
Mothers versus fathers	178
Friends	183
Partners	195
Doctors	198
Media sources, leaflets and books	203
The question of bias	210
<u>Chapter 8</u> <u>NEGOTIATING SIDE EFFECTS</u>	220
Consulting doctors	222
Is it related?	224
Is it serious?	233
Serious, but not related	235
Related, but not serious	238
What should be done about it?	241

	<u>Page</u>
<u>Chapter 9</u> <u>DOCTORS, SEX AND GENDER</u>	244
Patriarchal stereotypes	245
Male versus female doctors	250
Male-doctor-female-patient	255
Female-doctor-female-patient	263
<u>Chapter 10</u> <u>WOMEN TOGETHER</u>	268
Sexuality	268
Contraception	273
<u>BIBLIOGRAPHY</u>	277
<u>APPENDICES</u>	
Letters	288
Card A	290
Questionnaire	291

LIST OF TABLES

<u>Chapter 2</u> <u>METHODOLOGY</u>	
Table 1. Derivation of the sample	41
<u>Chapter 5</u> <u>CONTRACEPTION</u>	
Figure 1. Proportion of women in each age group, along with contraceptive method used, at first sexual intercourse: 1960-69 and 1970-77.	109
Table 1. Methods of contraception in current use, last used and ever used.	112
Table 2. Percentages of women reporting preferences for use/use again of methods ever used and never used.	116
Table 3. Percentages of women attributing disadvantages to each contraceptive method.	120

ACKNOWLEDGEMENTS

I would like to thank Professor Margaret Stacey who provided me with the opportunity, encouragement and criticism, without which this work would not have been begun let alone reached completion. The deepest respect for the academic freedom she induced and nurtured to pursue my own empirical and theoretical approach to the study, whilst compelling me to clarify my thinking, is owed to her.

The Sociology Department at the University of Warwick furnished both intellectual resources and political debate. In particular the members of the Sociology of Health and Illness Workshop confronted the issues central to this research and provided ongoing evaluation and support.

The Women's Liberation Movement impelled my social and political development and taught me the value of the work that women can do. My involvement with the Women's Self-Help Health Movement inspired the thesis topic and made me aware of the need for such research to be done. With the help and guidance of many sisters I have increasingly come to understand the relationship between theory and practice.

Personally I am indebted to my parents for their determination that I complete the thesis. My sister Melanie has always been ready to show me warmth and pride. Barbara Alford has cared for me through many changes. The responsibility to write and to learn from experience was impressed upon me by Janet Harris. To Leslie Kay I owe much of my feminist awareness; she has always managed to balance argument with

encouragement. Jo Sutton has given me the precious gift of an unceasing faith in my intellectual ability and potential. Her belief in the importance of feminist research, writing and theoretical development has compelled even me to envisage the possibility of 'life after the thesis'.

I am grateful to the Social Science Research Council for providing the studentship grant which enabled this research to be undertaken.

Finally, I would like to thank the women who participated in the study for their time, the effort of personal reflection and revelation, and their confidence in the research project. Whilst the views expressed may or may not be shared by them, I sincerely hope that the attempt to show consideration and respect for their experience has been successful.

SUMMARY

The relationship between women's contraceptive experiences and the social relations in which they take place has been little explored to date, either empirically or theoretically. The importance of such an approach lies in its ability to perceive women's contraceptive concerns, capacities and problems, as socially and politically derived rather than as the consequence of individual/couple/group inadequacies. The position of women in society is central to this perspective. The search for a theoretical framework which allows for visibility of the social relations between women and men, and the potential for explanation, is as significant in this research process as the gathering of empirical data.

A small scale qualitative study was undertaken to explore the experiences of women with sexuality and contraception. The decisions and actions women took regarding contraception, the problems they encountered and the information they received provided the focus for data collection and analysis. In-depth, semi-structured interviews with a random sample of fifty women postgraduate full-time students at the University of Warwick were conducted in the Summer Term of 1977. The sample was deliberately highly selective for motivation, access to information, alternative career possibilities and experience with contraception. The purpose of this selection was to highlight the experiences and difficulties with contraception faced by even those women in a relatively good social position, and thereby to indicate the problems in contracepting likely to affect all women.

Data analysis revealed three major areas of social relations to influence the conditions in which women made decisions and took actions: first, the arena of personal sexual relationships; second, the quantity and quality of information received about sexuality and contraception; and third, the field of contraceptive health care services encountered. The sex-based division engendering social relations of male domination and female subordination were seen to be operable in each of these areas. The social and political relations of this sexual hierarchy emerged as central to the understanding of the experiences of women in the study with sexuality and contraception.

Adequate methods

The starting point for most research into contraceptive use, whether descriptive or explanatory, contains the assumption that current methods of contraception are adequate for the separation of sex and reproduction, and thereby, the achievement of pregnancy prevention. If people wish to engage in sex but avoid pregnancy, the means to achieve this end is thought to be possible in virtually all cases through the efficient use of one of several effective contraceptive methods at present available. Improvements are always possible and to be welcomed but in the meantime, it is assumed, existing contraceptive technology enables men and women to plan their families.

Whilst the decline in birth rate in many countries is recognized to have begun before the increasing availability of the most effective methods of contraception through the growth of family planning programmes, that the input of such massive resources will have had some consequence cannot be denied (Cross and Arber, 1977). Certainly the enforced use of contraception, particularly those methods which are least likely to involve the individual's participation in use (Depo-Provera, for example), would have the effect of limiting families and lowering birth rates. It is not the alleged purpose of family planning programmes, or the research which informs and guides their activities, to use coercion to promote the use of contraception. Rather, as Malcolm Cross and Sara Arber point out, the ideology presented is couched in the language of individual choice and making available the means to achieve desires and preferences. Yet, the practices which were observed in their own study at least, drew them to the conclusion that 'the programme is orientated towards the control of family size' (1977, p.205).

The issue of whether the development of family planning services contributes to individual choice or coercion raises many questions. For instance, what is the social context within which people choose to use contraceptives, and which ones? Who is exercising social control upon whom, and for what purpose? Are the answers to such questions differentiated according to the sex, race, and/or economic class of the individuals involved? To raise these queries is perhaps to complicate the process of discovering the important variables which may enable us to identify, understand and predict patterns of contraceptive use. Not to do so is to risk simply reiterating prevailing ideology, misdirecting the search for the variables which would help to explain contraceptive behaviour and being confronted with patterns of contraceptive use which appear irrational and unintelligible.

To base enquiries upon the assumption that adequate means of contraception exists is to run such a risk. The implication of employing this taken-for-granted view of contraception is to seek the source of any apparent aversions or difficulties in contraceptive use in either those individual who experience the difficulties or in those family planning services which do not make these adequate contraceptives sufficiently available to individuals. The problems which result from this approach will be elaborated upon in this and further chapters; here it is important to note that the concept of what is adequate, to whom and for what purpose is not open to investigation. What is, is adequate. Therefore any problems are implied to reside with those who do not find it so. Research is thus directed towards the question: what is wrong with the people who have access to, but do not use, this adequate contraception?

The success of family planning services is assessed largely upon 'whether increasing use of the services has resulted in improved control of fertility throughout the population' (Bone, 1978, p.39) Evidence of this improved control can be seen in the more extensive use of contraception, or in the use of more effective methods, or both. Good services are those which promote

the use of effective contraception. Improvements in the quality of services are directed towards 'inducing or enabling people, who otherwise would not, to use them and so to practice effective contraception' (ibid., p.3).

Effectiveness is equated with adequacy; what is adequate is thereby closed to other concerns. Difficulties or objections to using these contraceptives thus become relegated as problems of acceptability of the services, or of the methods themselves.

The concept of acceptability is based upon this assumption of adequacy, and its equation with effectiveness. The problem from the point of view of the service providers is how to encourage the acceptance and use of effective contraception. Acceptability thus denotes what people will accept. Margaret Bone, for example, suggests that aspects of acceptability include motivation, knowledge, availability, safety, aesthetic factors and ease of use, cost and reliability. Recognition of, and research into these aspects, she argues, are of central concern to service providers: 'Evidence about the acceptability of different methods should suggest which of the more reliable it would be profitable to promote' (Bone, 1973, p.24). Finding that many women regard the pill as a health hazard, she recommends that the services put a greater emphasis on IUDs. However, she points out, 'it is possible that further information about the IUD might deter them' since although fewer women rejected the IUD as a possibility, fewer too had heard about it or felt they knew much about it, compared to the pill. It is not, then, that the pill's possible health risks are taken to qualify its adequacy; rather, it is the fact that many women regard it as a health hazard that is seen to be the problem. The alternatives available to the services are, by implication, to 'reassure' women about the pill or to encourage women to use another adequate/effective method which has not, as yet, come to be seen as unacceptable to those who would use it.

What people are prepared to accept will obviously depend upon the alternatives which are available to them. The fewer the choices, the more likely the acceptability of contraceptive methods that do exist will be high. If there are few or no alternatives, the choice available is whether or not to use the contraceptive in question. If there are several alternatives, what is acceptable is tempered by what else there is, hence which is more acceptable than others. Acceptability is also affected by what is known about those alternatives which may be available. As Margaret Bone implies, above, the acceptability of the IUD may depend upon the fact that fewer women know about it and its possible health hazards, than know about the pill.

To introduce the concept of acceptability does not, therefore, solve the problem of assuming method adequacy. It is still the people who do not find them so who become the centre of inadequacy in research and service projects. The basis on which acceptability is explored is the assumed adequacy/effectiveness of the contraceptive methods, and thus what is seen to be in need of identification and explanation are the people who do not accept them (as indicated by the fact that they do not use them).

One of the central aims of this study has therefore been to open to investigation the adequacy of contraceptive methods. This is explored from the viewpoint of those who use, or do not use them. As it is women who are at risk of becoming pregnant, it is women's experiences and perspectives of contraceptive adequacy which are paramount to such an investigation. Women's views and experiences are analyzed to discover if, how and why particular contraceptive methods come to be seen as adequate or inadequate, and as more or less adequate than others.

Inadequate users

If it is assumed that contraceptive methods are adequate, and good services are those which successfully promote the use of these methods, then the 'failure' to prevent pregnancy would seem to lie with the user. If it can be seen that people do not intend a pregnancy to occur yet do not use an effective form of contraception, it is the people themselves who are therefore implied to be inadequate. As the means of avoiding pregnancy appear to be adequate and available, research tends to be oriented towards a) the identification of those who do not employ effective contraception and b) the explanation of why it is that they do not do so. The 'problem' may be located within individuals or within groups or classes of individuals; explanations are then sought or found in their personal or group attitudes, knowledge, rationality, capability, perceptions and psychology.

Recent British surveys highlight, as did the earlier American ones, that it is the lower social classes (according to husband's occupation) and the young (both married and unmarried) who are most likely not to use contraception, to use it irregularly, or to use unreliable methods (Cartwright, 1970; 1976; Bone, 1973, 1978; Peel and Carr, 1975). By 1975, however, Cartwright (1978) indicates these differences to have markedly diminished, particularly between social classes. Bone, too, suggests that by 1975 use of family planning services begins to appear more common amongst wives of manual workers. The increasing availability of family planning services throughout the early 'seventies, and with them the greater availability of the contraceptive pill, seem to have minimized differential use of contraception amongst the population. In addition, Peel and Carr (1975) in reviewing the findings of a range of national family planning surveys, imply their conclusions to be 'rather sobering' as the control of fertility appears to be achieved by a mere minority whilst the majority of women continue to experience unintended pregnancies.

Thus we are pointed towards the identification of differential groups or individuals who are most likely to be the most inefficient contraceptors, while increasingly the evidence suggests that contraceptive use and unintended pregnancies are commonly experienced across the population. The contradiction between the direction and findings of research which has attempted to identify the inefficient contraceptors in the population would seem to suggest that another approach is needed. Given that the majority of the population appear to encounter difficulties with birth control, it would perhaps be more useful to look towards common problems and patterns of experience with contraception which may account for these difficulties and perhaps 'failures' of pregnancy prevention.

The consequences of seeking to differentiate a proportion of the population from the rest, identifying them as the inefficient contraceptors as compared to the efficient contraception practised by the rest of the population, are seen in the explanations offered to account for this distinction. If the majority are assumed to be normal and efficient, the identified inefficient group appear as deviant and in some way, defective. That is, if contraception is not a problem for everyone, then the problem is centred upon those people who experience it as such. If it can be established that an awareness of contraceptive methods exists amongst the population in question, explanations are likely to be based upon personal or group characteristics pertaining to responsibility or rationality.

Individual rationality is the most frequently employed basis of such explanations. Its popularity is perhaps because it implies a medical model denoting the possibility of cure once the correct treatment is applied to the individuals concerned. The irrationality of the identified inefficient contraceptors tends to be related to a variety of psychodynamic factors affecting the subconscious emotions and motivations yielding

inadequate personality patterns and thus unwanted pregnancies (see Pohlman's review, 1969) or to the psychological conflict which is a normal result of contraceptive practices upon the urge to procreate (for example, Draper, 1972).

Criticizing this approach, several authors have pointed out that such explanations assume as given and universal, ideas which can be seen to be socially defined and culturally bound (Pohlman, 1969; Clavan, 1972; Busfield, 1974; Luker, 1975; Macintyre, 1976). They cannot account for historical variation or differences of race, economic class or geographical location (Luker, 1975), yet they often distinguish differential endowment of psychodynamic factors, the maternal instinct for example, in married and unmarried women (Macintyre, 1976). Having identified differential contraceptive use by social groupings, whether based upon economic class, cultures, age, marital status or geographical location, this form of analysis cannot account for the differential rationality of such groups which is presumed to have given rise to their patterns of contraceptive use.

Attempts to explain in social terms the findings that lower economic class people tend to have larger families and to contracept less efficiently than people of higher occupational standing refer either to a culture of poverty or to situational deprivation (Askham, 1975). In her own study, Janet Askham argues for the need to combine these approaches into an 'adaptational approach'; in this way behaviour can be viewed as an adaptation to the situation and as being reinforced by the values and norms which derive from that deprived situation. The approach is similar to that used by Lee Rainwater (1965), stressing the problems which arise from economic insecurity, poverty, low status and powerlessness, and the norms which derive from poor life chances. The observed 'pathologies' can thus be seen to relate to the social environment, mediated by norms and behaviour patterns

'involving no planning ahead and being unable to control one's own environment' (Askham, 1975, p.14).

Despite its appreciation of the economic conditions which may influence people's attitudes and opportunities for contraceptive use, Askham's approach remains bounded by the assumptions of the existence of adequate/effective contraceptive methods and services. The location of the problem is thereby with the people who do not use them effectively. Whilst recognizing that people are not either effective or ineffective users of contraception, the analysis is limited by the attempt to contrast the behaviour of people in different social groups in order to locate 'the kinds of behaviour which constitute the upper and lower ends of the spectrum' (Ibid., p.65). In differentiating the personal characteristics of lower economic class people, whether or not they can be seen to derive from their living situation, from those attributed to people of a higher economic class, the study presents efficient contraception as possible and implies that it exists for a large proportion of the population. As such, it contradicts the survey findings which indicate that the majority of women continue to experience unintended pregnancies.

This contradiction emphasizes the questionability of taking for granted the adequacy of available birth control methods, for it leads to a search for the inadequacy of the users. In assuming contraception to involve a rational and possible process of employing appropriate means to achieve intended ends, those who do not accord with this model appear as irrational. Seeking to locate those sections of the population who appear to be relatively less likely to use the most effective forms of contraception, explanatory hypotheses are directed towards possible causes of inadequacy in such people. What is lost, and indeed, denied, by this focus is what the process of contraception is like for the majority of people. An examination of the normal, or at least the experience of a selected sample of the

population for whom contraception is seen to be a rational and possible process, is clearly necessary before such assumptions about rationality and adequacy can be made.

Women 'at risk'

The importance of being able to identify those individuals who are the least effective contraceptors, and to explain why they are not more effective, lies in the consequent indications for service provision.

'Recognizing the needs' of the lower class and the young, for example, promotes the extension of existing family planning services to reach these groups in order to induce or enable those people who are not already doing so, to use the services and to practice effective contraception.

There are, however, a number of difficulties associated with the attempt to locate those 'at risk', or even those 'most at risk'. The concept suggests, for instance, that there are many people who are not at risk of becoming pregnant, or at least, who are subject to very little risk. Yet anyone who is engaging in heterosexual intercourse, is female, and is not known to be infertile is at risk of becoming pregnant. The concern of family planners must therefore be with 'all women who might be able to conceive and (are) therefore potentially in need of contraception' (Bone, 1978, p.4).

Endeavouring to locate the women who are 'most at risk' brings to light the central asymmetry between the theory and the practice of family planning. In theory it is the couple who is considered to be at risk of pregnancy; in practice it is the woman. In theory both partners are seen to be mutually taking decisions or risks; in practice it is the woman who may become pregnant. The illogicality of this position is rarely confronted. When it is noticed, it tends to be treated as deviant or denied. Rainwater (1965) for example, suggests that such asymmetry occurs only amongst the

lower class who typically engage in 'segregated conjugal relationships' while Luker (1975) argues against such asymmetry by insisting that it is the couple who become pregnant. Regardless of the nature of the social relationship between partners, however, the fact remains that it is the woman alone who may become pregnant. In addition, the political relations which characterize our social order render the birth of a child to primarily affect the woman's life. The relations of contraception cannot be said to be equal between women and men, as the consequences of decision-making and risk-taking are borne primarily by the woman. In practice this is usually recognized, but the theory of family planning ignores, denies or treats sexual inequality as abnormal.

The result can be very confusing. Looking more closely at the example that women in the lower economic classes are found to be 'most at risk', we discover that it is not women but men who are being classified as being at risk of pregnancy. As it is the men who are classified as belonging to one of five social class groups, depending upon their occupation, the survey findings pertain primarily to them. In practice it is of course the wives and daughters of the men with whom family planning services are concerned, and who are regarded as being at risk of pregnancy. Should the daughter of a non-manual worker marry a manual worker; should the wife of a man in one occupational class divorce and remarry a man in another class; should women become divorced, separated or widowed - the theoretical findings become unintelligible and inapplicable. Women, who can frequently be seen to change class in these ways, may be regarded to be 'at risk' when living with one man but not with another, or when with no man at all. Explanations for contraceptive behaviour which are based upon the perception of the couple as a single unit, characterized by relations of equality yet identified by assuming a male head-of-household, are at once contradictory and confusing. What is clear is the inappropriateness of such a model in locating and explaining the risk of pregnancy experienced by women.

Another approach to the identification of women 'at risk' is by result. Women who have become pregnant, particularly if the pregnancy is unwanted and more particularly if an abortion is sought, are taken to be those 'most at risk'. Research frequently focuses upon abortion-seekers and asks why it is that these women have 'taken chances'. Reviewing this work Kristin Luker astutely argues: all women who are engaging in sex with men are taking chances. The attempt to identify qualitative differences between those women who have taken sufficient chances to become pregnant from those who have not is misleading. Some women become pregnant more easily than others and thus, those whose risk-taking results in pregnancy may reflect little more than a group of women who are more fertile than others. Different situations, too, may affect the chances which women are likely or compelled to take at various times. Finally, an element of randomness is involved, since in order for risk-taking to result in pregnancy, a woman 'must have sufficient exposures to a fertile male while she herself is biologically able to become pregnant' (1975, p.90). As one of the consequences for women of engaging in sex with men is the risk of becoming pregnant, pregnancy itself is insufficient evidence for the location of women 'at risk'.

Akin to the use of this approach is the moral disapproval cast upon some women who become pregnant unintentionally. Women who have large families, have children by different men or seek an abortion are often subject to such disapproval on the part of service providers (Luker, 1975). The research of Sally Macintyre, too, indicates the importance of seeking an abortion or remaining unmarried while having a child (1973; 1975; 1976) in the attitudes of service workers towards their women patients. Such actions are very likely to be perceived as indicative of women's irrationality and irresponsibility and hence, they come to be viewed as 'most at risk'. All women who experience unintended pregnancies are not necessarily regarded to be in this category; it is predominantly those who do not experience

pregnancy within the socially acceptable framework of family organization and size, who tend to be perceived to be 'most at risk'. Those women seen to be irrational or irresponsible by service providers are those thought to be most in need of inducement to use effective contraception.

The entanglement of the assessment of women's needs with judgments about their moral attitudes and sexual behaviour raises the question: from whose point of view? Research which is oriented towards the identification of women 'at risk' has as its goal the inducement of these women to use the most reliable methods of contraception available. Assuming both available methods of contraception and family planning services to be adequate and effective, it appears the rational and responsible thing to do to use them. From the point of view of service provision women therefore appear rational or irrational, responsible or irresponsible, adequate or inadequate. Women who attend, or perhaps do not attend, the family planning services are subject to these definitions and judgments. The quality of the contraceptive assistance they receive will thereby depend upon the moral, social and political views of those who decide policies and provide services for the planning of families.

Population control

Any study of contraception/family planning must be viewed in context of the project on a world-wide basis. The government funded and internationally organized movement for population control has been concerned to find and distribute contraceptive methods which are reliable and cost effective, particularly in terms of service provision. The priority given to these advantages by family planning organizations accounts for the popularity of the pill, the IUD and more recently, the injectable Depo-Provera in their programmes, despite the known and suspected risks to the health and comfort of the women who use them (Vaughan, 1972; Seaman and Seaman, 1978; Rakusen, 1981).

The concern with 'overpopulation', especially in 'underdeveloped' countries, has resulted in large scale funding of research and programmes for family planning. Throughout the 1960's aid given to third world nations became increasingly dependent upon acceptance of family planning programmes; during the 'seventies more sophisticated measures were preferred incorporating birth control into a wider development plan but still maintaining a high priority on population control (Gordon, 1977; Doyal, 1979). The problems and failures of many early programmes led to a greater concern with 'acceptability' of the contraceptive methods, services and incentive schemes being offered. The WHO Acceptability Task Force, set up in 1974, attempted to extend the effectiveness of family planning programmes in developing countries through an understanding of the cultural beliefs and perceptions which might affect the individual's use of contraception. By 1977 there were 67 different projects being funded, with plans to expand to include a wider range of psychosocial issues affecting consumers' attitudes (World Health Organization, 1977).

On this scale of research into family planning it is, in effect, whole nations or cultures which are being viewed as 'most at risk', rather than particular sections of the population of a single nation. There is some overlap, of course, suggesting the economic class and race distinctions often employed. In Britain, for example, there is a greater likelihood of Asian women being offered or given Depo-Provera injections (Rakusen, 1981). The testing of new methods of contraception, first marketed by US companies, such as the pill trials in Puerto Rico and Mexico and recently, the widespread use of Depo-Provera (still banned as unsafe in the US itself) reveals the racist practices in operation. Those considered to be most at risk of becoming pregnant are those at whom family planning programmes are principally directed, and they are those people considered by the policy makers and programme directors to be most in need of controlling the numbers of children they have.

Effectiveness, in terms of preventing large families, is clearly of greater importance to those concerned with population control than the health, welfare and autonomy of the women, primarily, whose bodies are affected. The recent emphasis upon acceptability factors has less to do with side effects and health risks, than with the need to ensure that consumers will in fact use the contraceptives made available to them. One approach to increasing acceptance of effective contraception is to promote methods which involve the least amount of consumer control. Both the IUD and Depo-Provera have been heralded for the 'advantage' that women have little control over them once inserted or injected (Roberts, 1979; Rakusen, 1981).

The maintenance of profit and privilege adds another dimension to population control programmes. The drug industry with its continual endeavors to increase profits and the competition between companies for controlling shares of the market, and the medical profession's determination to protect its clinical autonomy and authority, negate the likelihood of women's concerns achieving priority in decisions taken regarding the contraceptive methods and services which will be made available. These powerful bodies may in fact interfere with the goal of family planning programmes and with the cost-effectiveness of local programmes. For example, Cross and Arber (1977) found that the pre-eminent position of doctors can be a negative influence on the efficiency of clinics and the comfort of clients. Consumers' needs might more easily be met through a range of inexpensive contraceptive methods being made available through nursing or other local health workers.

The problem for population control organizations, as for family planning services everywhere, is to 'motivate' those identified as 'most at risk' to want to limit the number of children they have, to use the most effective

methods of contraception available, and thereby to achieve families of limited size. The aim is thus to direct people to conform to the standards deemed socially acceptable by the policy makers and programme directors nationally and internationally. These acceptable standards include: the desire for the optimum family size, the use of birth control methods regarded as adequate/effective and morally sound, attendance at the clinics provided and successful results.

Family planning

The significance of the term 'family planning' is its reference to the social and political context within which birth control methods are intended for use. Audrey Leathard (1980) points out that 'birth control' was the phrase first coined by Margaret Sanger in 1914 to emphasize the social and personal significance of contraception and its liberating possibilities for women; racial distinctions and eugenicist concerns were brought in by Marie Stopes' organization following World War I; by the mid 1930's the term became suspect with the depopulation scare in Britain and 'family planning' emerged to reassure the nation that contraception was to be limited to the spacing of births within families for the purpose of promoting healthy, wanted children. Population control is clearly a question of both quality and quantity.

The stability of the family as the basic unit of society has been a pervasive concern expressed in the arguments surrounding the political battles for contraception, abortion and sterilization to be made widely available. The provision of facilities or even information about birth control has often been resisted by policy makers on the grounds that the freedom from fear of pregnancy in women would lead to the disruption and destruction of family life. Historically the 'social grounds' for the right to contraception, abortion and sterilization services have had to

be fought for with reference to the effect of too many children upon the family unit. Overburdened and unwed mothers could be seen to threaten the stability of the family and evidence of increasing numbers of such women gained a sympathetic ear while arguments about women's rights did not. Not surprisingly, proponents of birth control have usually presented their case for legislation and service provision in terms of the health and welfare of the family unit (Hindell and Simms, 1971; Greenwood and Young, 1976; Gordon, 1977; Lewis, 1979).

Concern with the question of whether birth control leads to sexual permissiveness and moral degradation is directly related to the issue of the effect of birth control upon the family structure, particularly its constraints upon women. For example, arguments against the provision of contraception for the unmarried in the late 'sixties centred on the fear of increasing sexual immorality. These arguments were countered with evidence of increasing illegitimacy rates and abortion figures. The concern with the likely consequences upon family life began to illuminate the provision of contraception for the unmarried as a constructive and protective measure. Political bodies and the medical profession soon found contraception a much more attractive alternative (Leathard, 1980). Similarly, abortion provision gained more favour when set against the realities of a rising illegitimacy rate, and the family strain caused by repeated pregnancies amongst women weakened by poverty and overwork (Greenwood and Young, 1976). Sex education, too, has found approval largely in the face of teenage pregnancies and even so, the emphasis has been much more upon the morals of family life and the mechanics of reproduction than it has upon practical sexual matters such as contraception (Schofield, 1976; Farrell, 1978; Jackson, 1980). Fears of encouraging or condoning 'promiscuity' have largely been weighed against evidence of the occurrence of sex and reproduction outside of marital boundaries. The provision of birth control has come about predominantly on the basis: the lesser of two evils. The

phrase 'family planning' expresses this point of view.

Family planning is the form which population control takes. In the promotion of small families and the prevention of unwed motherhood, a reduction in the quantity of births is achieved while the family as the basic unit of social organization is maintained. The international emphasis upon family planning supports family based social orders whilst diffusing the differential ways in which population control may be applied to various racial, national and economic groups.

Medical monitors

The emergence of the medical profession was based upon the usurpation of the position of women as local healers throughout Europe over several centuries. The trials of the wise women, or witches as they came to be called, and their executions were extremely brutal. They were most widespread during the late fifteenth and the sixteenth centuries. Mary Daly (1978) has argued that the witchhunts constituted a massacre of women who were seen to be living outside the control of a patriarchal family; such women were regarded as a threat to male potency, as deviant and as evil. Their 'crimes' included healing, midwifery, the provision of contraceptives and the performance of abortions. The significance of this political development to the contemporary status of medicine has been pointed to by Barbara Ehrenreich and Deirdre English:

'The witch trials established the male physicial on a moral and intellectual plane vastly above the female healer. It placed him on the side of God and Law, a professional on par with lawyers and theologians, while it placed her on the side of darkness, evil and magic.' (1979, p.35)

The growth of 'scientific' medicine at first denied, and then incorporated the teachings of the wise women. Supported by the church, medicine rose in status, developed its own system of training and registration and became a professional body. It excluded women.

The history of the medical profession has revealed not so much the establishment of men's dominance in healing as a process of transferring control from women to men - from laywoman to male professional. The takeover of midwifery, however, was slower than in more general aspects of health care. Attendance to women in labour was considered by the new male medics to be dirty and polluting, as well as inferior to proper medical work. It was largely left to women to do, although control over midwives through a system of licencing was first introduced in 1512. The man-midwife, overwhelmingly a medical initiative, was evident from the seventeenth century. He aided the ascendancy of the male medic in this field through the exaggeration of the dangers of childbirth, denigration of the competence of the midwives, magnification of the capabilities of the male attendants and development of surgical intervention in childbirth as their specialty. Men-midwives were paid a higher rate for the same work, and increasingly they gained hold of the better paid aspects of the work. Although obstetrics was not perceived to be an appropriate field for the medical profession until the nineteenth century, the predecessor of the modern male obstetrician was the man-midwife (Oakley, 1976; Donnison, 1977; Versluysen, 1981).

An active policy of surgical intervention with women's sexual and reproductive organs was characteristic of gynecology, as well as obstetrics, as a developing medical specialty. Disgust and hostility towards women and their genitals is clearly expressed in the medical literature of the nineteenth and early twentieth centuries. J. Marion Sims, inventor of the Sims speculum and known as 'the father of gynecology', wrote of his distaste and reluctance to treat women until realizing the possibilities of acquiring notability amongst his medical colleagues for the exploration and surgical manipulation of the vagina. Repeated and painful operations upon black women slaves brought him triumph for his 'devotion to medical science'. Other important aspects of gynecological medicine in this period

included surgical cures for masturbation and sexual appetite in women through clitoridectomy and female circumcision. In the light of such a history, and with a critical eye towards women's health care in recent years, women have begun to recognize the widespread employment of hysterectomies, mastectomies and obstetrical episiotomies as part of this history of sexually aggressive medical procedures (Barker-Benfield, 1976; Ruzek, 1978; Scully, 1980).

Until the 1960's doctors in Britain rejected contraception as a medical matter. The avoidance of pregnancy was not considered to be an appropriate goal for a married woman and therefore not a problem, while a single woman who engaged in sexual activity was not seen to be deserving of medical assistance. As a social matter of which they generally disapproved, medics were reluctant to become involved in the provision of contraceptives. The Family Planning Association took the lead in the provision of contraceptive services and the publicity of the need for such provision, for married women since the 'thirties.. Staffed almost entirely by women - lay workers, nurses and doctors - 336 clinics were operational in 1960, showing a 50% increase in demand over the previous five years. Helen Brook broke away from the Association to provide similar assistance to unmarried women, at first secretly, and eventually opened the first Brook Advisory Centre in 1964. (Leathard, 1980). Changing sexual morality, an increasing illegitimacy rate, increasing demand for abortions and the marketing of the contraceptive pill and IUD during the 'sixties, forced the medical profession to reconsider its position.

Increasing medical involvement in contraceptive services enabled the monitoring of the new contraceptives and their availability to women to be brought into the control of the male dominant medical profession. The potential dangers of the use of a hormone drug or intrauterine body legitimated medical involvement but the social grounds for choice about

pregnancy and childbearing raised the issue of whether contraception should be provided as a medical service on the NHS. Medics, trained to treat the sick, had difficulty justifying treatment of healthy women, appearing to condone the sexual and reproductive choice contraception brought to women, and doing so on the National Health Service. In addition, the arguments focused upon how medics were to be remunerated for the provision of contraception to their female patients. A system of fees was established in 1964 for the distribution of contraceptive pills and fitting contraceptive appliances and IUDs by medical practitioners on non-medical grounds. In 1964 a meeting of the FPA decided to support medical involvement as the direction of expanding availability of contraception and of respectability as a professional organization. The woman-centred approach of the organization was feared to be out-of-date and parochial. The process is reminiscent of earlier centuries and the transference from women-centred health care to male-dominant medical professionalization. Elizabeth Mitchell, Family Planning Association reporter, described the changeover as a 'graceful and calm act of suicide...we fell on our swords in the Roman manner' (quoted in Leathard, 1980, p.121).

Having had little to do with the development of new methods of contraception, historically having opposed the widespread provision of birth control or information about birth control to women, the medical profession in recent years has increasingly placed itself in a position of control over reproductive technology (Doyal, 1979). As monitors of abortion, sterilization and the most reliable forms of contraception, the exercising of moral judgments through the system of granting or withholding services or prescriptions has become a medical privilege. Reluctant to be demoted in status to technical providers of medical skills and services, doctors have vigorously claimed that such moral judgments belong within the scope of their clinical autonomy and professional authority (Macintyre, 1973; Simms, 1974). The debate which has continued to

rage over whether abortion should be provided to a woman upon 'demand' or 'request' to her doctor has revealed both the nature of this medical claim of 'privileged access' to morality and the consequences it holds for women. The retention of control over access to facilities, the monopolization of knowledge, and the 'right' to exercise moral judgments over women has rendered women vulnerable to and dependent upon medical favour, irregardless of their current state of health.

The expansion of doctors' involvement in contraception was not based upon their competence in this area. Ann Cartwright's study (1970) revealed that although women looked to their doctors as experts on contraception, few had received training in the provision of birth control services. Indeed, it was one of the major concerns of the Family Planning Association that educational courses for doctors be provided, once the medical profession had secured the responsibility for family planning provision. Nor were doctors equipped for the counselling role required of them for the provision of contraceptive services. Jean Aitken-Swan has noted that this role was alien to the doctors she interviewed. Despite the importance to the woman who seeks contraceptives, as perhaps to other patients, of assistance which may help her to clarify what she wants while choices are presented, judgment withheld, and her decision supported, Aitken-Swan's survey indicated: 'many doctors have no idea how to play this receptive and constructive role, but assume that their advice is what is wanted' (1977. p. 212).

The 1967 National Health Service (Family Planning) Act, appearing as the lesser of two evils, went through parliament relatively easily in the wake of the controversy surrounding the Abortion Act of 1967. Audrey Leathard (1980) has pointed out that although this extended services to include the provision of contraception on social, as well, as medical grounds, and without restrictions of age and marital status, it was a permissive rather than mandatory measure. Local authorities were thus able to provide themselves, or through the Family Planning Association, contraceptive

advice and services; however, it was not required. The result was much regional variation. Nor was it provided as a free service. The provision of a free service eventually came about in 1974 when the increasing illegitimacy rate, high demand for abortions and concern with overpopulation, particularly amongst the poor, young and unmarried, appeared the greater evil.

State support for the role of the medical profession in the monitoring of these expanded services thus provided for social control as well as population control, moral supervision as well as medical assistance. Doctors' reactions to their increasing responsibility throughout this change was not always favourable. Aitken-Swan's research indicated that doctors did not always welcome the extra burden to their workload, some found the procedures distasteful, others disliked the controversy and criticism it attracted to the profession. Yet, she observed, 'doctors are not noticeably willing to give up any of their powers in this field or to share its burdens with any other group' (1977, p.210). Attempts to demedicalize contraception and abortion have met resistance on grounds of the dangers to women's health. At the same time, efforts to expand birth control services have been resisted by medics for being a social and perhaps, immoral issue rather than a medical priority. The social and moral influence wielded through the monopolization of contraceptive service provision has enabled the medical profession to monitor the lives of the healthy as well as the sick.

Women's liberation or coercion?

The question of liberation or coercion must take into account the historical development of women's struggles to control their fertility within the context of population control; the development, testing and marketing of contraceptive methods, the dominance of the medical profession in monitoring the most reliable methods; the legal provision or denial of

a range of birth control methods and services; the changing role and position of the church in relation to sexuality, reproduction and contraception; the structural organization of the family and its relation to sexuality and family planning. It is of course impossible to discuss all of these aspects in detail here. I shall focus, therefore, upon a few key issues which have arisen out of the previous discussion, and which have guided the present study.

The assumption of the adequacy and effectiveness of existing contraceptive methods, and their widespread availability, has given rise to a view of liberation for women. The current possibility for women to choose if and when to have children is said to have provided for sexual equality and sexual liberation. The existence of modern contraceptive technology, argues Derek Gill, has given women 'the same freedom of choice with respect to pre- and extra-marital intercourse that was formerly reserved for men under the double standard of sexual morality' (1977, p.198). Further, the separation of sex and reproduction achieved by such technology has meant there is no longer the need for women 'to concern themselves with the possibility of conception and the fears which the relationship between sex and reproduction previously engendered' (Ibid., p.189) As the joys of sex cease to be burdened by the possibility of pregnancy, sexual relations become of a different order.

On the basis of such an assumption, similar confusions arise with regard to sexuality as they do in relation to contraception. If contraceptive methods are taken to be adequate/effective, then an unintended pregnancy or inappropriate use of contraception is anomalous. It thus appears to have arisen because of some inadequacy in the user. If sexual relations have become free and equal, and separated from the possibility of pregnancy, then any concern of women to the contrary also appears to result from the inadequacy of the individual involved. Thus, not only is she portrayed to be inept in her use of contraception, but it seems that she is not very

sorted out about sex and its liberating potential either.

Clearly, whether or not contraceptive methods are adequate to the women who use them must be subject itself to investigation. Similarly, the nature of sexual relations in the context of current contraceptive technology is one which needs to be explored empirically. The analysis of the relationship between sexuality and contraception cannot be assumed on the basis of contraceptive technological development. A sociological analysis must be able to account for women's experiences and it must be based within a theory which allows for a social explanation of sexuality, of liberation and of coercion. This has been a central concern in the search for a theoretical perspective, the gathering of empirical evidence and the analysis of data in the present study.

It could perhaps be argued that contraception today is liberating for some women, whilst it is less so for others. It is tempting to lean towards this view on the basis of evidence that it is poor women and young women who are 'most at risk' in Britain at least; other women, by implication, are more 'free and equal'. Yet, all women engaging in heterosexual intercourse are at risk of pregnancy unless they are known to be infertile. since even with the most careful attention, there is no 100% reliable method of contraception. The possibility of pregnancy occurring, even where the chances are statistically reduced, negates the case made for sexual liberation based on contraceptive technology, for all women.

Arguments regarding the coercive nature of contraception are generally based within criticisms of population control programmes. The racial orientation or effect, particularly, of these programmes is noted. Discrimination in the application of contraception, abortion and sterilization measures amongst women of differing racial groups reveals the selective practices of family planning provision (Cade, 1970; Ruzek, 1978; Rakusen, 1981). Discrimination in birth control services can also be seen to be

based upon economic class and marital status (Macintyre, 1976; Aitken-Swan, 1977; Roberts, 1979). Population programmes clearly distinguish who it is who should be having more or fewer children, the family structure within which children should be born and outside of which they should not be born, and the socially acceptable methods by which fertility may be achieved or denied. Within Britain, the 'imbalance' in the quality more than the quantity of the population has been lamented from the Report of the Royal Commission on Population in 1949 to the provision for family planning programmes with the National Health Service, instituted by Sir Keith Joseph under 1973 legislation.

It is within this context that women are able or unable to control their own fertility. The social relations which surround contraceptive technology and direct the provisions made available, to whom and on what basis, determine whether contraception itself is liberating or coercive to the women who use it. To elaborate the social context of contraception as one which constrains women's behaviour because of the limited choices made available to them through social policies and practices, is not to deny women's efforts to protect themselves and affect social change. Rather, it is to locate women's experiences and their struggles within the structure of social relations which surround them, and thus to explain them.

The relationship between women's contraceptive experiences and the social relations in which they take place has been little explored to date, either empirically or theoretically. The importance of such an approach lies in its ability to perceive women's contraceptive concerns, capacities and problems as socially and politically derived, rather than as the result of individual/couple/group inadequacies. The position of women in society is central to this perspective; the search for a theoretical framework which allows visibility of the social relations between women and men, and the potential for explanation, has been as crucial to the current study as has been the gathering of empirical data. It is to these aspects of the research that I now turn.

Approaching the study

The methodology employed in this study to explore women's experiences with contraception was derived from the theoretical concerns discussed in the previous chapter. Because the project of the research was primarily to explain the processes involved in contraceptive decision-making and action-taking by locating them in the context of women's position in society, rather than to measure and predict which contraceptives are used by a particular sample of the population, the empirical study was seen to involve a more qualitative than quantitative focus.

The socio-demographic surveys have raised many interesting issues and prompted questions which guide further research. However, in themselves they are more useful in measuring the existence of a particular phenomenon in a population, than in providing an explanation for its occurrence or revealing the context of social relationships which provide for its likelihood. The inappropriateness of the survey method to research with an explanatory focus is discussed in detail by other authors (Kitsuse and Cicourel 1963; Cicourel 1964, 1974; Hawthorne 1968, 1970; Busfield and Padden 1977). The necessity to develop methods which do not isolate individuals from the social structure in which their perceptions and actions occur, has recently been stressed in reference to research which explores the experiences of women (Davies and Roche, 1980; Graham, 1982). The importance of an approach which allows and encourages respondents to elaborate upon their understandings of their situation has been argued to be particularly essential in the reassessment of taken-for-granted views of women which have traditionally shown a male bias (Millman and Kanter 1975;

Oakley, 1974; Spender, 1981; Roberts, 1981). Such considerations directed the present study towards an alternative approach to the survey method, one which would be more able to explore the social processes involved in contraceptive use and which would situate the individual woman's experiences in the structure of social relations in which they occur. (See p. 35 for details of the sample.)

The decision to interview women, rather than couples, was taken for several reasons. First, as it is women who become pregnant and who are at risk of pregnancy when they engage in heterosexual intercourse, women have a more immediate biological relation to contraception than do men. Second, and perhaps more importantly, the responsibility for childcare falls primarily upon women in our society, and therefore, women have a different relation to the consequences of contraceptive use than men. Third, the social dominance of men makes it more likely that women and men may have different concerns regarding contraception, but that in a joint interview, it would be the male view which is projected authoritatively as the joint view. Fourth, this latter process may be so prevalent that it exists even when the male is not present, hence, the importance of detailed discussions with women to explore their experiences, as a way of getting beyond what they might feel it is expected of them to express. Fifth, it is the woman who must attend family planning services for examination and interview, in order to obtain the most reliable forms of contraception, and sixth, it is the woman's health which may be at risk by their use. These asymmetries between the situation of men and women in relation to contraception meant that it was considered to be a priority to explore and make visible the woman's point of view.

Research design

A small scale qualitative study was designed to explore women's decisions and actions regarding their use of various methods of contraception. In-depth interviews with a sample of fifty women was decided upon in view of the time and finances available for the research, and the detail considered necessary for a relatively comprehensive coverage of the subject. This design was selected to provide an indication of some of the important factors affecting women's contraceptive practice and the possible relationships between them, rather than to be representative of all women. Hypotheses arising out of the study would require wider testing before generalizations could be accepted for all women, or even sections of women in the population.

Topic oriented interviews were considered most useful in exploring the important factors and processes involved in the women's contraceptive practices. Topics were chosen on the basis of previous findings in studies of contraceptive behaviour and indications in the literature on women's position in society likely to be relevant to the present study. The open-ended type of questioning used along with the topic oriented focus allowed for the precise hypotheses to alter according to the data obtained. In analysing the interviews, this approach was found to be most helpful in supporting the construction and reconstruction of hypotheses, in virtue of the range, depth and clarity of the responses obtained in this way.

At the same time it was decided to structure the interviews to the extent that they could be compared with each other, and to some extent to previous studies, notably the social surveys, relating to contraception. Similar topics were covered and several pre-coded

questions were included to act as a guide for comparison. The respondents were encouraged to expand on their answers where possible to allow for some explanation of their responses, and to seek out variations in meanings attached to these responses, while the form of these questions suggested possible aggregation across all cases. This combination of open-ended and closed questions was used to enhance the quality of responses obtained - using both forms of questioning in a compatible format, rather than assuming them to be mutually exclusive methods of obtaining data. The intention was to allow for flexibility and range of responses while ensuring some basis for comparison across all cases. Such an approach arose from the conceptual framework being used regarding women's position in society, where the project of contraception and consequences of sexual activity are considered to be similar in many ways to all women, while the situations, possibilities and meanings associated with such a project may vary with individual women.

The interviews

As a guide to the interviews, a series of questions were set out in questionnaire form, thus ensuring that all topics were covered in each interview. The pre-coded closed questions were asked in the same way of all respondents, while the open-ended questions were considered to act as prompts which could change according to the respondent's answers. If, for example, a respondent brought up a point that was part of a topic planned for later in the interview, it was discussed when she mentioned it. If the respondent answered a question in a simple yes/no fashion, it was reworded or returned to at a later stage in the interview, to explore the topic more thoroughly;

if she seemed not to understand the question, or said that she did not, it was repeated in another way. If she seemed embarrassed or uneasy, the question was asked differently, or left and returned to via another topic in the interview. Thus, the interviews were set up to provide for a maximum of flexibility and exploration of topics, by allowing for sensitivity to the reactions of respondents and for variations in responses.

The advantage of conducting all the interviews oneself, as with this research, is the possibility of maintaining both flexibility and a similarity between interviews which ensures comparability. This consideration and those described above, were felt to be particularly important to this study, where the data is obtainable only through interview. The privatised nature of contraceptive attitudes, decisions, experiences and actions, and of sexuality which provides its context, is of course prohibitive to the consideration of other methods of investigation available for research into other topics, such as participant observation. The importance of maximizing the quality of responses from interviews is, therefore, highly significant in topics such as sexuality and contraception.

The interviews explored the processes of taking contraceptive decisions and actions, for each woman, over the period of time since she began using contraception and/or began to engage in sexual intercourse with men. In this way, a woman's present actions could be seen in context of her past experiences, and her changing ideas and/or living situations. Because any woman may be concerned with contraception over a period up to 25 - 35 years, it would have been impractical to follow individuals over such a span of time. It was

decided instead to interview each woman only once, but to include past experiences through a discussion of her history of contraception, changing ideas and circumstances.

This decision raised the question of the accuracy of memory, especially as in most cases this meant recalling experiences over a number of years. This problem was a further consideration in the decision to use an open-ended form of questioning. With this method of interviewing it was hoped to be able to limit the unreliability which may arise from such recall by encouraging the respondent, via several different topics, to get back into thinking of an earlier period, and thereby to remember the situations and factors important to her at the time that particular actions were taken. Because various different topics were explored through recall (including for example, parental attitudes, sex education, previous relationships, experiences with contraception, etc.) the accuracy of an individual woman's recall could, to some extent, be checked.

The problem of accurate recall was considered in the end to be relatively minor, for whether or not recall of past experiences are precise in terms of what actually happened at any particular point in a woman's contraceptive history, the decisions and actions which are taken in the present are most likely based on those attitudes and experiences which are remembered. That is to say, the attitudes and views of past experiences which women can recall and relate in the interviews are likely to be those with which they are dealing in taking their present decisions and actions. Therefore, to explain present actions regarding contraception, it was considered adequate

to situate them in a context of recalled past experiences, rather than needing to recapture what actually happened, or what was considered to be happening at each point in time.

Each woman was interviewed only once because of the possible influence of the interviewing process itself. By the nature of the extent and focus of the interviews regarding the factors considered possibly relevant to the woman's contraceptive behaviour, individual women may have begun to think about their contraceptive actions in ways they had not done previously. Therefore, the data collected from subsequent interviews might have been biased by the first interview.

The form of the interview itself was designed to obtain comprehensive and accurate responses as far as possible. This goal was expected to be difficult at times to achieve due to the content matter, therefore, one to be kept in mind at all times. The respondents were initially asked to help me with my research and I briefly explained what the study was about. For the interviews I dressed casually in common university attire, and most respondents were dressed similarly. Given the fact that I, like they, am a graduate student, there seemed to be a sense of likeness between us, and the request for their help with my research generally met with a sense of understanding since many were involved in research projects of their own. During the interview, leads given out by the respondent were followed up, attempting to keep the conversation as relevant and sensitive to her as possible. The ordering of the questions was designed to follow easily in sequence,-- being altered to follow the respondent's train of thought as appropriate. Questions directly relating to sexuality were placed toward the end of the interview such that if the respondent took offence or became uneasy, the rest of the interview would not be jeopardized. It was explained to each respondent at

the beginning of the interview that she might find some of the questions difficult to answer or too personal, and should she find this to feel free to say that she would rather not answer these questions. It was hoped that by the time the respondent had discussed a number of different topics fairly thoroughly and been able to express her ideas and attitudes on other matters, that she would not mind answering a few questions about her sexuality. As it worked out, no one refused to answer any questions, although some of course, answered in greater detail than others. As one respondent remarked after the interview: 'It's no more personal than someone asking me in great detail about what I eat.'

Because of the need to be sensitive to the cues given out by respondents both verbally and non-verbally, it was impossible to be attempting to write down verbatim what they were saying at the same time. A tape recorder was therefore used, despite an initial apprehension that this might make the respondents uneasy. It was thought that the extra sensitivity required to guide the interviews and promote the best coverage of topics would outweigh the disadvantages of using a tape recorder.

The interviews were designed to last 1½-2 hours and this was explained to women in the initial letter so that they would allow enough time for the completion of the interview. This was a cause of concern to many of the women before the interview and they remarked to the effect that they could not imagine what they would talk to me about for so long. In fact most of the interviews lasted approximately 2 hours with several reaching nearly 3 hours where the respondent was interested in discussing topics at length.

All of the interviews were held in an office in the Sociology Department except where respondents stated a preference for being interviewed at home. In total only 5 interviews were conducted at home. The decision to use an office was one of convenience for me and for the respondents who were then able to drop by or ring up any time during the day to arrange an interview time or to decline to participate in the study. As all the respondents were engaged in full-time university courses it was assumed that they would frequent the university regularly; some however, by their own research, spent long periods away from the university, but this was a minority of the sample. On reflection I felt that the interviews which took place at the respondents' homes were more likely to be the most comfortable for the respondent; this was probably due to the fact that the relation between us was more equal when the respondent was on her own home ground. This was little more than an initial impression, but one which was strong enough to cause me to reconsider the best place for such an interview in future research, although an alternative would always be required for those whom it does not suit.

Before any of the interviews were actually carried out, the questionnaire was circulated amongst colleagues for criticism and clarification. It was then revised and a pilot study conducted with five women volunteers. As the topics to be covered were clarified and selected through previous informal discussions with women, involvement in several women's self-help health groups and a study of the literature relating to fertility control, the pilot study was carried out primarily to test the adequacy of the questionnaire in covering the selected topics and to increase my own skills in interviewing. As a result of the pilot study some questions were

reworded or placed differently in the interview schedule, a few additional questions were included and the need to tape record the interviews was established.

The sample

The sample of 50 women was drawn randomly from a university register of women students engaged in full-time graduate courses at the University of Warwick in the Summer Term, 1977. Those who had not been resident in Britain for at least 3 out of the previous 5 years and those who had not engaged in sex with men for at least six months prior to the interview request, were subsequently excluded from the sample.

One reason for selecting graduate students was to control for social position. Because it was considered important to include women across marital boundaries, it was not possible to classify women by husband's occupation. Classification according to father's occupation would have been difficult since at the time of interview many of the women's fathers were retired or deceased; a retrospective criterion would not have been accurate because of the extended age range of the women in the study and because it would have failed to account for the women's present social position. Further, as the study was designed to explore women's actions in context of the alternatives available to them it appeared more accurate to regard women's alternatives in terms of their own social position, rather than assuming all women who are married to, or are the daughters of men in various occupations to have the same alternatives or to be in the same social position.

A second reason for the sample selection was in choosing to interview women engaged in a full-time course of education, a control for motivation to avoid pregnancy would be included, assuming that all the women would be so motivated at least insofar as it would enable them to complete their studies. At the same time, this sample would be comprised of women who made regular use of libraries, thereby being used to finding information perhaps less readily available to most women. Finally, graduate students were selected rather than undergraduates because of the likely increase in their social position on completion of their courses, and increased alternative prospects to motherhood; further, this age group was more likely to have had experience with contraception for a greater length of time.

Thus, in selecting a random sample of women graduate students, the sample was deliberately highly selective for motivation, access to knowledge, alternative career possibilities and experience with contraception. At the same time it allowed for a range of marital and living arrangements, commitments to children, and age. The purpose of such a selection was to highlight the problems which face women in taking decisions and actions regarding contraception. By virtue of the fact that these women have better access to facilities, knowledge and alternatives than is true for the majority of women, we can extrapolate that the conditions which face women in lower social positions is likely to increase the contraceptive difficulties they encounter, considering their more limited access to facilities and alternatives. Thus, although some of the problems might be seen to vary with different social positions, the difficulties which are confronted by women in a relatively good social position highlights the problems in contracepting likely to affect all women.

To ensure consistency in the sample, only full-time students were interviewed. Further only those women who had resided in Britain for at least 3 out of the 5 previous years were included to control for experience with British contraceptive services. Finally, those women who had not had sex with a man in the preceding six months were not interviewed; it was intended to also exclude those women who were past their menopause, but in fact there were no such women in the sample.

Because of the sample selection from full-time women graduate students, the sample tended to be biased towards the selection of women with no children, or few children. This might be due to the fact that women with more children are less likely to have time to engage in full-time education - at least until their children are at school, and to the limited day-care facilities provided by the university. Also the age range was 23 to 38 years of age with an average age of 26-27 years, which might be explained by a range of factors including the more limited career opportunities for older women, a relatively long gap since their previous full-time education and/or the admissions policy and practices of the university.

The sample was selected from a university register of full-time graduate women students. As the total population was 87, the sample was selected by choosing every second name on the list plus every seventh as yet unchosen name, such that 50 names were initially selected. Since every woman had an equal chance of being selected by this method, the selection comprised a random sample of the population.

4

The women selected for the sample were sent "Letter A" via their department pigeonholes. Those who did not respond within two weeks were sent "Letter B" to their home address, along with a copy of "Letter A". Those who did not reply in a further two weeks were contacted by telephone, visited at their homes, or at the university wherever possible; where this was not possible they were sent a further personal letter requesting a response. In total only 2 of the non-respondents were not eventually reached in person or by phone. Because a check on their department pigeonholes revealed that their letters had been picked up, they were assumed to be refusals.

Each time a refusal was received, another name was selected for the sample by choosing the name listed directly after the name of the woman who had refused, on the register. The same process of contact occurred and this was repeated until a final sample of 50 women had been interviewed.

In total 22 refusals were received, out of 72 women contacted, who were eligible to be interviewed. This is a refusal rate of 30.6%, which is quite high. This rate can possibly be explained by both the content of the interviews and their length. Both were clearly specified in the initial contact letter because of the extent to which contraception was to be discussed, and the need for respondents to allow enough time for the completion of the interview (2 hours). Further, the refusal rate may have been influenced by the necessity of contacting the sample by letter, for most students did not have an office or location in the university where they could easily be found; the impersonal nature of the contact may have

tended to produce either no response or a simple refusal by letter. In addition, because the women were contacted in the Summer Term, those who were to finish their courses in September were likely to be working under pressure of time to complete their work.

It is unlikely that the refusals were those women who might have indicated different attitudes and behaviour than the women who were interviewed. As far as pressure of work was the important factor in refusal to participate, this is unlikely to be significantly related to contraceptive behaviour. It was, of course, sometimes difficult to know whether a refusal response of 'no time' was genuinely because of work, or as one woman put it: 'I've no time for that sort of thing.' The question of the content of the interview being personal, and therefore not a subject they wished to discuss with a researcher, was a consideration facing all the women contacted; many expressed some anxiety about what would be discussed for 2 hours. Those who openly expressed these concerns to me gave me the opportunity to explain in more detail the purposes and topics covered in the interview (briefly), and were perhaps reassured, considering that most of these women then agreed to participate. Others probably felt similarly, but simply refused to participate rather than to discuss the matter further with me. Again this difference was unlikely significant to patterns of contraception; that women did not wish to discuss their contraception with a researcher does not necessarily indicate they would not discuss it with friends, doctors, partners, etc. One factor which might have indicated a different attitude to contraception, but it would be difficult to tell if and how it might affect it, was the woman's partner's attitude to the interview.

It is difficult to know how many refusals may have resulted from the partner's anxieties rather than the woman's. That it had some influence on refusals was indicated, for example, by one woman who explained: 'I would have done it, but I thought it only fair that I should discuss it with my husband - and, well, we think it's too personal.' On the other hand the partners of women who did participate were likely to experience some anxiety, as indicated by a few men who revealed to me that I had interviewed their partners, joked about the depth of the interview and probed for more information on 'what exactly had I been asking.' In these cases the men's anxieties did not seem to be a sufficient reason to the women for refusing to participate. Whether this difference in the women's attitudes also reflected differences in contraceptive behaviour was impossible to identify on the basis of this study, except to say that the result would likely err on the side of even greater difficulties for women, than were identified on the question of partners influence from those women who were interviewed.

Confidentiality was stressed throughout the stage of data collection. This was considered particularly important for this sample since being engaged in university courses, these women might easily be recognized by other students and staff at the university who might hear about and/or read the data analysis. It is for this reason that great care has been taken in presentation of the data not to present details of particular case histories in any depth, to disguise names and to take care in presenting aspects of the data which might serve to identify the woman involved. "Letter C" was given to each respondent after the interview to assure her that care would be taken to ensure her anonymity and the confidentiality of the information she imparted during the interview. Jennifer Platt (1981) raises the issue of confidentiality in interviewing one's peers. As

Table 1. Derivation of Sample

Total register of women graduate students attending full-time = 87
Total number of women contacted for sample = 80
Number of those contacted who proved to be ineligible for sample = 8

Reasons for ineligibility:

Error of list = 2
Out of Britain more than 2 of past 5 years = 1
No sex with men in previous 6 months = 5

Number of eligible women contacted for sample = 72 (100 %)
Number of women who refused to participate = 22 (30.6 %)

Reasons given for refusal:

No time = 10
Too personal = 3
No reason given = 4
No reply = 2
Appointments arranged but not kept
(two or more) = 3

Number of women who agreed to participate and were interviewed
= 50 (69.4 %)

with this study, the likelihood of recognition, highlights the importance of protecting the confidentiality of respondents in all sociological research.

Characteristics of the sample

The range of the women's ages were between 23 and 38 years. The proportions of women in each age group was as follows: 20 - 24 (44%); 25 - 29 (44%); 30 - 34 (4%); 35 - 39 (8%). The average age was 26 -27 years.

The number of years that women were 'at risk' of pregnancy was calculated from the time of first sexual intercourse to the time of interview. The length of time was divided into three year periods and the proportion of women in each category was as follows: under 3 years (14%); 3 - 6 (38%); 6 - 9 (32%); 9 - 12 (6%); over 12 years (10%).

The experience of the women with the range of contraceptive methods; age of first sexual intercourse; contraceptive methods ever used, last used, currently in use, and the likelihood of future use; experience with contraceptive services; perceptions of the advantages and disadvantages of different birth control methods are detailed in chapter five.

Twenty-four percent of the women were married and living with their husband at the time of interview. Married and unmarried, 48% of women were living with a sexual partner. A total of 78% of the women in the sample stated the frequency of sexual relations to be regular (at least once per week); the remaining 22% experienced either occasional sexual intercourse (1 - 2 times per month) or periods of regular sexual relations at less frequent intervals.

Only three women (6% of the sample) were living with their own children; each of these women had two children. One other woman was pregnant at the time of interview with her first child. Several other women were living in houses with other children, taking on varying degrees of the childcare responsibilities.

The total number of pregnancies which had occurred amongst the women was 20; 14 of these pregnancies were unplanned. Of the unplanned pregnancies, one resulted in a live birth, two miscarriages occurred and eleven were terminated by abortions. Five of the unplanned pregnancies were reported to happen in conjunction with the use of no contraceptive method (including one pregnancy which resulted from a violent sexual attack), nine pregnancies were said to have occurred while some method of contraception was being used: two in conjunction with use of withdrawal, two with the sheath, one with a combination of the sheath and the safe period, one with the safe period, one with the pill, one with the coil, and one with spermicidal pessaries.

As indicated earlier, the sample was selected by the women's educational level to control for social position. Attempts to situate the women's current status in context of the occupational class of their family of origin proved to be unhelpful. The range of the women's ages, marital status, age of their fathers (many of whom were now retired or deceased) and their own transitional status as students made it difficult to select a single criterion which could be used as a consistent measure. The problem encountered here highlights the questionability of the general use of the measure of a woman's husband's or father's occupation in determining the social class of women themselves, a problem recently identified in doing feminist research (see, for example, Roberts, 1981b). One criterion which did appear as highly relevant to the women's current educational status, but which could be little more than 'suggested' by the

extent of the data collected, was whether another woman in the family had achieved a relatively high level of educational attainment or a consistent pattern of employment. Mothers, elder sisters and sometimes, aunts seemed to be significant others to women in their decisions about education and career possibilities.

The position of women .

Sexual relationships and contraceptive practices cannot be understood without reference to the position of women in society. The attempt to locate women's contraceptive concerns as social and political requires a theoretical framework which provides for, or at least does not preclude visibility of social relations. It is therefore necessary to distinguish between biological and social derivation and equally, to recognize the social construction of what is taken to be biologically natural.

In addition, the position of women cannot be perceived theoretically in isolation from the position of men. It is the social relations between women and men which provide for the relative position of each group. Thus, for example, if we speak of discrimination against women, we are at the same time speaking of discrimination in favour of men. In describing or explaining the position of either social group, we are recognizing, explicitly or implicitly, the difference between them and the relativity of their social positions.

While there may be said to be many social divisions in our society, sexual division is undoubtedly a central one. Feminist critiques in recent years have revealed both the male bias which pervades existing social and political theories and the urgency to develop feminist perspectives and theory. To explore the social relations between men and women is not to deny the existence of other divisions; rather it is to recognize the predominance of sexual division, notwithstanding other important social divisions. Whilst a theory which is able to incorporate all such divisions is yet to be developed, the social relations between men and women will clearly affect it and feminist theorizing will need to be more than

appendaged to it.

The dominance of men

In a social order which celebrates heterosexuality and family life, embedding women within marriage and maternity, it has been difficult enough to recognize that women's 'natural' realm is a social construction. Explaining it becomes more problematic, for the social theories which do not render women's position invisible, either deny it or trivialize it. Explaining the problem of explaining, Dorothy Smith (1978) points to 'a peculiar eclipsing': women's experiences are denied because they are excluded from the manufacture of culture. Positions of dominance being occupied by men has meant that systems of thought are produced or controlled by men. The information which we have about women's experience is, thereby, from the point of view of men.

It is not simply that men have a one-sided view of the world, which becomes consequential for women. More problematic, argues Smith, is that by virtue of their authority as members of the social category of men, what they say counts. Women thus learn to perceive themselves from the perspective of the dominant group even though, as Dale Spender (1980) points out, this does not accord with the reality of women's lives. The dominance of men, she suggests, mutes women, denies their experience, subjects them to the tunnel vision of men, affirms the superiority of the male perspective and so reaffirms the dominance of men.

In the field of family planning, Helen Roberts (1981) maintains, there exists a male hegemony which ensures that it is men who control reproduction, and women who are made to fit into male-defined categories. Male domination in the church and the state, the medical profession, research institutes and drug companies allows men, on an individual as well as institutional level,

to impose their perspective of women on women.

Patriarchy and male domination are terms coined by feminists to express this authoritative position of men, relative to women, in our social order. The consequences of the structures, institutions and perspectives which support and protect men's interests in controlling women's behaviour is frequently referred to as the oppression of women. These phrases are general terms which have derived from the growing political awareness of the women's liberation movement and its experience of political struggles in recent years. Although attempts to limit their use have co-existed in opposition to feminism, feminists have insisted upon their political significance to our understanding of the social relations between men and women. It would indeed be foolhardy, and arrogant, to assume that the expressions which have arisen in the theory and practice of feminist struggle can, or should, be muted. I therefore use the terms interchangeably, in general reference to the male-dominant/female-subordinate relations which characterize our social order, in the spirit in which they were named.

Heterosexuality and the family

Having sex and having children are the two activities which are most frequently taken to necessitate social relations between men and women. The biological is assumed to give rise to the social. Yet, what is seen to be biological is itself a social construction. It is therefore necessary to explore theoretically why it is that having sex and having children are equated with heterosexuality and the family.

Heterosexuality, couples and parenthood tend to be viewed as natural and further, as a form of natural progression. In our own experience it seems obvious that one thing leads to another. Concepts such as the complementarity of men and women, and the mutual interest they have in

rearing their children, are generally used without question. The concepts are rarely defined, or seen to be in need of definition. Nevertheless, they are often used in different ways. At times, naturalness is taken to denote biological instincts and drives; other times, the need for social order is assumed to determine what is natural. In both cases, what is regarded to be instinctual, or to reflect consensus, is itself the product of social relations and social theory.

Sociology, despite its project of providing social explanations, can be seen to be no exception in taking for granted assumptions of the naturalness of heterosexuality and the family. The traditional theoretical approaches do not question the social nature of heterosexual relations, or consider that an explanation is required. However, these assumptions are incorporated into their perspectives on society. Relations between men and women are therefore implicit within sociological theory, but the nature of these relations are taken to be, in effect, pre-social.

The problem involves more than the need to make implicit assumptions explicit for what we find is that what is assumed to be natural varies within and between theories, providing for contradiction as well as confusion. It is thus essential to examine the assumptions to discover what they are, how they inform the theory, and the extent to they support or contradict the theoretical approach employed. In addition, it must be recognized that the social theories passed down to us by 'the fathers of sociology' were developed within a patriarchal context, and we therefore need to be critical of the ways in which they may be seen to protect male-dominant/female-subordinate social relations.

It is not possible in this context to all of these theories in depth. I will therefore examine three theoretical approaches which have been of great influence in sociological investigations and theorizing, and compare

them. Biological (or sociobiological) theory, functionalist theory and marxist theory have informed contemporary sociology in their differing approaches and opposing standpoints. Yet, all three assume heterosexuality and the family to be natural. In discussing their similarities and differences I focus upon the fundamental assumptions which inform the viewpoint of each, and concentrate upon two questions: first, how does each perspective describe the relations between men and women? and second, how adequately does each theory explain why these relations occur and are maintained?

Biological theory

All social behaviour, according to this approach, is derived ultimately from biology. The biological goal which is deemed to be the most important determining force affecting each and every man and woman - and the social relations between them - is the reproduction of young. It is success in producing offspring, rather than physical characteristics of size or strength, which distinguishes the 'fittest' and thereby, the genetic material which will survive through future generations. Social relations, then, are seen to be predominantly instinctual with environmental factors remaining relatively unimportant.

The instincts and interests of females and males are assumed to be different on the basis of their differing relations to biological reproduction. Because the female knows that the young she bears are biologically 'hers', her heterosexual concerns are presumed to be to do with the quality of a male's genes and his reliability in helping her to rear her young. The male, since he can never be certain which offspring are biologically related to his sperm, is presumed to be concerned to use his reproductive capacity towards producing as many young as possible; his interests, genetically speaking, are in mating with the maximum number of females while assuming a minimum of parental responsibilities. Heterosexuality is thus based primarily upon the 'survival

of the fittest', a relationship characterized by conflict and antagonism (see Janson-Smith, 1980, for a more detailed discussion).

Political and economic relations are seen to be the other side of the coin to heterosexuality and parenthood, being derived from the competition to propagate. The motivating force for all social behaviour is self-interest in perpetuating one's genes, and any social structure is presumed to have resulted from this competition, indicating the most successful survival mechanisms which have evolved. Theoretically, men and women are considered biologically-driven equals. However it is sometimes argued that co-operation between males has developed in order to subordinate women and impose upon them an inferior status. In this way, their chances of gaining sexual access to women, and thereby perpetuating their own genes, are increased.

While social cohesiveness with regard to the mother-child bond is considered to be biologically natural, the male-female bond is viewed as an adaptive system of protection for the mother-child bond and as not necessarily monogamous, long-lasting, nor solvent of the antagonisms of heterosexual relations. Behaviour in the female continues to evolve from her need to lure and keep the male for assistance in rearing her young; the male continues to fight other males for dominance over females and the maximum exercise of his reproductive potential. Marriage, for example, is viewed as a social mechanism adapted primarily to secure the interests of women, whilst men are more inclined towards multiple sexual relationships with minimal responsibilities to any partner or resulting offspring.

To opt for a theory of 'naturalness' based on biological necessity, then, is not to view the family, the relations of heterosexuality, couples and parenthood as based on a harmony of interests or on expressions of love, trust, security and mutual enjoyment. Rather, it is to recognize the present family system as an evolved form of antagonistic self-interest, of tenuous connection and temporary duration.

A major inadequacy of theories of this kind, whether biological or psychological, is that in locating the motivating force of social behaviour within the make-up of each individual, there is no way to explain variations. Whether variations occur between individuals in the same culture, or in different cultures or historical periods, there is no possibility of exploring the influence of different forms of social organisation, cultural distinctions or historical contexts - except as more or less successful adaptations of the organism. Women who do not conform to their assumed biological fate, for example, can only be seen, according to this approach, as biological failures, and their behaviour as a consequence of some hormone imbalance, genetic mutation or some other unfortunate lack in their make-up. Social relations are seen to require no wider analysis than as the sum total of individual instinctual expressions, consequences and adaptations; indeed, no other explanation is possible. Male domination of women, rape and other forms of violence are explained as no more than biologically-driven activities for producing young. A moral stance would appear to be irrelevant; such activities are likely to be inevitable, and perhaps even necessary. The results of these aggressive instincts and behaviour comprise the societal power relations; if some people benefit at the expense of others, this is simply part of the 'natural' processes of selection. Thus questions which might indicate a need or desire for social change are explained away, conveniently (for those who enjoy the benefits of the status quo) avoiding even beginning to look at the social construction of such events, and at who holds responsibility for what consequences.

As all social behaviour is ultimately derived from biological instincts according to this view, there remains little possibility for change. For example, the fight for improved education and career opportunities for women is at best pointless and irrelevant, and at worst harmful in interfering with natural instincts (not the least concern being male impotence). As women we are left with the problem of male domination as a mere 'fact of life' - and by implication, we must learn how to cope with it as best we can; our concern with women's liberation is simply 'making everyone miserable' over

something which admittedly exists, but cannot be changed.

Functionalist theory

The advantage of a functionalist approach over a biological one lies in the recognition of social organisation - that people living together in societies involves more than the sum total in individual instincts and consequent behaviour. However, the functionalist view of social organisation is based upon a biological model, with its concepts of all the parts fitting together and performing activities which are necessary to the smooth functioning of the whole unit. Rather than being determined by biological drives, social relation and organisation are assumed to derive from the need for a stable social system in order that the biological reproduction and the social reproduction of the 'social body' may occur.

One major problem with posing social relations as analogous to a biological organism is that of assumed consensus. While an individual body could not exist without its parts working together in harmony, a social order could, and does. In assuming harmony to be necessary to the existence of any society, a functionalist approach excludes the possibility of recognizing conflict between individuals and/or groups as based on antagonistic interests. Assuming a harmony of interest, conflict can be seen only in terms of confusion of roles, misguided judgements, or improper adaptation to changes in environmental (ultimately economic) conditions.

It is assumed, then, that people now combine into units of heterosexual couples and their biological offspring - 'nuclear families' - because this is functional (necessary) for meeting their own individual needs and for the stability of the whole societal body of which they are a part. If all of one's needs or desires (for example, sexual desires) are not able to be met within such an arrangement, this is seen to be because it is important for the

stability of the social order that such activities be controlled (or repressed, as Freud would say). The particular form of the family and the functions which it is seen to perform is described as an evolutionary process of adaptation to economic progress. Parsons and Bales (1956), for example, contend that with increasing industrialization, the family lost its productive economic function and became focused on two major functions: the socialization of children and the provision of emotional support for adults. In this way activities presumed necessary to ensure the survival of a stable social order can be seen to be subject to historical development, whilst a perfect fit between reproduction of young and economic production is maintained through a continuous process of social adaptation of the family unit to increasing industrialization.

According to this view, men and women are different but equal. They are presumed to have roles to play which are not interchangeable with each other, since they are based on biological suitability; however, both are deemed to be equally necessary for the proper socialization of children. The role itself, in each case, is considered to be a set of norms and expectations which governs a person's actions. Masculine and feminine roles are derived from the positions which men and women hold within the family - most importantly, those of husband/wife and father/mother. The relationship between these roles is seen to be one of mutual dependence and harmony of interests; the purpose of the activities governed by these roles is the provision of emotional support for each other, and the socialization of the children into their appropriate sex roles so that the existing social order is reproduced.

This image of the perfect heterosexual couple whose members engage in mutual care of each other and their biological offspring is the romantic dream of love and security which appears so 'natural' and yet so difficult to attain in practice. In assuming that the family must have arisen because of the need for the social organization of biological reproduction and the maintenance of

social order, and that it continues because it is the best adapted system for achieving these needs, functionalists have allowed no space to question whether this romantic image is a reality - i.e. whether the family system works. Given evidence of the high percentage of the population which does not live in family units, of increasing divorce rates, of wife-battering, of child abuse, of juvenile delinquency, of rape, of 'break-downs' and 'break-ups' of families, they can suggest only poor adaptation, a strain in roles, inadequate socialization or a cycle of deprivation in proper family life. Since it is assumed that the family works, evidence to the contrary must be explained in some other way.

Nor is it possible to question whether the role itself is achievable, especially in the case of the woman whose role it is to keep the family together, to smooth out any tensions between family members, and to make the family system work (despite the possibility of its impossibility, as suggested above). Rather than informing the theory, evidence is taken to indicate, and by implication to blame, those whose responsibility it is to make the family work - women. Almost anything which goes wrong with the way the system is supposed to work can be, and frequently is, put down to the problem of the inadequate wife/mother, the dominant wife/mother, the passive wife/mother, the overprotective wife/mother, the rejecting wife/mother, the castrating wife/mother, the permissive wife/mother, and on and on. It becomes increasingly difficult to imagine what it would take to manoeuvre one's way around this maze of the wife/mother role avoiding all these pitfalls. In short, rather than question whether the role is possible, and/or whether the family system as described by functionalist theory works, women are blamed for their inadequacy in fulfilling their rôle of making it work.

In assuming that men and women have different but complementary roles to play, and that these roles are equally necessary to the whole, it is suggested, by a sleight of hand or by omission, that the positions of men and women in occupying these roles are equally powerful. However, as with the roles of

'master' and 'slave', albeit they are complementary and equally necessary in the overall system, it is clear that this need not be the case. When one looks more closely at what is entailed in male and female roles in the family unit, the inequality of their positions becomes evident. Likewise the question of who benefits, and at whose expense, from the existence and perpetuation of this family unit, comes into view.

For example, although it is presented that the family is concerned with the emotional support of its adult members, it is in fact only the female role which is oriented towards providing for the emotional needs of the other members. The male role is, conversely, concerned with bringing into the family an income, with maintaining ties with the 'wider' society characterized by male occupations and status (although women work in industry as well as at home, they are considered to be primarily oriented towards their role in the family), and with introducing male children into this world of men. This would suggest that emotional servicing flows in one direction primarily - from women to men. Men, on the other hand, because of their access to the world of industry and occupational status (and money), are in a position to be able to afford to 'provide for' (in effect, to buy) the services included in the wife/mother role. The division of these family roles according to sex are derived, we remember, from biological suitability; hence, the question of inequality and who benefits from these relations is not posited nor an answer seen to be required.

A concern for the position of men is the implicit, although generally unstated, basis for the functionalist view of the world. The starting point of the theory is the biological problem for men that they can never be certain that their biological offspring are 'theirs', in the way that women can. Why this should be considered a problem at all is not explored. It is presumed, nevertheless, to provide a necessary and sufficient reason for the formation of the social institution of the family. The particular form the family takes

varies historically according to economic development in the 'wider' society - the world of men. It is considered the man's role (indeed, his prerogative) to ensure that the link between this world of men and the more private world of the family is maintained, by virtue of his masculine authority, status and breadwinning capacity. Within the family itself the presence of a man is seen to to promote the social reproduction of the existing social order by ensuring, via his monopoly as 'authority figure', that sex roles are maintained between husband/wife and reproduced in the socialization of the children. His presence is particularly seen to be important to provide male children with protection from being dominated by their mother, and to integrate boys into their appropriate dominant role in relation to women and their place in the 'wider' world of men outside the family.

Neither the concern of functionalist theory with the interests of men, nor the presentation of the 'natural' harmony of the family as a social institution as being in the interests of men, can be recognized from a functionalist vantage point; nor can the costs to women. So long as this is ignored, there may be a possibility of change, but there is no need for it. Any fundamental change is seen as likely to lead to chaos and hence, be against everyone's interests. Should any costs to women begin to appear, they must either be minimized - so that it appears obvious that her concerns (or she herself) should be 'sacrificed for the sake of the family' - or else they must be seen to derive from her own inadequacies and difficulties in 'coping'. Once these costs are acknowledged as real, as important, and possibly as indicating a conflict of interests, the theory falls. It can no longer be maintained that there is a harmony of interests and, therefore, no need for change.

Marxist theory

The very great advantage of marxist theory over functionalist theory

lies in its recognition of the conflict of power between social groups throughout history. The social order is seen to be divided into antagonistic social classes - the ruling class deriving its power and benefits through its exploitation of the oppressed class. However, in assuming economic development to be the ultimate determining force in history, from which the relations of class conflict are derived, a marxist approach does not allow for the possibility of acknowledging any conflict of ruling class/oppressed class which is not derived from the economic class division. As such, the possibility of recognizing men occupy a class position in relation to women, that they are a ruling class deriving their power and benefits through the exploitation of an oppressed class, is within the marxist concept of history (as the exploitation of some social groups by others) but denied by the marxist premise of economic reductionism (where all social relations are ultimately seen to be derived from the economic mode of production).

Marx and Engels maintained that until the development of surplus production and the antagonistic class divisions which resulted, the structure of society was based on 'an extension of the family; patriarchal chieftains, below them members of the tribe, finally slaves' (The German Ideology 1970, p.44). The 'slaves' are the wives and children of the men, and this slavery is the first property. The sexual division of labour is the first form of the division of labour, and is considered to be the reverse side of the coin to private property: 'in the one the same thing is affirmed with reference to activity as is affirmed in the other with reference to the product of the activity' (ibid., p.53). This is the basis upon which, later, more developed divisions of labour evolved. Sexual division and exploitation can thus be seen to be at the root of marxist theory.

It is important to note, however, that this sex-divided exploitation, where women were the slaves and property of men, is assumed to be a 'natural' state of relations between men and women. Such a conception of what is

'natural' contains both biological reductionist and functionalist assumptions. Heterosexuality is assumed to be a biological fact, a given from which the social relations between the sexes are said to have come about. 'The sexual act' is posed as the origin of the division of labour, which then develops 'spontaneously or naturally by virtue of natural predisposition', until there exists a division between material and mental labour. This mature phase of the division of labour implies that 'enjoyment and labour, production and consumption - devolve on different individuals, and that the only possibility of their not coming into contradiction lies in the negation in its turn of the division of labour' (ibid., pp.51-2). This negation, then, is a negation of biological predisposition. It is only by overcoming this 'natural' phenomenon, this biological fact, that it becomes possible to engage in voluntary activity and, thereby to bring the division of labour within our control.

The functionalist assumption implied in Marx's and Engels' conception of the 'natural' is that the patriarchal family spontaneously came into existence because of the need for men (sic) to organize the propagation of the species. The family, 'which to begin with is the only social relationship', is seen as the necessary circumstance in the historical formation of any society (ibid., p.49). Why this first social relationship is seen to necessitate men as masters over women and children is not explained, nor is any explanation indicated to be necessary. As with the functionalist approach, this framework presumes biological reproduction to provide a necessary and sufficient reason for the formation of the social institution of the family.

So, too, the functionalist concern with the position of men and the interests of men is incorporated into marxist theory at the level of its most fundamental premises. Once again we find this male orientation exists to the exclusion, trivialization or assumed consensus of women's position and interests. - despite formally acknowledging their slavery to men. The ambiguity in the use of the terms 'man' and 'men' to varyingly include and exclude females

allows both the denial and the justification of this myopia to be maintained. Thus, for example, the premise that from the outset of history 'men, who daily remake their own life, begin to make other men, to propagate their own kind: the relation between man and woman, parents and children, the family' (ibid., p.49) is used on the one hand, to imply the similarity and harmony of men and women as historical beings and, on the other, to explain their dissimilarity and disharmony in the 'natural' master/slave social relations of the family as necessary for the propagation of the species. The implicit concern of the theory with the position and interests of men is denied in the first case, justified in the second.

Whilst prior to the production of surplus with the domestication of animals, the social structure is said to be an extension of the patriarchal family system of the tribe (or gens), once this economic change occurs, the family is seen to become subordinate to a more developed form of private property. This transformation of the family from being the basis of the social structure to becoming the consequence of economic development, and functional (necessary) for its perpetuation, hinges on Marx's assertion that 'property differences in a gens changes the community of interest into antagonism between members of a gens' (Marx, quoted by Engels, Selected Works 1968, p. 582). Although never explicitly stated, this assertion is logically coherent only where 'members of a gens' implies men alone. That is to say, in the early patriarchal tribe, or gens, the women and children constitute a pool of slaves, the communal property of the men. With the development of surplus production, property differences between men in a gens arise. The family system is transformed; the relations of men to women are adjusted so that they become functional for the continuation and further development of this economic class antagonism amongst men.

Engels suggests in The origin of the family, private property and the state that this transformation of the family was the consequence of the establishment

of father-right to children. Father-right is deemed to have replaced matrilineal groupings when the establishment of private male property enabled the men of the gens to overthrow the mother-right, by virtue of their economically strengthened position relative to women. At the same time, father-right to children was seen to be required by this economic development; in order to maintain this form of male ownership and control through inheritance, Engels argues, the men need to know which boys were their biological sons. Monogamy is therefore required on the part of the woman, and the man is enabled to enforce it because of the exclusive rights of men to private property.

In this account of the development of the family, Engels contradicts his earlier joint writings with Marx, claiming that it was only with the establishment of private property that male domination of women came into being. Previously, as outlined above, they had maintained that until the development of class society, the social structure was based on an extension of a 'natural' patriarchal division of labour, where women and children were slaves to the men. Whilst Engels' later position would more closely support the thesis that the social relations between men and women are derived from economic production, and change as a consequence of change in economic development, it is, however, an untenable argument.

The argument is logically inconsistent: Engels proposes that the conditions for male domination of women arose with the development of a 'hitherto unsuspected source of wealth' from the domestication of animals. Until this stage, property was communally owned and used, and no wealth greater than the subsistence requirements of the gens was produced. Suddenly the excess wealth was owned by the men. This is not considered a theoretical problem by Engels: 'according to the division of labour then prevailing in the family...(the new wealth) fell to the man' (Selected Works, 1968, p.494). But to suppose that this new wealth belonged to the men is to presume them to be in a privileged position relative to the women. Whether or not they performed different tasks, to suppose that

an event of such import, the first production of surplus wealth, simply 'fell' to the men by custom, rather than the new produce being shared by everyone, is either to presume that women are by biological predisposition extremely passive and/or stupid, or that this sexual division of labour, as the earlier work of Marx and Engels suggests, already comprises patriarchal master/slave relations.

Either way, the thesis is biologically reductionist. Whether male domination of women is seen to arise from 'the sexual act', or with the production of surplus wealth because of the need for men to know who their biological sons are, biology is presented as the determining factor. Why this heterosexual activity is assumed to be a biological given, why it is presumed to give rise spontaneously to a sexual division of labour, and why inheritance is presumed to need to pass along biological lines - these are not recognized to be questions which demand further explanation; nor is it seen that they question the validity of the theory itself.

Change, on the other hand, is presumed to depend upon and somehow follow from the overthrow of private property. I say presumed, since it does not follow from the accounts presented by Marx and Engels how this might come about. Indeed, a wide range of confusions and assertions arise in their work as a result of these inconsistencies, including, for example, that there is no basis for male domination in the proletarian family since there is not property to pass on; that if women are private property, then the first stage of the abolition of this property includes the community of women being owned by men (despite assertions to the contrary); that the family will be abolished; that the family will be secured with male monogamy as well as female, and so on.

Marxist theory, like functionalist theory, is protective of men. In presupposing heterosexuality to be a biologically natural phenomenon, and presenting the family as having arisen because it was functional for economic

class-based societies, this approach conveniently (for men) averts its eyes from questioning how these social relations can be seen to benefit all men at the expense of all women. Men are excused from the oppression of women - in the first case, because it is 'biologically natural' and in the second, because it is 'necessary for the economic system'. And just as the direct interest of men in the exploitation of women is rendered invisible and legitimised in this view of the world, so any fundamental future problems in the achievement of the liberation of women remain unseen.

It is not surprising that marxist-feminists have run into major difficulties in attempting to 'extend' marxist theory to explain male-dominant/female-subordinate relations. This is not to deny the considerable and invaluable insights into the conditions of women's lives which have been highlighted in the work of feminists who use a marxist perspective. However, as an explanatory framework for understanding why these conditions exist for women and not for men - i.e., why they are not the same for anyone who labours in a particular job or task, whatever it might be - marxism is weak, contradictory and I would contend, precludes the possibility of creating a new theory which may provide an adequate explanation. As long as the framework which we use to understand male-dominant/female-subordinate relations denies the possibility of theorizing that men directly benefit from the exploitation of women, that men as a group or class actively maintain, perpetuate and protect their privileges over and against women (whether they are aware of it or not), then, of course, such a theoretical perspective can never be developed. Again, it must be asked: in whose interests is it to deny the possibility of developing the theory of male supremacy?

Original cause

In attempting to provide an alternative description as well as analysis of male/female relations, we are often confronted by the question: what is

the original cause - the conditions which determine that such relations exist? When we find it difficult to answer, it is proposed that even our description of the world as characterized by antagonistic power relations between men and women is unsound. That is, if there can be seen to be no cause outside of the relations of power described, then indeed, no such relations exist. However, it may be that the fault lies with the question, rather than in the lack of an answer.

The demand for an original cause of why men should oppress women is premised on the determinist assumption that there is such a thing. For marxists, antagonistic class relations are created by the economic development of private property, which itself arises out of the technological possibility of surplus production. The supposition is that the oppression of one group of people by another is predated and ultimately caused by the mode of production. Since, according to this view, antagonistic social classes did not and do not exist outside of the need for them in terms of the division of labour necessitated by the economic mode of production, then either (a) the division between men and women is false (we're all in this together; the oppression of women by men does not exist), or (b) the oppression of women is derived from the division of labour based on private property and is primarily in the interests of the maintenance of that economic system. The fact that men of whatever economic class benefit from the exploitation of women of whatever economic class (women being assumed to be of the same class as their fathers or husbands) is considered a mere by-product, a secondary consequence of economic class antagonism.

The inadequacies of the marxist economic reductionist approach have led many feminists to seek the cause of male domination of women in some determining factor other than the economic system. The intention is to indicate some causal factor which predates the development of private property and is founded upon a division of labour which is sex-linked. Generally, the solutions have been sought in terms of biological differences; these are said to have caused

the conditions which provided for the establishment of patriarchal relations - through the physiological weakness or defencelessness associated with pregnancy and lactation causing women to be dependent upon men (see, for example, the now classic thesis of Firestone, 1971). Apart from the questionability of the assumptions about women's defencelessness, which seem to presuppose a continual state of childbearing for each and every woman, and that women are dependent only upon men rather than upon each other or upon the rest of the men and women in the society, the major difficulty with this approach is its reductionism. Such reductionism implies that the physiological differences between men and women in some determinate way cause the class of men to exploit the class of women for their own benefit. It fails to recognize that while biological differences may provide possibilities and limitations for heterosexual relations, the ways in which these biological factors bear social significance is the product of social relations, not the cause of them.

The untenability of claiming the cause of the power relations between men and women to be inherent in biology per se is widely recognized. What is less generally recognized is that this approach is modelled upon the marxist method of economic reductionism (except for Firestone, who identifies the method she uses as marxist). There is no more reason to support the proposition that the ultimate cause of power relations is the technological possibility of surplus production (economic development) than there is in biological possibilities per se. As with biology, the ways in which these economic factors bear social significance is the product of social relations, not the cause of them. Economics, as biology, may more fruitfully be viewed as one of the avenues through which those with power will try to maintain and perpetuate that power at the expense of those subordinate to them.

The demand for an original cause of why men oppress women, then, needs to be answered with the question: why does any group or class of people oppress any other group? That is to say, why is history a history of the domination and subordination of social groups? Why does any ruling class exploit the

subordinate class to its own ends? It is not an easy question to answer, but we must not assume the answer is to be found in biology, economics, psychology or sexuality per se. Social relations are based on actions taken by people; social structures are set up and maintained by people. The oppression of women is the consequence of men creating and perpetuating their position as the ruling class (knowingly or unknowingly, but benefitting all the same).

Key institutions

One way to approach the study of power and conflict between the sexes is to explore and analyze some of the key institutions through which this relation of domination and subordination is maintained. Feminist groups have repeatedly pointed to the family, and to heterosexuality, as institutions which have confined and controlled women's behaviour and attitudes. The importance of sexuality to a study of contraception has been noted to be paramount; the study of sexuality itself cannot be understood without reference to the family. The socially acceptable parameters for having sex and having children within our society is patriarchal family life.

Margaret Stacey and Marion Price (1981) elucidate that the discussion of power must be inclusive of both individual interactions and the structures and institutions within which individual actions and relations occur. To speak of one without the other is to develop a distorted picture of the rigidity/freedom of actions on either level. In addition, it is necessary to recognize that power relations between men and women, as between other groups, are evidenced not only by the imposition of one's will over the other; they are also revealed by:

'those circumstances in which the views, interests or wishes of one category or group are normally given precedence, in which there is not struggle or conflict, but in which their superiority is taken for granted either because that is believed to be correct or because there appears to the subordinate persons no way to make a challenge.' (p.102)

The levels at which male-dominant/female-subordinate relations occur are both individual and institutional, and need to be perceived in relation to each other. Individuals do not experience their relationships or take actions 'free' of the political relations supported and perpetuated through social institutions; institutional relations do not exist and can not be maintained apart from the actions taken by people. In discussing heterosexuality as a key institution of a patriarchal social structure, then, it is necessary to explore both levels. Further, they must be viewed with regard to whose views, wishes and interests are normally given precedence; the taken-for-grantedness of heterosexual family life must be questioned in terms of whether there appears to subordinate persons that there are any alternatives.

Sexuality

The relationship of sexuality to the social order is one which Ken Plummer (1975) points to as a central problem for sociological theory. The significance often attributed to sexuality as either 'the demon within' or 'the great liberator', he argues, is based upon biological notions of sexual instincts causing social relations. Taking an interactionist perspective, he suggests that it is preferable to view sexuality as an effect, rather than a cause of social order, *its significance/being directly related to the way in which it is perceived socially.*

Stevi Jackson (1978a) applies this perspective to the study of female sexuality, arguing that it has three main advantages: first, it allows for a positive sense of the social construction of sexuality rather than as the negative control of innate mechanisms; second, it presents the individual as an active participant in the process of socialization rather than as a passive recipient of biological and social forces; and third, masculinity and femininity appear to be the result of differing learning experiences rather the outcome of a differing relation to the libido which, according to Freudian theory, is

essentially an active, masculine force. Hence, it allows for a view of female sexuality which can be other than a distorted (and lesser) version of the masculine or as a functional complement to it.

However, while this view of sexuality as the effect of the social order emphasizes the social shaping of sexual experience, it remains based upon a false dualism. To pose sexuality as either cause or effect is to set it apart from the social order; its relation to that order then becomes theoretically problematic. Rather, sexual relations need to be recognized as an integral part of the social order and the political relations within it. The specific form that sexuality takes is a social relation, not an aspect of life which is expressed through social relations.

This distinction has important consequences for our understanding of sexuality, and of the social order. To present sexuality as a social effect, in order to differentiate it from biological causation, encounters the problem that our view of the relation between sexuality and society is limited to that of a 'reflection'. That is, sexual activities are said to reflect male/female social relations. The male typically engages in a sexuality consistent with masculinity and the female correspondingly reveals a feminine sexuality. The social significance of sexual relations is no more than that they provide us with an example of the relations between the sexes.

What is not explained by this portrayal of sexual behaviour as a manifestation of social relations is the way in which sexual activities can be seen to affirm and perpetuate male-dominant/female-subordinate relations. Sexual activities are causal as well as an effect of social order - not in the sense of an original cause or a determining force, but as integral to the maintenance of the power and privileges of men relative to women. Just as the institution of patriarchal heterosexuality influences the quality of relationships between individual men and women, so too do individual relationships support and perpetuate (or contradict) male supremacy.

Sexuality would appear to be pivotal in the maintenance of patriarchal relations for three reasons. First, is its symbolic importance. Symbolically, sex signifies who belongs in which social group or class, genitals being the most obvious difference between the sexes. Kate Millett (1971) identifies the crucial significance which is given to the penis as a badge of the male's superior status and a symbolic weapon in the battle of the sexes. The image of women, on the other hand, is one of complementarity to the male, having been created by men and fashioned to their dominance. Second, the activity itself is defined in accordance with the sexual arousal of the male, with female arousal being relegated to an 'optional extra', revealing and affirming that men's views, interests and wishes take precedence. Third, the consequences of 'the sex act' are borne primarily by the woman, for it is she who is at risk of becoming pregnant and whose life will be most affected by the requirements of childrearing.

The patriarchal nature of sexuality, of sexual relations and relations between the sexes, forms a major theme of this study. The experiences and concerns about sex and sexuality which were reported by the women who were interviewed provides the basis of the analysis of the relation between heterosexuality and the family. In the next chapter the interplay of social institutions and individual sexual relations is explored in more detail through the empirical data, and a theoretical framework for the discussion of sex and sexuality is presented.

Chapter 4 SEXUALITY

The inextricable link between contraception and sexuality makes it imperative to explore the social relations of sexuality in which women engage in order to understand their contraceptive decisions and actions. The issue of sexuality, however, is as sensitive as it is central, and the discussion which follows is therefore necessarily detailed in its examination of the expectations, experience and conditions of sexual relations encountered by women in the study.

The terms 'sex' and 'sexuality' are often used loosely to refer to essential sexual drives or characteristics which comprise and differentiate male and female sexual experience or attitudes. In her perceptive critique of male heterosexism in both traditional sexology and sociological research based largely upon the interactionist perspective, Annabel Faraday makes very clear that the conception of 'sexual' must be radically questioned. The political significance of taken-for-granted assumptions about female sexuality, she argues, is that such definitions 'serve as a control mechanism to divide and isolate women, either by reinforcing concepts of "femininity" or by delineating categories of "woman" presumed to possess or exhibit varying peculiar characteristics' (1981, p.127). Explanations of female sexuality within a patriarchal society must recognize and account for the subordinate position of women, and the ways in which male domination is perpetuated through taken-for-granted sexual ideas and practices.

In developing a framework in which sexual relations can be explored from a social and political standpoint, it is perhaps useful to distinguish between the concepts 'sex' and 'sexuality'. I therefore use 'sex' to refer to physical activities or practices involving genital arousal, and

'sexuality' to denote emotions and attitudes. This concept of sexuality is primarily one of social orientation towards three things: first, the people (oneself and others) with whom one engages in sex; second, the physical practices which comprise what sex is; and third, the purposes for which it is done. Within such a definition of sexuality it is possible to explore both the individual's experience and the social context within which this experience occurs.

Setting women's contraceptive decisions in the context of their sexual relations thus is not a question of defining their sexuality as either essential to their femaleness or as individually defined and negotiated. Rather, it is to pose sexuality as a relation of political significance. Within a patriarchal social structure, sexual relations as other aspects of social relations are characterized by male privilege and female subordination. What individual women perceive and experience must be analyzed in view of the social norms and constraints which influence with whom sex takes place, what type of activity occurs and the purposes for which it is done.

Sex - with whom?

Far from engaging in sexual activities 'with whom one pleases', denoting a free choice amongst a range of equally possible alternatives, individuals confront a set of sexual relations which rigidly define and prescribe their actions. Sex itself is a highly structured ritual in our society and the question of with whom it should take place is governed by social rules and sanctions which allow few possibilities. The choices which do exist for women are confined within the parameters of women's subordination to men.

It is possible, of course, to challenge these parameters, but not without penalty. The institutional support for the confinement of women's sexuality to men generally, and to one man in particular - in marriage, render such challenges extremely difficult for individual women. The privileged position of men, inside and outside of marriage, locates women in a defensive position. Women's sexuality, whether it conforms to or challenges these male-dominant relations, is nevertheless affected by them.

The boundaries of heterosexuality and marriage delineate the sexually acceptable. The processes which gear women in this direction have recently been described by Adrienne Rich to comprise 'compulsory heterosexuality' (1980). The portrayal of family life as the primary route to happiness and fulfilment for women suggests one means, at least, by which women are encouraged and may come to confine their own sexual expectations and practices within these limits.

a) Lesbianism

It is significant that in planning the content of the interviews the decision was taken to omit any question about lesbian relations, for to raise this 'taboo' subject might have been detrimental to the interview as a whole. Although the focus of the research is upon heterosexuality and not lesbianism, the actions women take need to be seen in context of the alternatives from which they choose. The risk involved merely by mentioning the possibility of lesbian sexual activities clearly indicates that it is not regarded as a socially acceptable alternative, and therefore that heterosexuality itself is not 'chosen'.

Awareness of the importance of alternatives to heterosexuality meant that despite not directly asking about lesbian sexual activities, the respondent's lead was followed whenever taken. One woman who had received a request to participate in the study explained that her lesbianism had been a political choice based on her love and respect for women, as well as her understanding of male domination; she was, however, excluded from the study since she did not fit with the criterion of experience with contraception. Another woman asked pointedly after her interview why I had not included questions about lesbian sexuality, suggesting that its importance should not have been neglected. Several others mentioned lesbianism either in terms of their own increasing understanding or experience of sexual relations, or with regard to lesbian friends who seemed to have a greater ease in discussing sex than most people.

The remaining ninety per cent of women in the sample did not mention lesbian sexual relations as a possibility they had either experienced or considered. Asking about possible living arrangements with a child elicited a number of responses which revealed clear views about lesbian relations, predominantly reflecting lesbians negatively and as something to be wary of:

'Living with one sex isn't a good idea. People go a bit peculiar.'

'A child should be brought up by a man and a woman. If I was living with a woman, if she was a lesbian, I'd worry what effect would occur on the child.'

Fear and recoil at the thought of living with women were expressed in remarks bearing a close resemblance to male-dominant ideology which glorifies the benefits of heterosexuality and denigrates lesbianism. The idea that living with women would be second best, if not total

failure, was prevalent in comments made even by those women who tended to see themselves as open-minded and as taking active choices about their futures. Yet, the effect of the idealised importance of men in women's lives is to pose any other possibilities as the 'failure to get a man', and thus the alternatives open to women appear both negligible and negative.

b) Masturbation

Masturbation, too, is generally taken to indicate failure, misfortune or immaturity - the result of the lack of a man with whom to engage in 'the real thing'. Although sexual liberalism in the 'sixties and 'seventies has transformed masturbation into less of a deformity or sign of mental illness than it was previously, suspicion that it may still be regarded in this way, or as a failure, is sufficient reason to keep such activities closetted. Of the aspects of sexuality which were included in the interviews (i.e. not lesbianism), women reported masturbation to be the most difficult to talk about. Fifty-six per cent had never discussed it with friends; thirty per cent had never talked to sexual partners about it. When it was mentioned, it was usually on the level of a joke. /

While two-thirds of the women reported that masturbation was a part of their sexuality, many did not feel entirely comfortable about it. The reasons which they gave for their discomfort suggest that the taboo which surrounds masturbation is oriented primarily towards women. While disapproval may be expressed about male masturbation, it is particularly women whose masturbation is seen as offensive:

'It's the various connotations of masturbation not being good for you, and not being the thing ladies do. You shouldn't touch yourself, sort of thing.'

Father than being sexual in themselves, women are regarded within patriarchal ideology as being sexually responsive to men. Masturbation expresses an independence on the part of women which offends this image of their need for men. It is therefore more likely to be seen as a possibility for men, than it is for women:

'I don't. Men masturbating doesn't worry me ; women masturbating makes me feel a bit squeamish, I don't know why.'

Although several women felt that perhaps masturbation had been overglorified in some of the recent feminist writings, for many it was not even a possibility to be contemplated. If they did do it, they hesitated to admit to it, and frequently found themselves attempting to justify even to themselves why they should be doing such a thing.

Justifications of masturbating, as fears about masturbating, were largely weighed in terms of whether it indicated or could lead to failure. If a woman was engaged in a regular sexual relationship this behaviour became difficult to justify, since masturbating was seen to be necessary only in circumstances where a woman lacked a man:

'I mean I've always done it and I've always had the feeling that I shouldn't. I've always pulled myself up towards the end. I mean there isn't any reason for masturbating since I have sex fairly regularly.'

'I still do although I've a regular partner. Sometimes I'm surprised that I should. I think to myself: why should I want to now? But then I don't know why I ask that question.'

To masturbate despite being involved in a sexual relationship with a man implied a rejection of him, or a disloyalty to him. It signified a failure in the relationship, for there appeared to be a sexual need where no such need should exist. Women, being said to have no independent sexual response, signified by masturbating, some failure in their partner's sexual prowess:

'I'm probably a bit wary about it because I associate it with some kind of failure, not because it's wrong or nasty. I'd only really consider it when I'm alone.'

'I tend to feel it might interfere with my sex life; that, if masturbating frequently, you tend not to be able to reach orgasm internally.'

The prescription that women's sexuality ought to be confined to responding to men extends, as this latter quote indicates, to responding in what is regarded as the appropriate way to men. The sense in which masturbation is taken to be a failure, may seem to suggest that it is the man who has failed until the woman's appropriate response is considered. The proper response is one which makes the man feel potent. Therefore, for him to be revealed to be a failure implies her failure to make him feel good, and appear sexually capable. Even where women felt confident and relaxed about masturbating, they were often reluctant to let their partners know:

'It might make him feel bad. Probably I wouldn't admit to it.'

'It's a normal part of my sexuality but I think a lot of men feel threatened by it.'

Thus, despite feeling able to justify masturbating to themselves, women were aware that admitting to it could give offence to their partners. Indicating an aspect of women's potential, as well as existing independence, masturbation was often silenced, if not denied, lest the man feel it signified rejection of him, or disloyalty to him, and be offended.

Because masturbation may appear more of an additional activity to heterosexuality than an alternative to it, it tends to be seen as less of a threat to heterosexual norms, than is lesbianism. Yet, it too presents women with an alternative form of sexuality. The basis on which masturbation appears to be a failure to find a man, and respond appropriately to him, is the assumption that the route to success and

and happiness inheres in heterosexuality, and heterosexuality al n .

The answer to the question: with whom should a woman engage in sexual relations? is first and foremost: with a man. It is only secondarily that the question: which man? arises. Both lesbian sexual activity and masturbation are portrayed as poor seconds to heterosexual intercourse. Their justification rests on the misfortune of women who have been unable to attract men and who, therefore, must c n ole themselves with something rather (penis)less. If and when the opportunity for regular heterosexual activity is presented, other forms of sexual activity are assumed to become immediately redundant.

c) Promiscuity

Promiscuous behaviour denotes sexual activity which, it is feared, would threaten the stability of social order. The label is applied differentially to men and women; the sexual double standard reveals the relative positions of men and women in that order. Fear of women's sexuality reflects less a concept of biologically-driven anarchic potential in women than a concern for the continuation of patriarchal family life (Lown, 1981). As Diane Scully and Pauline Bart have clearly and humourously pointed out in their review of gynaecology textbooks (1973), women's sexuality is presumed to be, and women are guided towards the provision of pleasure and children for their husbands.

The imputation of promiscuity is the accusation that one is stepping out of line sexually. For women, it implies taking sexual actions which are, or appear to be autonomous to the servicing of husbands. Despite social pressures upon men to marry, evidence of extra-marital sexual activity is more likely to gain men applause for their virility than blame for their autonomy. Promiscuity as an accusation of guilt upon a man is dependent upon the proven innocence of the woman; if she can be

seen to have stepped out of line, he is pardoned and perhaps, congratulated. As women are assumed or prescribed to possess no sexuality for themselves, which man with whom it is acceptable for a woman to engage in sexual activities is simply answered - her husband.

The implication of the charge of promiscuity is that these women are wicked and deserve to be punished or at least, brought into line. A range of negative sanctions may be employed which serve to control this behaviour. For example, Cohen et al (1978) suggest that promiscuous women are regarded as unworthy of protection in law. Ridicule, scorn, isolation, poverty, too may be the alternatives to sexual conformity which face women. Other sexual decisions are denied as moral, and having children disclaimed as legitimate.

An awareness of the difficulties facing single women who have sexual relationships, especially those who have children, was prevalent in women's minds when considering their present and future positions in relation to marriage. The reasons for getting married appeared largely to be practical ones: family acceptance, social ease, financial protection, pregnancy. Women had learned to expect marriage would be a major feature of their lives, and though they may have themselves reconsidered its supposed benefits, most of the rest of the world still expected them to conform:

'The social pressures not to have done so were too great. I suppose I wanted to conform to be normal, and I was fed up with all the difficulties of being a single woman.'

'I would like to be able to say it wasn't important, because although I'd like to be able to see myself as being able to stand out against opposition, I probably wouldn't be.'

The inevitability with which many women viewed marriage had less to

do with romantic visions than with an awareness of the social and material sanctions which would confront them, should they decide otherwise.

Some women hoped they would be able to conform formally to these standards, without the social pressures affecting their individual relationships. However, those who had tried it found further expectations surrounded their lives including, for example, gearing all aspects of their lives around their husband's work, friends and needs, and having children. As one woman described her decision to marry:

'It was very difficult when we lived together because both our families knew it but it was never discussed openly; you could never have people to stay because they wouldn't accept that we were sleeping together. It was just chopping out a whole half of your life. It just seemed easiest to get married and we felt it wouldn't make that much difference to the relationship, but in fact, it hasn't worked out like that. Since getting married I've felt very much as though I've lost part of my identity...I feel, you know, I'm still me. I might be his wife but if we were living together, you wouldn't be treating me like this.'

Interestingly, although the decision taken to marry had been a joint one, it is the woman who becomes socially appendaged to her partner. Clearly the consequences of mutual decisions are not reciprocal.

The point at which most discussion of the question: with whom? occurs is not in terms of: a man, or: a husband. Heterosexuality and marriage are taken-for-granted. The bulk of advice to women is focused upon: which man to marry? This is the level at which women may be regarded as having some choice, since it is the only level where alternatives are legitimate. Even here, a plethora of guidance on how to define 'a good

catch', whether to marry within economic, race and religious demarcations, and how to acquire and maintain the favoured marriage, surrounds the possibilities available to women.

The opposite end of the spectrum to respectable married sexuality is 'casual' sexual encounters. It is because this type of sexual activity does not appear to lead to marriage, that it is seen to be promiscuous. A range in types of relationships between these two extremes are regarded as more or less promiscuous in proportion to their apparent proximity to marriage. Thus, for example, sexual activity while 'engaged to be married' or planning to get married is nearly acceptable. Women in the study found, for instance, they they would sometimes be asked when seeking contraceptives 'how long' they had been with their boyfriend and whether he was 'the same one' they had the last time they requested contraception, implying a judgment of the women's relative morality.

The double standard of sexual morality meant for these women that it was not a simple matter to engage in casual sexual relationships. Despite access to contraception, the possibility remained that a pregnancy might result and despite a concern to assert sexual choice, women remained subject to accusations of promiscuity. Unlike the men they knew, women found it difficult to engage in sexual relations without second thoughts, when they felt like it:

'It's difficult for a woman to go out and have sex without love because of all the comments that are made about it. I'm not saying it's right or wrong, but it's the way things are.'

'It's probably upbringing and attitudes that we've had for centuries, that women are still men's servants; that they're entitled to go out and do what they want, but a woman should have to stop and think.'

'I think women tend to want a deeper relationship,
as its her that is likely to have the baby.'

Concern about the consequences of engaging in sexual activities tended to make women wary of casual sexual encounters. Yet, an awareness of the sexual double standard lent itself to the feeling that women ought to be as sexually mobile as men.

Although the sexually 'permissive' atmosphere surrounding university life in the mid-seventies, plus the technologically improved methods of birth control available, certainly gave women a greater opportunity to enter into casual sexual encounters than previously, it was not as liberating a position for women as is often suggested. Women also found themselves under pressure from men to engage in casual sex, since it was relatively 'safe' and considered to be the liberated thing to do. Still the consequences firmly landed in the women's laps, and they often came out feeling 'used'.

Attempting to assert sexual independence by engaging in sex on the same basis as men, ran into a number of difficulties. For one thing, women generally found having sex with someone they hardly knew to be a strange and unsatisfying way to relate to another person. Having little involvement in the other person's life meant that the sexual relationship, too, was based on a limited involvement between partners. As one woman succinctly described it:

'I think if one is out for a casual screw, then all you're really interested in is your own screw; it's not the other person's so much although the two obviously do have a certain amount in common.'

The problem for women, in addition to the consequences of sex, was that sex is geared to men. In a situation where women felt little or no emotional commitment from their partners, it was particularly difficult to challenge

what sex is. It was not that women felt guilty about such encounters so much as the fact that they found them awkward and unsatisfying. Ironically, it was precisely these situations where 'good' sex was considered to be most important;

'Orgasm matters more in terms of a casual thing... Like if you're interested in the person, it doesn't really matter at all; whereas, if you're only there for a screw, it's either good or it isn't.'

The excitement of casual relationships seemed to lie more in the efforts which men took to convey their interest in the uncertain early stages of a potential sexual encounter, than in the sexual activities themselves. Also the improved bargaining position which women felt they had within relationships, based on their freedom to become involved sexually with other men, added an important dimension to casual relationships. However, because sexual pleasure is focused primarily towards men's desires, women remained at a disadvantage.

Sex - what is it?

'The sex act', by legal and common definition, is the penetration of a man's penis in a woman's vagina culminating in his ejaculation. This definition presupposes sexual excitation and penile erection in the man, and therefore that the sexual process is oriented towards: 'what turns him on?' The woman's enjoyment, or lack of it, is irrelevant for 'sex' to happen. As Stevi Jackson (1982) points out, this view of what sex is, is presented as fact; and further, it relegates female pleasure to either an appendage or a perversion, and clearly demarcates sex as 'something men do to women'.

a) Sex drive

The social construction of what sex is becomes hidden in the conception that sex drive is a biologically natural and therefore inevitable fact of life. The mechanistic and linear logic applied to the sexual process - i.e. drive:act:relief - is at once a denial and an example of the social construction of biology. Sex is claimed to be what it is since it is merely 'doing what comes naturally'. Yet, there are rigid prescriptions for what should come naturally and these rules are carefully maintained through positive and negative social sanctions, lest 'following one's own instincts' lead into promiscuity, illegitimacy and disorder.

Recognition that the concept of sex drive has masked, amongst other things, a double standard of sexual morality, raised the importance of questioning the advice given to women about how they ought to feel sexually:

'I think that women are conditioned into believing that they shouldn't be as forthright and open as men. They tend to believe that they have less sexual needs because they're conditioned into believing that.'

'There are a lot of misconceptions about how men are, need it more, and that men are more quickly aroused. I think that women can be aroused, but they've never really been aware that this is what is going on.'

Women found that they too had sexual feelings. The differences they discovered between men and women were not based upon sexual urges, but upon what to do about feeling aroused.

It was the behaviour of men, rather than their innate sexual drives, which women found to be different from their own. Men, they felt, were less likely to 'stop and think' about the consequences of their actions. Whether with regard to specific details such as their partner's arousal or the use of contraception, or more general negotiations about the quality

of the relationship, men were experienced as being more impulsive or demanding than women about the primacy of their sexual urges. Men placed their own sexual desires as primary to the sexual desires of their female partners, or appeared to expect the latter to coincide with their own. In addition men's response to the curtailment of their sexual impulses was found to make them 'moody'. These differences were commonly experienced, and this frequency itself led to some confusion regarding whether or not it indicated a biological need in men:

'I simply don't have as much appetite or need for sex as my husband does. It does have a much wider effect on him if we're not having much sex. It has a terrible effect on his mood and temper.'

'The blokes I've been out with, they've wanted sex more often than I certainly, so perhaps they need it more, I don't know.'

For the most part, however, women felt that these behavioural differences reflected less on biology than on social attitudes about sex. 'What men are like' about sex was thought to have more to do with ignorance or selfishness than biological compulsion.

b) Foreplay

The taken-for-granted assumptions about what sex is tends to make sex 'easier' for men. Being organized around what is arousing to the man, sexual activity is oriented towards his sexual satisfaction. By definition, for sex to take place, the man must be aroused, while the woman's desires remain tangential:

'It's just that I feel, it's true for me and it's true for most of my women friends, that we really do need a great deal more love-making to actually reach some sort of satisfaction; whereas for men it's just much easier to come off. Although they may enjoy lots of foreplay and things, for them it's much less important.'

For women, foreplay is essential since 'the sex act' is inadequate. Yet, the term itself suggests it is secondary, an optional extra to sexual intercourse. The inequality of what sex is places a woman in a dependent and vulnerable position; mutuality is not hers by right but hinges upon an act of 'noblesse oblige'.

The mythology of the popular image of sex as mutually satisfying is revealed by what women themselves have to say about their experiences of sex. The inequality of normal sexual practices has meant to women that they are reliant upon the sensitivity of their partners to recognize and incorporate women's needs into sexual activities. This was often found to be a problem:

'I tend to want a lot more time with it, a lot more exploratory work than a man normally tends to want or is often prepared to give.'

'I like an awful lot of foreplay and he doesn't. I also like someone putting their arm around me constantly when I'm in bed and that causes a lot of rows which have never been ironed out.'

For the majority of women, foreplay was not something which they could necessarily expect during sexual activity. Those whose partners were more considerate and with whom they had negotiated a more mutual form of sexual practice, thought themselves lucky and were grateful. Awareness that most men could not be relied upon to engage in a reciprocal sexual arrangement meant that those men who were even slightly better than the average were very much appreciated.

Even during foreplay, however, women's arousal tended to be treated as secondary to the main event. Regarded largely as an activity leading up to the culmination of the sex act, foreplay was found in practice to denote before male orgasm. Foreplay was often enjoyable for women, but it was not necessarily clitoral or oriented towards their sexual satisfaction. Rather,

women felt they were expected to achieve satisfaction through those sexual activities, including foreplay, which were primarily geared to men's sexual arousal. So foreign a practice was foreplay to women's sexual arousal that some women did not find the term even applied to them; what did turn them on was outside of what sex is:

'I only do (have an orgasm) in the course of conscious manipulations with the fingers or the tongue - in other words, while being masturbated by my partner rather than doing it myself. I'm not sure that's anything unusual but it tends to be particularly conscious with me rather than an automatic part of the way we make love.'

Masturbation, as foreplay, carries the connotation of being a second-rate as well as secondary sexual activity. That women were compelled to describe their own sexual arousal in these terms demarcates what sex is to incorporate women only in a relation to the sexuality of men. What happens after male orgasm, if anything, was even more difficult for women to find the words to describe - afterplay?

c) Orgasm

Few women regularly experienced orgasms during love-making although their partners almost invariably did. The importance that women placed upon having orgasms varied but they were more likely to see having orgasms as relatively important if they did, at least sometimes experience them. As a goal of sexual activity, achieving orgasms was thought to be too narrow a concept and yet, sex was more satisfying to women when they did have orgasms.

Women frequently felt confused about whether they ought to expect to have orgasms or not:

'It's not all that important. I enjoy the sex act although I may not experience an orgasm. I spent years not knowing what an orgasm was and then started to feel very cosmopolitan

and went around thinking everybody had orgasms all the time. I suppose through my sexual experience I've found that I don't orgasm very easily. And I don't believe that sexual relations are about orgasms. Men, of course, do.'

Male orgasm is, of course, incorporated into the definition and practice of what sex is; female orgasm is by-the-by, if at all. The result of this relation meant for women that they did not orgasm easily, since sex is not designed for women to reach orgasm. Confusion often arose when women felt they ought to be having orgasms too, yet sexual activities continued to be geared to men. Women sometimes felt under pressure, as well, from their partners' expectations that they should be experiencing orgasms:

'I don't have them very easily. In my case I'd say it depends entirely upon my partner's attitude towards it. I can easily feel under pressure that I should have one, and I don't if that's the case. And because that tends to be a general expectation of mine, I don't very easily at all.'

Expectations surrounding the experience of orgasm, whether it should or should not be happening, and what that experience should be, could add to the uncertainty women felt about what actually was happening:

'I sometimes do and sometimes don't. It's very difficult to actually know when I'm having orgasm. Sometimes I think I am, but not actually. I mean there's a lot of stuff been written and said about orgasm that's really clouded the issue. You think you're supposed to be having something really stupendous and because you're not, you wonder why not.'

If what sex is is presumed to be satisfying for women, then either orgasms are deemed to be unnecessary for women's sexual satisfaction or they too should be experiencing orgasms. That women tend not to find this form of sexual activity orgasmic is taken as evidence, as Patricia Faunce and Susan Phipps-Yonas (1978) have suggested, that women are either less sexually responsive than men or too sexually demanding for men. Thus the implication of women's experiences of sexual activity that there is something wrong with what sex is becomes redirected; the question becomes: what is wrong with the women who do not find sex satisfying?

It is therefore difficult for women to assess what they are experiencing and a risky business to voice dissension, since this would be to 'admit' abnormality, or even perversity. At the very least, raising objections to what sex is is likely to be seen as selfish, and as unfeminine. This applies not only to whether or not women ought to be experiencing orgasms, but to what kind. Insistence upon the significance of the vagina to the denial of the almost-unmentionable clitoris as the centre of female sexual feeling clearly fits comfortably within the male-oriented definition of what sex is. However, it fit less comfortably with women's experiences and often left women feeling there must be something wrong with them:

'I feel that sexuality is sort of clitoral really, but I find it hard to talk about that sort of thing. I don't know if it's because women's sexuality has always been connected with penetration, so I suppose in some ways it makes me feel maybe I'm abnormal or something if I don't have an orgasm through that.'

Even though women came to realize the importance of clitoral sensation in their own experience, over time, it was more difficult to assert this in their relationships lest their partner identify them as abnormal. Clitoral sensitivity, not being central to what sex is, was often associated with masturbation, and masturbation bore connotations of failure and selfishness.

Denial of the clitoral orgasm and projection of the vagina as the appropriate centre of women's sexual feeling achieves an image of female sexual satisfaction as being dependent upon that of men's. Herein lies the significance, argues Anne Koedt, of 'the myth of the vaginal orgasm':

'The establishment of the clitoral orgasm as fact would threaten the heterosexual institution. For it would indicate that sexual pleasure was obtainable from either men or women, thus making heterosexuality not an absolute, but an option.' (1970, p.166)

Her argument is supported by the evidence that despite the establishment of the clitoral orgasm as fact, male-dominant ideology insists upon the

centrality of vaginal response (Scully and Bart, 1973; Overfield, 1982). For example, in a recent medical textbook on sexuality, Dr. Oliven defends the dominant view against feminist criticism:

'In female orgasmology intensity is not the same as quality, nor is relief the same as rapture.' (1974, p.187)

Clitoral orgasms, he argues, are self-centred; the woman 'extracts pleasure'. In preference, during vaginal orgasm, the woman 'surrenders..to her mate's desires and needs'.

The achievement, or the appearance of achieving what ought to be, at the expense of what is, will obviously involve a degree of self-denial. Many feminists have pointed out that the extreme virtue of femininity is self-sacrifice. Women are taught from childhood that others' needs, particularly men's, take priority over their own; by adulthood it becomes so taken-for-granted that biological predisposition is often regarded to be the cause. Sexually, too, women are informed that what suits men should also suit them. Self-affirmation is denigrated as selfishness. The clearest example of this is the phenomenon of faking orgasms. A concern for the man's feelings, that he be protected from the knowledge of the actual experiences of the woman and the unsatisfactory nature of male-oriented sexual practices, would sometimes lead women to put on an act:

'It's difficult, if you don't have an orgasm, do you say anything? There's a lot of dishonesty sometimes and I'm not really sure how you cope with that, 'cos if you mention it the partner feels, somehow, rejection. There's the feeling: just pretend and it'll be all right.'

Faking orgasms is an immediate solution to a difficult problem; the man is reassured about his sexual abilities and the sexual relationship appears to be successful. The cost is the woman's, for the appearance can only be maintained as long as she denies the reality of what sex is like for her.

Self-denial was also evident in the views women held about the importance of having orgasms in their sexual relationships. While

there was a predominant feeling that orgasm had to be looked at in the context of the whole relationship, several comments suggested that the relationship was being stressed instead of, rather than as the context of sexual satisfaction:

'It depends on the partner you have. It's not just physical things. It's the whole kind of attitude you've got to your partner, the kinds of things you find enjoyable together. You can't just keep to sex.'

'Sometimes I don't feel so satisfied with the sexual side of the relationship, so I make sacrifices, but it's not the most important thing.'

The importance which their male partners placed upon engaging in sexual intercourse and having orgasms was usually very different. It was often because of the prominence their partners gave to the sexual aspect of the relationship, that women continued to engage in the sex act.

The large gap between their partners' interest and experience of sex, and their own, was seen by a few women to be 'unfair'. For the majority, however, it was simply what sex was like, and what men were like about sex. They had learned to lower their expectations in order to accommodate this difference of experience:

'It's difficult, but if you don't expect much when you start out...'

'Sometimes I worry about it and think I'm missing out on all these wonderful orgasmic climaxes, but it's not a thing I've come to expect really.'

For a few women this pattern of self-denial extended to self-blame. That is, they blamed themselves for 'not putting enough into it' and therefore 'not getting much out of it'. And more important than the fact that they did not enjoy it much was the effect it could have on the man:

'Perhaps I'm just awkward; I don't relax enough. It's a bit bad. I can feel that I'm taut inside. I worry I'm not giving him all I've got.'

It is only where taken-for-granted notions about what sex is conceal the inequality of sexual practices that women's self-denial and self-blame can appear to be perfectly reasonable. The supposed mutuality of the heterosexual endeavor denies the actuality of what sex often feels like to women, and implies that any problems emanate from inadequacies in the individual woman concerned. Improvements, too, may appear to rest upon the women whose 'hang-ups' or 'inability to enjoy' are portrayed to be the cause of problems; it is seen to be their responsibility, if not their failure, which is the key to change.

d) Changing sex

The importance of the appearance that women either enjoy, or do not object to what sex is lies in its justification of the status quo, i.e. that men's needs and desires take priority. Why it is that men's desires appear to hinge upon women's subordination, or femininity, is a difficult question, but one which must also be seen in its relation to the maintenance of sexual inequality. It is clear that claims by a growing number of women in recent years for equality with men, in and out of the bedroom, have resulted in considerable concern (primarily by men) for the effects such mutuality may be having upon male sexuality; for example:

'A man's power and the woman's admiration and gratitude were important aspects of sexual desirability and sexual arousal. The yielding, responsive, appreciative woman was sexually stimulating and desirable while the new woman, who does not need to be conquered, who does not need to submit to male sexuality but demands it as a right and does not become dependent upon the male, undermines his patterns of sexual desire. (Frankl, 1974, p.163)

'Uppity women' stand accused of creating an epidemic of male impotence.

The fragility of male potency was less a central concern to women in the study than the fragility of men's egos.. Offending their male partners, causing them to feel inadequate, threatened or rejected, was the main

reason given by the women for their hesitance to inform their partners about what sex was like for them. For some it was expressed in terms of general politeness:

'I find it difficult, as on any social occasion, if somebody thinks they're doing something that they really enjoy and you really enjoy, and it's boring you to death. I find I'm embarrassed to say I'm bored; so I don't.'

For others it was a matter of simple consideration:

'If you're discussing something with someone else that partly affects them as well, I think it can be rather selfish just simply to feel you've got to be able to say everything you feel about something.'

The risk of offending men was weighed against the importance women attached to their own sexual satisfaction. The fact that women tended to find men were easily offended or insulted by their sexual honesty complicated the process of change:

'He finds it quite easy to talk about his (sexual likes and dislikes), but not mine. I feel I might hurt him in some way. I think they see it as more of a hit on their ego than we do.'

'If I had intercourse and didn't have an orgasm, I'd feel justified masturbating to have one, but I think it would depend who I was with because a lot of men feel insulted by that.'

'It's the thing about making him feel inadequate, even though I know there's no adequate or inadequate.'

The misconceptions which their partners had about how women did or could experience sex were difficult to correct when this was seen as offensive. Talking, or taking other actions, were approached very cautiously so as to avoid making their partners feel insecure.

If the relationship was one which the woman wished to continue, she was likely to be concerned not to offend her partner. It was only once a woman began to rely upon his emotional commitment to her and envisage the long-term

possibility of the relationship, that the risk began to appear worth taking:

'It's entirely a question of whom I'm with, which has to do with how long I've known them. Generally it takes a very long time.'

'It becomes easier eventually, but it's not something I'd start rabbiting on about straight away.'

'I don't think my husband and I know each other well enough yet.'

For many relationships the time for working out such difficulties never came. Becoming involved in another relationship was sometimes the first indication that women had to suggest changing what sex is to be a possibility:

'I only just discovered sex since I left my husband. It's so nice not to feel a freak anymore.'

'It was important that I was able to (have orgasms) in this relationship because I'd got into a feeling that I never would and I hadn't recognized that it was to do with the relationship, rather than any incapacity to erupt.'

Having sufficient freedom to change relationships was of value to women both in experiencing the possibility of change and in negotiating change in sexual ideology and practices. Certainly varied experience tended to make women feel more critical of their partners, and sometimes to increase their expectations of what sex could and should be like for them. Increased expectations about what sex should be like decreased their feelings of tolerance for male-centred sexual attitudes and practices.

Whether change is possible within individual heterosexual relationships is a question much debated by feminists. It was clear that many women in the study hoped that their sexual situations would improve either when they knew their partners better or when men became more 'educated' about women's sexuality or when they found the right man. Their confidence that 'things are changing' was related primarily to increasing acceptability, in some

social circles, of women's freedom to engage in 'extra-marital' sexual relationships with men. Also some women's present situations were an improvement upon sexual relationships they had experienced in the past. There were differences in the consideration to women's feelings and sexual desires which appeared to be given by male partners.

Despite the difficulties involved, some women had worked very hard at confronting stereotypical attitudes and demanding that their sexual relationships be conducted on a more equal terrain. They had braved incurring their partner's displeasure, causing offence and confronting the possibility that he might prefer to be involved with another woman who was more 'normal' and accepting of male privilege. They had confronted, too, their own fears and expectations and learned patterns of how to relate to men. And, to some extent, things had improved.

Clearly, some change is possible. The question of whether heterosexual relationships can become equal, however, must be viewed in terms of the structural supports for the privileges accrued to men and denied to women. As long as it remains the prerogative of men to choose whether or not to implement their privileges over women, or to grant women freedom and consideration, in individual sexual relationships, they remain unequal. This is not to deny that individual women are likely to appreciate good will from individual men, but it is to point out that these men retain their prerogative to do otherwise. Equality in sexuality can only exist when mutual consideration, as equal privilege, is taken to be a matter of course, rather than being dependent upon one of the parties involved to grant or withhold from the other.

Sex - for what purpose?

Sex is generally presumed to be an exchange between equals for some mutual purpose - be it pleasure, affection, having children and so forth. At the same time, the social norms and sanctions which surround with whom sex should take place and the activities involved in what sex is reflect and perpetuate male-dominant/female-subordinate relations. Therefore, while sex may be an exchange, sex between men and women cannot be said to be an exchange between equals.

a) Pleasure

As long as the definition and practice of what sex is centres upon penetration and ejaculation of the man's penis in the woman's vagina, then women are limited to obtaining what pleasure they can from this experience. Indeed, while with whom one engages in sex and what practices occur remain oriented primarily towards men's desires, women's pleasure is at best secondary and at worst an impediment. Women's sexual attractiveness to men is the predominant theme of sexuality reflecting on the one hand, that sexual pleasure is about male pleasure and on the other, a prescription that this theme comprise a major pre-occupation in women's lives.

The orientation of sexual ideology and practices towards what turns men on, and against what might offend men, has been discussed in preceding sections. The majority of women did not find this form of sexuality orgasmic or satisfying. Nevertheless, they found sexual relationships enjoyable in a number of other ways. The sensuality of being in bed with their partner and the warmth of feeling close was physically and emotionally pleasurable to women. The pleasure which they were able to give to their partner was enjoyable for several reasons including feelings related to the ability to give such pleasure, the emotional security in feeling their partner enjoyed being with them, and the shared enjoyment of their partner's

pleasure. Sexual arousal was found to be closely tied up with the sensuality of affectionate and caring relations.

Women's enjoyment of their sexual relationships was enhanced when they felt their partners shared this form of pleasure:

'I have found men who are quite similar to me in that total bodily contact is as important as actual intercourse and ejaculation. But I do know men who, sex is just about, very genital, just about getting in and ejaculation and release and "Wow! What a climax!" It's very frustrating and depressing really. I think on the whole, it's more divorced in men from affection and physical comfort and caressing than it is for me.'

When they did find someone who was sexually considerate, sensual and affectionate with them, they were inclined to make sure that their partners shared this pleasure:

'You sometimes feel it's been particularly satisfying, if you start a love-making session and you have a lot of satisfaction from it, then you feel that you want to give something as well so that the other person enjoys it too, and gets the same sort of feeling from it.'

Whether women enjoyed the sexual activities, or primarily the sensuality and closeness of being in bed with their partner, their sexual pleasure was dependent upon the reciprocity of the emotional relationship:

'Affection is just sort of an extension of the whole thing, not just a sexual need, but it's just sort of part of loving, if you like, and of sex and everything.'

The emotional closeness which women felt with their partner was an important aspect of the physical enjoyment they experienced. Sexual pleasure was intertwined with the emotional experience of caring for and being cared for, of giving and receiving affection.

b) Affection

Affection, or being affectionate, was expressed as that behaviour which revealed an emotional commitment between partners. To women it meant a feeling of security in thinking that their partner would be concerned about their welfare, and feeling a concern for his. Sexual pleasure was linked with this emotional assurance, but affection and sex were clearly distinguishable. Affection formed the basis of a sexual relationship, and perhaps the precondition for it:

'Affection is much more important to me than sex.
I think I need the proof of the affection before I
can allow myself to think about sex.'

This emotional commitment, though it did not necessarily need to be intensive or long-term, was considered to be important with regard to the consequences of sex for women. The possibility of pregnancy and the double standard of sexual morality made it more likely that the woman rather than the man might suffer as a result of becoming involved in a sexual relationship. It was therefore significant to women that they be able to count upon their partner's emotional commitment to them if such consequences should arise.

The experience of 'being used' referred largely to the fact that when this emotional commitment was tested by circumstances which developed, it was found to be unreliable. As one woman who discovered that she was pregnant explained:

'I felt very let down...He just told me to get lost and get on with it, which I found was an amazing attitude.
He just wrote me a letter saying good-bye.'

In other cases women had found that men were affectionate with them only until, or insofar as, sexual activity would occur, and thus could not be relied upon for any emotional support. These experiences, and awareness of the possibility that such experiences might occur, tended to make women wary of engaging in sex:

'I've reverted back to the kiss and cuddle stage. The three men I have had sex with usually ended up finishing the relationship quite quickly.'

'My feeling as a woman is that the relationship has to be built or one has the feeling of being used, and I don't think men experience that.'

Unless women had at least some degree of assurance that their partners would be interested in them even after sexual activity had taken place, they generally felt reluctant to engage in sex.

Within ongoing relationships, too, women tended to feel that being affectionate, and feeling assured of their partner's affection for them, was at least as important as having sex and necessary to their sexual enjoyment. Men, however, were found to be less able or less willing to distinguish between sex and affection:

'I think that women tend to be much more physically affectionate, just when they need a cuddle without anything else, than men. Men seem to take that as some kind of initiation.'

'He thought every time I put an arm around him or gave him a hug that I was ready to leap into bed with him.'

For some women, engaging in sex with their partners was a way of acquiring affection from them; as one woman expressed it:

'If there was a choice between affection and sex, there'd be no competition.'

suggesting that, in fact, there was not that choice. The tendency of men to not be affectionate with their partners, outside of sexual activity, was frequently remarked upon, and explained in various ways:

'Men tend to see being affectionate as being effeminate.'

'Men sometimes say they cannot be bothered with giving affection to women.'

'It's probably more repressed with men.'

'I want affection more than sex, whereas men, well, perhaps they show their affection through sex.'

Whether men considered giving affection to their partner as unmanly, too much of a bother, or too difficult for them except through sex, it was not a very comforting position for women. The problem was not that men did not seem to want affection:

'My husband needs more affection than I do...I don't know what it is, but I'm quite aware that he needs quite a lot of attention and affection.'

'I find blokes want affection. I think it's a real myth about men wanting sex and women wanting affection. I think men are dying to flop their heads against your chest and be protected.'

but that they were less likely than women to give it, and less likely to be affectionate outside of sexual activity.

Women's sexual pleasure was closely related to the warmth and affection they exchanged with their partner. Compatibility in sex hinged on compatibility on an emotional level, before and after, as well as during sex:

'I think there's much more of an emotional involvement on the female side, and therefore what happens before and after is an integral part, where with the male, it's much more of a separate thing.'

The differences they found between men and women in giving affection, and in the importance of feeling emotionally close, before and after sex, often interfered with the expectations and conceptions women had of the mutuality of sexual enjoyment:

'Afterwards he's all ready to get up and go and do something, whereas I like to lie there and be relaxed for a couple of minutes and just be together, and he's all ready to go and play his guitar or mend the car or something. I used to be upset when that happened but I think that's just the way a lot of men are.'

Sex itself was an activity oriented more towards men's enjoyment than women's. Men's physical and emotional satisfaction is the central focus

of what sex is, and hence, men were more likely to have their affectional needs met through sex than were women. Because sex is, by definition, geared towards the man's relaxation, sexual stimulation and satisfaction, sexual activity presupposes the woman's sensitivity and responsiveness to his needs (unless he is unconcerned with her response); thus, engaging in sex is likely to be emotionally as well as physically satisfying for men. For women it could be quite the reverse:

'When I'm extremely anxious about something, I feel sometimes that love-making's an indication of how totally unaware the bloke is about how anxious I'm feeling because when I'm all tense it's virtually impossible to relax... I tend to feel used.'

Because the sex act does not necessarily include the man's emotional support and sensitivity to his female partner, sex is less likely to be emotionally or physically satisfactory for her. This imbalance was expressed by women in terms of their concern for affection as distinct from sex, while for their partners it was the same thing:

'I probably want more affection and he probably wants more sex.'

'I like to be cuddled and he likes to make love.'

It was largely because women did not find their affectional needs were met through sex alone, that they emphasized this distinction. Men, who were found to be less likely than women to give affection to their partners outside of sexual activity, were also discovered to be less considerate of their partner's emotional needs during sex.

It is perhaps because men acquire affection through sex that their partners found them to be less affectionate at other times. It may be difficult for men to understand that women tend to experience sex differently. The privileged position which they occupy in relation to what sex is suggests that they do not need to understand, since their own needs are more likely to be met. Within male-dominant sexual ideology there are innumerable justifications for such privilege, including the denigration of women's concern

for affection.

c) Having children

Engaging in sex for children may initially appear a contradictory purpose, when contraception is being used. Yet, as women repeatedly pointed out, sex cannot be isolated from the context of the relationship in which it takes place. That context includes visions and plans for the future and part of that future for women is seen to be having children or at least, allowing for the possibility of having children. Although their immediate concern was to avoid pregnancy, women planned for a situation in which they might be able to 'comfortably' bear and rear children.

To create and secure a comfortable situation appeared to most women to involve the establishment of a steady and reliable relationship with a man. Social pressures and a lack of alternatives structured their practical decisions to living within heterosexual family units:

'People don't make a definite choice to have children or not to have. Like marriage, it tends to be something that just happens because it's the next stage along a life pattern, and I feel that particularly women don't have access to things that would widen their choice.'

It was not that many of the women would not have preferred to have the possibility of raising children in situations which appeared more attractive to them than the nuclear family unit. Group situations, living with another woman or living on their own were thought to be varyingly preferable but simply too difficult to take on:

'It's not a question of choice usually. It's just the prevailing attitude that children should be brought up in marriage. I wish it wasn't like that, but I think it is.'

'I don't think it's right to have children without being married...If I got pregnant we'd probably get married. I wouldn't want to. I don't know, I would just have to wait and see.'

I think a mixed group would be one of the most preferable but I don't know how practical that would be. I've thought about them (alternatives) but I would simply take what came, what seems most convenient at the time.'

What seems most convenient tends to be a heterosexual relationship, probably married. Despite objections or hesitations about marriage, two-thirds of the women interviewed felt they would want to be married when children were involved. Most of the remaining third envisaged living with their partners, either in a marriage-like arrangement or in a larger mixed group.

Ninety-two per cent either did, or thought it would be most practical to live with a man who was involved with them in having or caring for children. Whether or not to be married was weighed up largely in terms of the added security versus the added problems which were thought likely to result. For example, one woman who definitely wanted to be married explained:

'It's because I don't think he would break away so quickly. He's quite up and down; he'll disappear for a couple of months. So it would be more reassuring to me. I'm not against having children out of marriage; it's just that it would be more reassuring.'

while another who did not stated:

'I'd rather have children without being married. The idea of marriage frightens me. I feel more free; I'm still me. Society would see me as someone's wife if I was married I think. And if you split up, you'd have to go through all the divorce rituals and custody hassles.'

The importance of establishing a relationship with a man who would be involved as a father to the child/ren was expressed more often in terms of what hardships might be avoided than in positive terms. The decision about marriage, too, was viewed in this way. It was the lack of choice which women emphasized to be most central to their decisions.

One reason which was given involved the avoidance of becoming labelled a 'fatherless family' and having to confront the social disapproval and punitive attitudes attached to women who have children but live without men. . Women often noted that this possibility remained whatever they did initially to prevent it, but thought they ought at least to attempt to achieve a normal nuclear family arrangement. Their most immediate source of disapproval was their own parents; other potential sources were indicated to include employers, neighbours, social services, medical services and schools:

'My family wouldn't tolerate it at all. They would always assume that it was a mistake rather than a child I wanted.'

'They're pretty disappointed in me anyway and I think that would be the last straw. They'd be disappointed because of my father's job. They would be rather ashamed, I think, to tell people that I'd had a baby.'

'Funnily enough, for social reasons, it's hard to withstand all the pressures on you as an unmarried mother because of the stigma attached.'

Awareness of the ways in which unmarried mothers tend to be viewed and treated made women feel that they would not want to be one. It seemed easier to avoid this situation if possible, by getting married or at least securing a marriage-like heterosexual relationship. The 'catching' and 'keeping' of a man can thus be seen to be much more than a romantic fantasy on women's part, for it is a woman's major document of proof of her sanity and her passport to social acceptability. Without it she would be seen predominantly as immature, incomplete and an irresponsible mother.

Second, establishing a relationship with a man was seen to be necessary for financial reasons. Women were concerned to secure an income high enough to care for their child/ren without living in poverty. Although to 'marry for money' was not viewed favourably, few women felt there would be any choice in the matter, when they had children or were planning to have children.

Despite their high levels of educational attainment, an awareness of high unemployment rates and discrimination against women, particularly those with children, meant they did not see themselves to be in a position to support themselves and their children without recourse to another source of income. The threat of poverty brought marriage into an attractive light, perhaps for the first time:

'It would mean taking time off work which might influence employers attitudes towards me, as I haven't a job that's ongoing. Then I'd have to have the child looked after while I was working which would be difficult. I very much doubt whether I'd end up having a job, to be honest. I'd probably end up living on social security. If I didn't have a job, I wouldn't be able to afford to have anybody help look after the child so I'd have to do it all myself. It would become a full-time thing, taking up all my time.'

'It's the material problems of bringing up a child alone. I mean it would be fairly difficult just to survive and that would probably mean that I couldn't give the child all the things I think it needed. I think I'd prefer to be married, for my own protection as well. I'd be in a very vulnerable position.'

The alternatives were thought to be maintaining employment, either full- or part-time whilst caring for the child/ren, or becoming dependent upon social security payments. Employment prospects would be extremely limited, and dependency upon social security was frightening with regard to the minimal payments, moral harassment and personal intrusions which it was seen to involve. Again, the lack of choice was persuasive.

A third reason for women's concern to be in a heterosexual relationship, and married, centred upon the comfort of the child/ren. Even where women thought they would be prepared to brave the disapproval and poverty they were likely to endure, they did not think it fair to 'unnecessarily' have their child/ren subjected to it. For the sake of the child/ren the social stigma of 'illegitimacy' and accompanying poverty would be avoided:

'People can be very cruel and ultimately you think I suppose, if you're going to bring a defenseless being into this world, you want to make his path as easy as possible - mistakenly, perhaps, but you do.'

'I don't think much of marriage but I think the only drawback is that it's going to have an effect on the child in the present attitudes. It would only be for the child that I'd consider it, if I did at all.'

Marriage is the only means by which women can protect their children from bastardy, by definition. The social abuse of unmarried mothers and their children is difficult for individual women to confront, and marriage may therefore appear the preferable alternative.

Linked to this was a fourth reason to form sexual relationships with men. What is deemed to be in a child's best interests is the inclusion of a father figure - either the biological father or his social replacement - in the household. The positive contribution of this figure is not clear, and indeed, recent feminist explorations of fatherhood suggest that the idealised importance of the father figure may be based more upon patriarchal myth than the reality experienced by women and children (Polatnick, 1979; Rights of Women; 1979; Rich, 1980; Sutton and Friedman, 1982). Women in the study expressed the significance of male influence predominantly in terms of a counter to, or avoidance of the effect of women upon children:

'I think it's a more healthy situation if men are there. It gives children a father figure and sort of balances out the bitchiness associated with women in groups.'

'I would prefer to have some male influence around in terms of child-rearing; I think it's more balanced. Therefore, unless I was absolutely forced into a situation where that would be deprived, I wouldn't choose to live with just women.'

The exigency of a father figure to off-set the mother's influence bore connotations of ill-health and danger, as well as implications of lesbianism, for women-only households and their children. As lesbianism itself, such an arrangement is posed within male-dominant sexual ideology to constitute

failure. Responsible mothers, as sensible 'girls', aim for success, for their children if not for themselves.

Finally, securing a heterosexual relationship in preparation for having children was thought to be necessary to decrease the workload of raising children. It was on this point that women envisaged alternative arrangements most frequently, emphasizing the need for communally shared child-care. In combination with one or more of the other reasons, discussed above, for forming heterosexual couple/nuclear family units, women thought primarily in terms of sharing child-care with a male partner. To decrease the woman's workload and to extend the child/ren's social network, it was seen to be preferable for more than one person to be responsible for child-care:

'Both should share it 'cos it places too much burden on the woman and restricts her completely. And it's not good for the children to have a relationship with one person.'

'You're both parents and you can both get a lot out of looking after the children. Also with the chores that aren't so very nice to do, it's not fair that just one partner does it. You should share the nice aspects and the nasty ones.'

In addition, women were concerned to have someone with whom to share the worries as well as the enjoyment involved in having children. This meant a disinclination to live alone. Living with one or more women was seen to be problematic, as indicated above, though possibly very supportive. A mixed group was thought to be a good situation, but perhaps difficult to organize. The importance of an ongoing relationship was stressed:

'I honestly feel that, having had kids myself, it's really important to have a very regular relationship with somebody 'cos I think the responsibility is quite enormous and that for me, I really needed a hell of a lot of support in getting through it basically.'

For all five of the above reasons, women were most likely to look to marriage, or at least to a heterosexual relationship, as the context in

which to have children.

The negativity with which women viewed alternatives to heterosexuality and marriage clearly reflected practical decisions in the face of the difficulties which they foresaw, should they do otherwise. The position is a defensive one. Engaging in heterosexuality, and seeking to secure a long-term heterosexual relationship and marriage, is likely to appear to individual women to be the best defence. The subordinate position of women to men, the lack of socially acceptable and comfortable alternatives, and the ideology of male-oriented sexuality add up to the appearance of inevitability about the 'choices' available to women. It is in this context that the inequality between men and women in their sexual relations and activities must be understood, for it is the apparent lack of choice which undermines women's dissatisfaction and efforts for change. It was this lack of choice, too, which characterized their decisions regarding contraception.

Decisions about contraception are taken in context of the relations between the sexes. The dominant ideology and practices which surround what sex is, with whom it should occur and the purposes for which it is done bear influence, too, upon what is desirable in a contraceptive. The information, or lack of it, regarding sexuality which is prevalent also affects what is known about contraception. To seek to obtain a contraceptive method is to admit to sexual behaviour which may be regarded as socially unacceptable. The availability of specific forms of birth control hinge upon medical prescriptions and judgments about specific forms of sexual relations. Male-dominant/female-subordinate sexuality entails a similar relation in contraceptive practices.

Choosing and using contraception involves women in a process which may extend over a period of 25 - 35 years, comprising their fertile life span. It is therefore not a matter of taking a single decision in a static situation. Rather, it involves a series of negotiations which may be influenced by changes in age, fashion, information, experience, availability, health, relationships, employment, living situations, having children, political attitudes and so forth. The processes involved in decision-making and action-taking develop with changes in these aspects of women's individual lives, and in the social milieu. Women learn with experience which methods of contraception work best for them, re-examine this knowledge in the light of changes, and sometimes find ways to obtain the contraceptives they prefer through the services which control their distribution.

Negotiating which contraceptive method, if any, to use at any particular time involves individual women in personal transactions with their sexual partner and, if they seek to use a method available only through medical services, with one or more doctors. The content and outcome of these

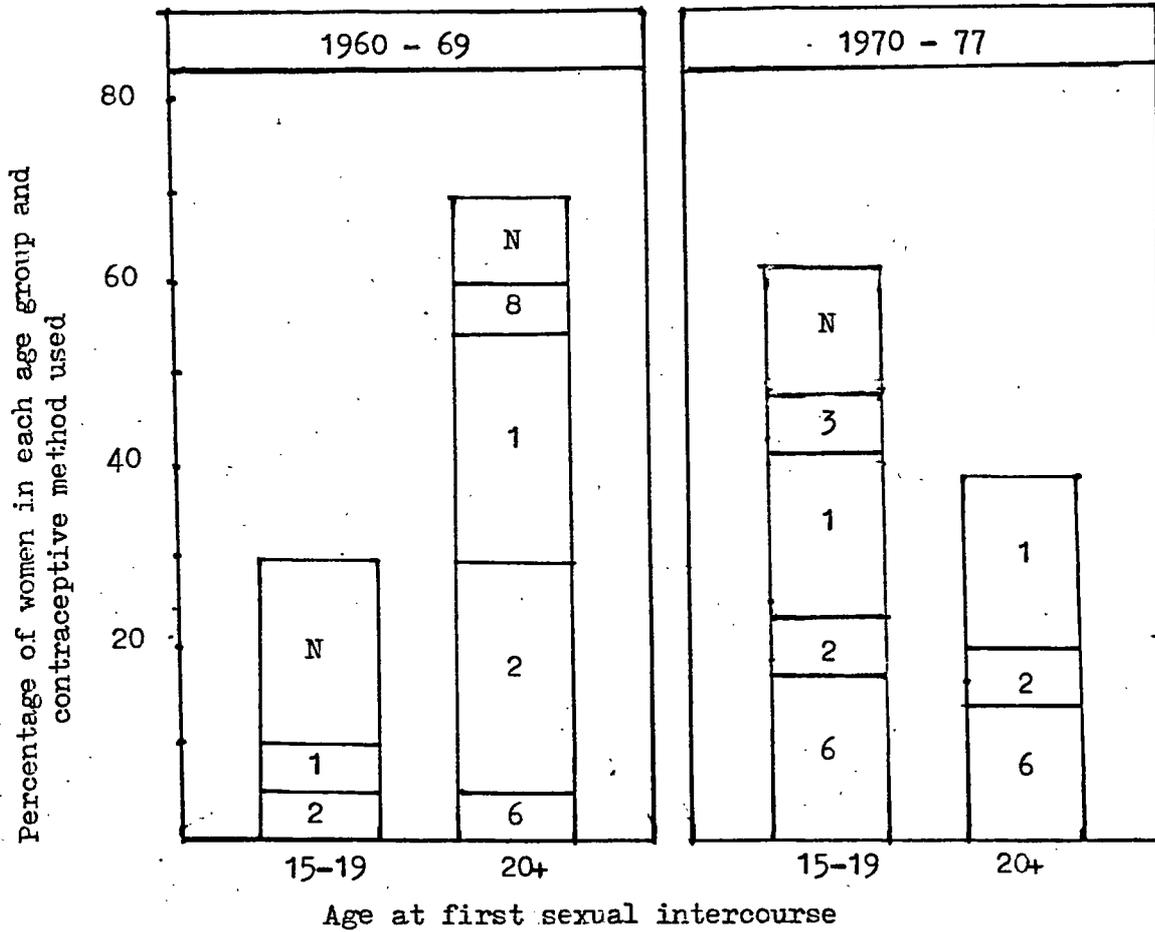
exchanges will be influenced by the relations of domination and subordination which characterize them. The position of women in these negotiations is a defensive one. Their socially subordinate position to men places their concerns about contraception amidst a body of ideas and practices which assert men's privileges and interests over and above those of women. Thus, for example, men's sexual arousal and enjoyment is portrayed to be of paramount importance, while the side effects and health risks to women which this orientation may involve contraceptively is presented as relatively minor. Taken-for-granted notions about contraception are therefore much more likely to be comfortable to live with for men than for women. For women to take positive decisions about meeting their contraceptive needs will involve them in defensive action, re-assessment, redefinition and assertion of their own needs and concerns.

The first contraceptive method

Nearly one-quarter of the women involved in this study had used no method of birth control at first intercourse. Most had not expected, or at least planned, that sexual intercourse would take place. Only once sexual intercourse had occurred was the danger of pregnancy brought to the fore, and with it the urgency of using some form of contraception. Two-thirds of this group began to use contraception within one month.

Twenty-two per cent reported that the initial decision as to whether or not contraception would be used, and if so, which one was taken by/left to the male partner. Naivety about sex, contraception, pregnancy and services, and a belief in the male partner's knowledge, were the main reasons given. Worrying and waiting for periods to come raised doubts in the women's minds, and they began to search for information, talk to their friends and become more involved in contraceptive decisions.

Figure 1. Proportion of women in each age group, along with contraceptive method used, at first sexual intercourse: 1960-69 and 1970-77.



Note: Based on data from 49 women as one woman was known to be infertile at this stage in her contraceptive career. Percentages are based upon 20 women in the period 1960-69 and 29 women in the period 1970-77.

KEY to contraceptive methods:

- N Nothing
- 1 Withdrawal
- 2 Sheath
- 3 Safe Period
- 4 Abstention
- 5 Cap, Diaphragm
- 6 Pill
- 7 IUD, Coil
- 8 Pessaries, foams
- 9 Douching

The age at first intercourse appeared to have had less effect upon the type of contraception used, than it did upon whether any contraceptive was used at all. Figure 1 depicts the age and method of contraception at first sexual intercourse, divided into two time periods: 1960-69 and 1970-77. From this it can be seen that those women who first experienced sexual intercourse in their teenage years were less likely to use contraception than those who were older. In the second time period, 1970-77, this relation is accentuated by the fact that all of those aged 20 plus used some form of contraception. Yet, it must be noted that the proportion of women who engaged in sex at an earlier age differed dramatically, from 30% in the period 1960-69 to 62% during 1970-77. This finding is similar to the recent research of Michael Schofield (1976) and emphasizes the importance of contraceptive information and facilities for teenagers. The earlier age of first sexual experience has been significant to the expansion of sex education in schools, yet the sexual mores and fears of encouraging promiscuity amongst the young, particularly the girls, may severely limit the quality of information made available.

Interestingly, for those women who had used some method of contraception at first intercourse, age did not appear to affect which method was used. For each time period, the proportion using the different methods, indicated in Figure 1, were remarkably similar irrespective of age. Although the 1970-77 group were more likely to use the pill, use of withdrawal remained popular. Rather than suggesting that the 1970's were a time when increasingly more reliable contraceptive methods were used, at first intercourse at least, this indication points to a change in fashion whereby the pill decreased the sheath's popularity, and largely replaced it as the 'obvious' method to use, apart from withdrawal.

Changing fashion

In the early stages of women's experiences with contraception particularly, choices about which method to use were often based upon what was thought to be 'easiest' or 'obvious' at the time. Which contraceptive it was which seemed to be the most obvious varied with its widespread availability and prevailing social attitudes. Thus, for an unmarried woman who began engaging in sexual intercourse in the 'sixties 'the thing to use' was most likely to be withdrawal or the sheath. By the 'seventies withdrawal or the pill seemed to be the obvious method.

This change in fashion was not limited to the method used at first intercourse. It was also the pattern amongst women who began to use contraception during the 'sixties; by the next decade they had switched their use of the more reliable methods, from the sheath to the pill, at least for a time. One woman described the change this way:

'It's commonly accepted now that most women are on the pill, or if not, have some form of contraception. There used to be a time when every lad I went out with had a packet of three in his top pocket. It's reversed. I think it's just accepted that that's the way round it is now.'

Along with the change in the method used was a change in which partner was seen to be responsible for obtaining the contraceptives. The expansion of family planning services, particularly for the unmarried, along with the increasing presentation of the pill as the most reliable and sensible method to use, transformed the obvious by the early 'seventies.

Table 1 lists the proportion of women using a range of contraceptive methods, distinguishing between those in current use, last used and ever used. From this it can be seen that withdrawal, the sheath and the pill are the only three methods which have ever been used by a large majority of the women. Comparing current use with last used method, the most notable changes appear to be the increased proportion of women using the pill, and the relative

Table 1. Methods of contraception in current use, last used and ever used.

<u>Contraceptive method</u>	<u>Current Use</u>	<u>Last Used</u>	<u>Ever Used</u>
	%	%	%
1. Withdrawal	6	16	60
2. Sheath	22	32	82
3. Safe period	8	8	30
4. Abstention	2	10	16
5. Diaphragm, cap	4	6	20
6. Pill	64	24	94
7. IUD, coil	6	4	12
8. Spermicides*	2	2	4
9. Douching	-	-	2
10. Female sterilization	-	-	-
11. Male sterilization	2	-	2
N No method	-	2	50
Number of women	<u>50</u>	<u>45</u>	<u>50</u>

* These figures are for pessaries and foams used alone. In most cases women using the diaphragm, and a few using the sheath, combined their use with spermicidal creams or jellies.

Combinations (except spermicides) and alternations of methods are listed separately, hence percentages add to more than 100.

Last used listings are based on 45 women only, as the remainder have only ever used their current method.

In the case of one woman who was pregnant at the time of interview, the method used immediately prior to pregnancy is classed as current and the previous method as last used.

use between the sheath and the pill. The overall decline in the use of withdrawal, despite its high proportional use at first intercourse, suggests that women moved away from using withdrawal as they gained more experience of sex and contraception. The diaphragm does not appear to have been used widely by the women for either time period; once commonly prescribed for married women, before the pill gained in fashion, it largely did not affect women in the sample who were unlikely to have been married by the mid-sixties.

Finding a suitable method

The women ranged in the length of time they had been using contraception, from 6 months to 15½ years. Sixty-two percent had been using some method of contraception for 5 - 9 years, comprising the majority of the sample. A further 22% had used contraception for less than 5 years; 16% had experience of 10 years or more. Considering the potential of their reproductive life span, the study is focused upon the first third to half of the time they may personally be concerned about birth control.

Their current decisions and views about which method to use now, and in the future, varied with the experience of contraceptive methods and services they had themselves, as well as the experiences of women friends and relatives close to them. The information they had with which to make decisions was also largely derived from their own experiences, or the experiences of other women they knew well. Particularly for those women who either had little experience themselves, or who did not talk to other women about contraception, their knowledge and views about which method to use was constrained by a limited understanding of the alternative methods available to them.

This pattern was emphasized by the general lack of information about alternatives which women had before they personally had need of contraception. Because they had little access to information about sex and contraception, and

talking about such subjects had been discouraged by the requirements of feminine innocence and respectability, knowledge about sex and contraception had been gained largely through trial and error. At the time of interview there were very few women who did not have some general knowledge about the menstrual cycle, conception, and the alternative methods of contraception which exist. However, there was more confusion about how particular methods worked to prevent pregnancy, how to use them, and how available they were. The IUD was the method least understood from the point of view of how it worked, and the safe period and diaphragm appeared most problematic in terms of how to use them effectively. The IUD and the diaphragm were thought or found to be inconsistently available to women, depending upon their doctor, social class, marital status and fecundity. Not surprisingly, it tended to be those women who had used a particular method who were most clear about how to use it, its availability and to a lesser extent, how it worked to prevent pregnancy. The pill and the IUD gave rise to the additional uncertainty as to the possible side effects, risks to health and long-term effects associated with them, and the problem of which sources of information were to be relied upon. Once again the process of trial and error in their own experience or that of close friends was central to their understanding.

Finding a contraceptive method which is likely to suit an individual woman in her particular situation is dependent upon her knowledge of a number of factors: the alternative methods available to her, how to use them most effectively, the likely problems or side effects she might encounter, where to find out further information, where to turn for assistance. As the woman's situation may change or the method in use is found to become problematic, the lack of such knowledge is felt most acutely.

It was this experience of lacking knowledge which women in the study found most frequently when things started to go wrong. Until that point the contraceptive method which they had been using, whether or not this "choice" represented an active decision on their part, had seemed the most suitable. However, once they discovered themselves to be in doubt about the contraceptive method they were using and/or wondering what else they might use which would be more suitable, it often became clear to women that their previous assumptions of what was most suitable had been based on very little information.

Finding out more about contraception seemed to depend in fact upon things going wrong. The taken-for-granted assumptions encountered by the women included such an emphasis upon the pill that other methods were hardly mentioned, let alone presented as viable alternatives, and a view of the pill as being the most suitable contraceptive for most women. It was only when women began to experience symptoms thought to be related to their use of the pill that they found themselves actively searching for more information about other contraceptives, or more information about the pill, in order to decide upon its suitability.

Taking decisions about contraception involved an awareness of the available alternatives, how to use them and the likely implications of doing so. This knowledge was gained only slowly through experience and sharing experiences with other women. In addition, there appeared no easy answer to the need for a contraceptive method which would provide 100% reliability, have no adverse effects on health, and be completely separable from the sex act. Choices were therefore made in context of relatively limited information about less than perfect contraceptives. Finding a suitable method tended to mean finding one alternative which was relatively better than others, insofar as one knew about the alternative being used and the others being dismissed.

Table 2. Percentages of women reporting preference for use/use again of those contraceptive methods they have ever used, and of those methods they have never used.

METHOD	No.	EVER USED			NEVER USED		
		Might use again	Would not	Total	Might use	Would not	Total
		%	%	%	%	%	%
1. Withdrawal	50	22	38	60	6	34	40
2. Sheath	50	68	14	82	6	12	18
3. Safe period	50	24	6	30	8	62	70
5. Cap, diaphragm	50	12	8	20	58	22	80
6. Pill	50	90	4	94	6	-	6
7. Coil, IUD	50	8	4	12	46	42	88
8. Spermicides*	50	2	2	4	6	90	96
9. Douching	50	2	-	2	2	96	98

*These figures refer to pessaries and foams used alone. In most cases women using the diaphragm, and a few using the sheath, combined their use with spermicidal creams or jellies.

Combined totals for each contraceptive method add up to 100%, representing the total of 50 women in the sample. For each contraceptive method listed the total number of women appear as either 'ever users' or 'never users'; each of these categories is then subdivided into 'might use/again' or 'would not' use/again.

Table 2 explores the preferences which women expressed for using the various contraceptive methods, distinguishing between those methods which women had ever used and those they had never used. The figures in the total columns represent the proportions of women who have used the different methods and indicate which ones have been seen to be the easiest and most obvious methods to use in the women's experiences to date. The importance of the pill and the sheath, as compared to the IUD and the diaphragm, in the women's experience is clear. The preference for use/use again reflects knowledge about different contraceptives as well as the advantages and disadvantages of each compared to the others. For example, although few women had considered either the diaphragm or the IUD as a likely alternative in the past, the disadvantages of the methods they had previously selected provoked large proportions of the women to rethink the suitability of methods they had once dismissed. This was particularly noticeable amongst the more reliable methods and those which were primarily in the woman's control to use. Thus, while few women who had never used the safe period or withdrawal thought they might use them in future, a larger percentage of never users of the diaphragm, pill and IUD thought they might use them in future than thought they would not. Interestingly, those women who had ever used a contraceptive method, except in the case of withdrawal, were more likely to consider using them in the future than those who had never used them. This was most marked amongst those women who had ever/never used the sheath and the safe period. In the case of the sheath it appeared related to the fact that those women (or their partners) who had always used the pill were unwilling to tolerate the disadvantages of the sheath. With the safe period, it tended to be the case that women felt confused about how to work out the timing of their cycles, and combine the safe period with other methods, until they had in fact tried it; with experience, many became more sure of the method. The reliability and ease of use of the pill rendered it the one method which almost all of the women would consider using in the future, despite their concerns about the possible health risks involved with its use.

Women who had initially gone on the pill, or who had done so very soon after first having sexual intercourse, tended to depend upon its ease and reliability rather than try several different methods. This meant that when many of them began to experience symptoms, they were at a loss to know what other methods they might use. Having learned through family planning services, magazines and other media sources, that the pill was most reliable and had minimal risks to health, they did not know how to assess their symptoms and were unhappy about the lesser reliability and lesser separability involved in 'the rest'. If most of their friends were also on the pill, they knew little of other methods experienced by women apart perhaps from a brief knowledge of what their mothers or aunts had used. They rarely received information about alternative methods from their doctors prior to a diagnosis of their symptoms being regarded as sufficiently serious to warrant an immediate cessation of the pill. The attitude they had generally encountered was: if it suits you, stay on it; otherwise, try another pill.

Those women who had used one or several less reliable methods prior to using the pill (94% had used it at some time) were also reluctant to give up the ease and reliability which had been gained with it. When they either experienced symptoms, or wished to take a break from the pill, they were likely to have another method to fall back on. Some women used a combination of other methods, each of which may have been less reliable than the pill, but together they were thought to provide a high level of protection. If their friends had similar experiences, there was a range of information available to them about alternatives, and combinations of contraceptive methods to use.

The notion of coming upon a single method which would suit the individual was not realistic to women's experiences. More often a method would be relatively suitable, for a time. After months or years, symptoms might increase, circumstances and attitudes change, and the chosen method become

~~quite unsuitable.~~ —

The process of finding a suitable method was largely one of elimination. Women tended to use at first the method which seemed easiest the most obvious thing to use. Fears about pregnancy often confronted women with the desire to obtain a more reliable method in preference to the one they had been using. Although this was more likely to involve the less reliable methods such as withdrawal, the same process occurred for women who became pregnant or feared they were pregnant using a more statistically reliable form of birth control, including the pill. Those who used the pill first were more likely to eliminate on the basis of side effects or health risks, than were those who used the more mechanical methods, but the latter more often gave up their methods in favour of one which was more separable from sexual intercourse.

The likelihood of finding a more suitable method depended upon what alternatives were known about, seen to be possible, and ways found to enhance reliability through careful use or combinations of methods used. It also depended upon re-assessing what was important about a contraceptive including, for example, a weighing up of the need for reliability, relative to the health hazards or side effects involved; and rethinking the significance of non-interference of the sex act as a criterion as compared to health risks or discomforts. This process of reflecting upon judgments about contraception prompted women to try alternative methods they may have previously dismissed as unsuitable. Although they were still unlikely to find a method which had all the qualities they required, it provided flexibility in choosing a method most suitable to their situations and in replacing a method which had become unsuitable with a relatively more suitable one.

Table 3. Percentages of women attributing the following disadvantages to each contraceptive method.

	Unreliable	May be dangerous to health	Interferes with love-making	Difficulty obtaining it	Nuisance to use	Messy to use
	%	%	%	%	%	%
1. Withdrawal	98	32	100	6	86	66
2. Sheath	40	-	92	4	92	30
3. Safe period	80	4	88	6	68	6
5. Cap, diaphragm	18	18	68	40	86	54
6. Pill	2	90	6	22	20	-
7. Coil, IUD	10	74	12	54	16	6
8. Spermicides*	94	22	72	-	94	96
9. Douching	96	34	38	8	78	46
Number of women	50	50	50	50	50	50

*These figures refer to pessaries and foams used alone. In most cases women using the diaphragm, and a few using the sheath, combined their use with spermicidal creams or jellies.

Several other disadvantages were elicited for each method. The most frequently mentioned include dependency upon the man's control using withdrawal (4%) and the sheath (18%), heavy or painful periods with coil (11%), difficulty working out the safe period (22%).

Table 3 indicates the percentages of women who applied a range of disadvantages to the various contraceptives. In addition to those they were asked about, the most frequently mentioned disadvantages included dependency upon the man's control, heavy or painful periods, and difficulty working out how best to use the method. Of those disadvantages women were asked about 'nuisance to use' and 'messy to use' were considered the least important in themselves and were most often found to be closely tied up with the category 'interferes with love-making'. The following discussion examines the women's responses on the questions of contraceptive reliability, health hazards, interference with love-making, availability, control and menstrual periods with regard to how these factors have affected the decisions they have taken.

Reliability

The importance of reliability in women's contraceptive choices was related to their situations and their views about becoming pregnant and having children. Eighty per cent stated it was very important to them in their current situations not to have a child, and therefore required 100% reliable contraception. A further 14% felt it was fairly important, and 6% saw it as not very important that they should not become pregnant. All of the women, however, wished to have the choice of whether or not to become pregnant and hence, the opportunity to use reliable contraception was vital.

Deciding what is adequately reliable in preventing pregnancy is likely to be a statistical average to the biologist, sociologist or service provider. To the woman who uses it, a reliable contraceptive method is one she thinks or has found that she can rely upon. Women in the study assessed reliability less in terms of statistical effectiveness rates than in terms of a ranking of

the methods they might use, and the risks they viewed as permissible, considering the available alternatives:

'It depends on the way you look at it. I've never looked at it from what percentage safe it is. I just thought: is there any element that's unsafe? If so, out.'

Judgments about reliability were based upon what they had learned to expect were the most effective methods, and upon their own and friends' experiences of actual effectiveness:

'I was given advice that it (coil) was almost 100% effective but I just don't think it is. I know a couple of other women who got pregnant on the coil as well as me...I would only use the coil again if I didn't mind actually getting pregnant.'

'I tend to have a regular cycle so I can work it (ovulation) out almost to the day. My stomach always hurts and I always get very tense and bad tempered - which is always a good sign. So I know, always... I suppose the rates of reliability depend upon how regular you are.'

In general the methods which were regarded to be reliable were those contraceptives which were thought or experienced to be the better of the existing alternatives. Thus, although women may not have been satisfied that they were reliable enough to prevent pregnancy, those methods which were more reliable than others were the ones considered acceptably reliable. The pill was classified as reliable by 98%; the coil by 90%; the diaphragm by 80%; the sheath by 60%; safe period by 20%; spermicides by 6%; withdrawal by 2%; and douching by none of the women.

Apart from using the pill, or perhaps the coil, finding a suitable method meant taking more risks of becoming pregnant than was thought sensible. Willingness to try different methods was constrained by fears of pregnancy. Although a particular method may have worked out favourably, the chance which would need to be taken to find out was often seen as too great a risk to take. The availability of abortion as a back-up measure was favoured by 96%, although

not all of these women were certain that they would take up the option of abortion should a pregnancy result. Nevertheless, the possibility of obtaining an abortion opened for nearly all women a wider range of contraceptive methods from which to choose:

'I'd be more willing to try different methods now than I would have been five years ago but that's chiefly because I know, I hope, I could get an abortion if they failed. So I wouldn't be so frightened about something like the cap; I wouldn't mind trying it now.'

Concern for the emotional and physical stress of going through the process of becoming pregnant, seeking and experiencing a termination of pregnancy, meant that few women viewed abortion as a viable method of birth control except as a back-up measure. However, for those situations where unintended pregnancy did occur, the possibility of having an abortion was thought to be essential.

The pill was the single method which appeared to the women to provide almost 100% reliability. Its separation from sex and its relative ease of use added to its popularity, while its dangers to health were a dissuading factor. This balance was reflected in the large percentage of women who had ever used the pill (94%) and in the widespread concern amongst the women (90%) that it may potentially be dangerous to their health. Sixty-four per cent were using the pill at the time of interview.

In order to minimize the health risks of the pill while gaining the benefit of its reliability as a contraceptive method, women thought in terms of limiting the period of time that they would stay on the pill. This principle was, however, difficult to achieve in practice since the need for reliability remained throughout changing situations, and over many years. For example, women were most concerned to be on the pill when they were having sex regularly since the possibility of becoming pregnant at this time was greatest. The

time to not be on the pill therefore appeared to be when they were engaging in sexual activities infrequently. Yet, for those women who were involved in regular relationships, but only saw their partners for occasional weekends, it did not seem worth coming off after finishing a month's supply of the pill only to begin another cycle a fortnight before engaging in sexual intercourse again. For the pill to be effective there seemed to be little gained by going off it for very short breaks:

'I'm always considering going off it, obviously, because I'm not seeing him regularly. When I go back on it, there's the time when it's not safe, which is a nuisance. I lose the advantage of the irregularity. Sometimes I don't know when he's coming and sometimes I see him more often than others, so it's just easier to stay on the pill.'

Women who were not involved in regular relationships, and who had sexual relations infrequently, were more inclined to think it worthwhile not to be on the pill. Here, too, there were problems. While the risk involved of becoming pregnant may be reduced, the uncertainty of the partner's reaction or commitment should a pregnancy occur meant that it was precisely at these times that women wished to be very sure their contraception was reliable:

'There's no point being on the pill if it's irregular because of the chemical effects on your body. I would use it if I had a regular relationship. But then that means I'm relying on partners to use the sheath or withdrawal and the risk is higher of getting pregnant. I just don't know what decisions I'd make about abortion at all.'

Going off the pill when a relationship breaks up seemed sensible to some, but the possibility of reconciliation, or becoming involved with someone else, meant that these times too it was necessary to have reliable contraception:

'I'd been thinking about going off the pill for awhile. I picked a time when I just had a row with my boyfriend. Then of course, we got back.'

Beginning a relationship, women were often concerned to be covered contraceptively 'just in case', particularly as they found that men tended to expect or prefer women to be using the pill. Also, other methods required

more discussion and care in using them effectively at a time when they were least likely to know their partners well and feel comfortable in talking about sex and contraception with them. The combination of these kinds of considerations added up to very little time during which women could see that it would be sensible to come off the pill. The importance of reliability remained throughout their experience of regular and irregular involvement in sexual activities; beginning, during and at the end of relationships.

Thus although women envisaged alternating the pill with other methods, the reliability which the pill offered was required at most times. Most women using the pill, and a few who were not, intended to use the pill as their primary means of birth control indefinitely. Those who experienced few side effects, or were relatively satisfied that the potential health risks were minimal, felt happy to use the pill over many years. Others were less comfortable with the idea, but considered that they had little choice about the matter:

'I think the thing that influences you most in the contraception you have is the fact that you're limited in your choice. I would prefer not to be on the pill but what alternatives have I got?'

'I find it quite difficult to imagine being on the pill till my menopause. I can't quite see that happening, but then I can't quite see what else I would do instead.'

The difficulty with using another form of contraception was always the increased risk of pregnancy. Combined with the ease of taking the pill, and the separation of sex and contraception, the reliability of the pill made it the most popular method.

Using a combination of methods was an approach adopted by several of the women, to increase the reliability of their contraception. One woman who consistently used the sheath as well as the pill explained:

'I use Durex with the pill and I never used anything else or Durex by itself because it wasn't 100% safe, and I'm paranoid about getting pregnant.'

More frequently women would combine spermicides with the diaphragm, or with the sheath, to lower the risk of pregnancy. In addition, awareness of menstrual rhythms, allowed those who were regular in their cycles to take extra care with the contraception they used, or combine methods, on those days close to ovulation. Combinations were used sometimes by women who had forgotten to take a pill, or who were beginning to take the pill for the first time or after having a break from it. One woman who used the coil, combined this with other methods whenever she had to use antibiotics. For repeated sexual activities, women on the diaphragm would usually use pessaries or the sheath, rather than remove and reinsert the diaphragm. Combining methods was found to add flexibility as well as reliability, to changing situations and contraceptive needs.

Health Risks

The major disadvantage attributed to the pill was its potential risks to the woman's health, and to the health of future generations. Opinions varied on the extent of this danger, and on the relation between side effects and health risks. Ninety per cent of women were concerned that the pill may be dangerous to health. Although 8% were less concerned about the pill's dangers after using it than before, most women expressed increasing concern after a period of several years' use. Symptoms which might indicate side effects or health risks often prompted this change of view:

'I used to think the pill was the answer to everything;
you'd be on the pill indefinitely and you'd be all right.
I don't believe that anymore.'

Whether the threat to health was seen to be great enough to warrant ceasing to use the pill depended upon how serious the experienced symptoms were thought to be and whether any alternative contraceptive method was considered a viable possibility.

Eighty-three percent of women who had ever used the pill had encountered symptoms which they considered to be related to the pill. Usually the first solution sought was to change the type of pill used, and this was sometimes successful in clearing up symptoms. Another solution was to obtain treatment for the symptom, or simply to accept it as something to put up with, and carry on using the pill. Over one quarter of those who did experience what were thought to be side effects, ceased using the pill on grounds of health effects or risks; two out of ten were advised to do so by their doctors.

The hormonal changes introduced in women's bodies through the use of the pill were seen to have a few very serious consequences and many minor ones. The major threats to health were identified to be thrombosis, heart disease, cancer, sterility and the long-term or generational unknown effects. These, though serious, were thought most likely to affect very few women. The risk involved in using the pill was one which women did not feel happy about, but given the risk of pregnancy and the possible emotional and physical stress which might be associated with becoming pregnant, it was a risk that many women felt was necessary to take. Others thought that even though the risk may be numerically low, the seriousness of the dangers to health warranted an avoidance of using the pill where possible. The pill's high reliability was constantly being weighed against its potential dangers, and the balance reappraised with changes in age, health, regularity of sexual intercourse, and relationships:

'It's a relative danger. If it's an alternative to pregnancy the risk seems a good one; if it's an alternative to abstinence then the risks are in a different direction. Medically it is the one that interferes most with the body's natural make-up and organs so it poses the most potential danger, but you have to weigh it against the other risks. I've always wanted 100% protection, so...'

'According to statistics it's not a high risk but the risk is there. Even if serious cases are rare it still makes you think. If I was 25 probably I would just go ahead and use it because to me it's the safest method and it has a small risk. But at my age, especially with the higher risk involved for older women, as they say, I don't think I'd like to.'

As these comments suggest, the risks have to be compared between pregnancy and contraceptive reliability, and between the alternative methods of birth control available. One way to help make this appraisal is the careful review of symptoms which might be associated with the pill, seeking early indications of pending health problems. However, this was not an easy thing to do for deciphering which symptoms are side effects and which side effects are serious could be problematic in terms of the information available, medical attitudes and practices, sexual relationships and defining priorities:

'You can get various warnings such as pains in your legs and things like this but I can think of women who do have those sorts of side effects and the way I was about it too. While you were aware that it wasn't doing you any good and these were signs, you'd make a conscious decision to ignore it. I think women have a particular attitude to their health anyway which is that you tend to put the state of your health second. And the fact that there aren't any safe alternatives to the pill encourages you to do that.'

'Sometimes it takes so long for side effects to become apparent that you really don't know the dangers. I feel very much in the dark about it all, and it's difficult to know whether the side effects that you can have are actually dangerous.'

It was often difficult for women to know whether the symptoms they did experience were dangerous to their health, indications of possible health problems, or were simply effects which may be unpleasant but not a risk to their health. The relation between side effects and health risks was one which women found to be dealt with very vaguely by their doctors and the range of media sources and leaflets where they had learned about other aspects of contraception. They were aware that there were numerous side effects which might occur, but tended to be unclear about what relation this had to their

state of health.

Far fewer women in the sample had ever used (12%) or were currently using (6%) the coil. It was viewed as the next most reliable method to the pill, and one which many women would consider using if they were unable to use the pill for health reasons. Yet, it too was thought to be potentially dangerous to health by a high proportion of the women (74%). While the effects of the pill were generalized, the localized effects of the coil were slightly more easily identifiable. Concern was expressed about perforation of the uterus, ectopic pregnancies, and pelvic inflammatory disease, and about malformation of the fetus should a pregnancy occur. The coil was found to be much more difficult to obtain from doctors and this, too, added to a sense of its dangers to health, compared to the pill. Painful insertion was recognized as a possibility. Prolonged and painful periods were seen to be a likely side effect but were not thought to be a health hazard, unless this led to anemia or other problems of excessive blood loss. In addition, the idea of having something inserted in their uterus was remarked upon by many of the women as unpleasant, worrying or repulsive. The uncertainty which surrounds precisely how the IUD works to prevent pregnancy extended to uncertainty about the possible ill effects it might be having as well. Like the pill, the long-term effects which might occur with the coil were the cause for concern regarding the possibility of future pregnancy, miscarriage, birth defects as well as the long-term consequences upon the woman's reproductive organs.

Other contraceptive methods were seen to be a health risk to a much lesser extent. Douching, spermicides and use of the cap raised some questions about the likelihood of infections, whereas the sheath was seen to protect against infections. Withdrawal was thought by 32% of women to be potentially dangerous to emotional health, particularly of the male, considering the lack of orgasmic sexual satisfaction which may be involved. Interestingly,

having sex without having an orgasm was not perceived to be a health risk to women while it was thought to be often traumatic to men. As this suggests, the perception of health risks and the relative importance placed upon those risks in deciding upon which contraceptive method to use were closely linked to the ideology and practice surrounding what sex is.

Interference with love-making

Separating sex and contraception was seen to be a central criterion in choosing which contraceptive method to use. It frequently overrode the criterion concerning health risks and was tied up with the reliability associated with the various methods. Withdrawal and the sheath were regarded as most likely to interfere with love-making, primarily with the male partner's pleasure. The pill was thought to provide the least interference.

The advantage of using a contraceptive method which was separable from the sex act was twofold. It enabled normal sexual practices to take place unimpeded and it increased contraceptive reliability at the same time. The major drawback remained the fact that those methods which are most separable from the sex act, the pill and the coil, are also those which bear the highest risk to women's health.

The highly ritualized nature of the ideology and practices surrounding what sex is, and the primary orientation of sex to male rather than female pleasure, was discussed in the preceding chapter. The concern that contraception should not interfere with sex revealed a concern to fit in with this order of sexuality. Using a contraceptive which involved 'stopping half-way', 'premeditation' or 'having to discuss it being used properly' was generally regarded as a disadvantage, and problematic to the usual course of sexual relations.

Apart from those women who experienced a loss of sex drive when using the pill, this was the method seen to interfere least with sexual activities. Its availability was thought to decrease willingness to put up with other methods, particularly amongst men. Women frequently found themselves returning to use of the pill despite side effects or apprehension about long-term effects because of their partner's preference for non-interference with their sexual enjoyment:

'He didn't like it one bit when I was having him use the sheath. He prefers me to damage my health with pills. He doesn't have to worry about that. He reckons it (the sheath) spoils all the fun.'

'He'd prefer me to go on the pill. It would be easier for him instead of stopping half-way.'

'He got a bit fed up of using things like sheaths which I suppose pressured me into going back on the pill.'

'I'm not too happy about taking the pill. It's the simplest, but I thought the cap was quite safe. I've been thinking of taking a break but my husband said 'Oh no, the smell of the cream was revolting' so I guess I won't go back even though I was quite satisfied really with the cap.'

Because those methods which interfere least with sex are those which interfere most with women's health, the preference for the former tended to be gained at the expense of the latter. In addition, the general orientation of sexuality towards men's rather than women's needs and desires resulted in the situation for women that their partner's sexual pleasure was protected at the expense of their own health and comfort.

Women's preference for those methods which interfered least with sex centred on the difficulties of raising the issue of alternative methods of contraception. As the assumptions women found their partners had included that women would be on the pill, or taking responsibility for contraception in some way, the onus for change tended to rest with the woman. It was therefore easier for women to go along with the expectations of them, at least in the short run, to use the pill.

The premeditation involved in using the cap was portrayed as more of an interference with sexual activity than the premeditation of taking the pill regularly, or of working out which days were 'safe' according to the rhythm method. This distinction appeared to be due partly to the male-dominant ideology of sexuality specifying that it is the male who initiates sexual activity; while it is expected that the woman will respond to his virility, for a woman to initiate or control sex denotes her promiscuity. The nearness of putting in a diaphragm to the particular sexual episode in which it would be needed confronted women with the contradiction between the importance to men of their femininity and the need to protect themselves contraceptively.

This contradiction had also to be weighed against the advantage of the cap in terms of health risks. For some women this became an important factor, particularly after having used the pill for several years:

'I don't like the premeditation bit about the cap but I think on the other hand, it's not interfering with any of your body processes, so that's an advantage. It's not upsetting the hormonal balance or inflicting heavy periods on yourself.'

Its lesser reliability was of course an additional problem, although there was much uncertainty whether its assumed lower reliability, compared with the pill or coil, had to do with the method itself or the temptation to use it without spermicides or on occasion, not at all.

Contraceptive methods which were closely associated with sexual activities included withdrawal, the sheath, safe period, cap and spermicides - the majority of the available alternatives. To be used most effectively all of these contraceptives required information and discussion between partners. Male dominant sexual ideology and practices conflict with this requirement in the emphasis which is placed upon romanticism and emotionality during sex, to the extent that rational control is portrayed to be more or

less lost. This made life difficult for women who were worried about the likelihood of becoming pregnant. Not only did this approach to sex negate against discussions about and reappraisals of sexuality; it precluded discussions about and careful use of contraception. Hence, the concern of women for contraception which was totally separable from the sex act was as much in pursuit of reliability as ease of use.

One way which women found to bridge the gap between sexual romanticism and contraception was to treat the situation with humour. As one woman explained:

'Whether it (the sheath) interferes depends very much on the person, I mean your boyfriend. It doesn't interfere with us 'cos I don't know whether he does or not but I think it's very funny. They can actually add a lot of humour to the situation.'

Another way was to insist upon discussing contraception in detail outside of the context of sexual activities so that when sex did occur both partners understood what was expected of them regarding contraception. The equality of this latter approach was complicated by the inequality of the consequences should the mutual agreement not be carried out. The most frequently chosen solution was for the woman to use a method of contraception that was primarily within her own rather than her partner's control.

Control versus responsibility

For those women who began sexual relations before the pill became widely available and for those who had at least at one time regarded contraception to be the man's responsibility, the fear of becoming pregnant was always close at hand. The potential for using highly reliable methods, made even more reliable by the fact that their use was within the woman's rather than the man's control, was therefore welcomed with great relief.

The pill in particular appeared to present women with freedom from worry about unwanted pregnancy and thereby, sexual freedom. At last it seemed that women could engage in sexual activities on the same basis and with the same freedom as men. The difficulties achieving sexual equality within male-dominant structures and male-oriented sexuality notwithstanding, women's power in sexual relationships increased through their access to highly reliable, female-controlled contraception.

Eighty-six per cent of the women expressed a preference to take the contraceptive precautions themselves, 6% preferred their partners to take them and 8% expressed a concern that as the responsibility for contraception should be joint both partners ought to take precautions. Although the most reliable contraceptives available are those which are female methods, 56% of the women stated that the reliability of being in control of the methods used was most important to their preference:

'I'm the one who will get pregnant and in personal terms I like to be in control of what I'm doing.'

'I'm more reliable.'

'The same reason I like washing lettuce myself - then I know I've got all the bugs out. I can trust myself.'

The importance of retaining control over contraception was considered to be paramount in situations where women were uncertain about their partner's commitment to them should pregnancy occur. In some cases of long-term relationships women found the question of who takes the precautions to matter less for two reasons: first, they were more certain of their partner's commitment:

'Now I'm married I don't think it really matters because we do discuss it.'

and second, as the couple tended to use a number of different forms of contraception over time and to discuss their changing needs, problems, and use, control over contraception became less closely associated with who took the precautions:

'It's an area I very much want to be in control of since it's me that it affects, but I no longer regard him using the sheath as his thing and the pill as mine.'

Women were much more likely to trust men with whom they were involved in long-term relationships to be concerned about the possibility of pregnancy. But problems of men's conscientiousness in obtaining sheaths or their dislike of using the sheath and withdrawal often directed women in long-term relationships, too, to seek the added reliability of female-controlled methods.

Despite the relief of added reliability achieved through having control over the taking of contraceptive precautions, women felt much concern lest this allow men to become increasingly irresponsible about contraception. Recognizing themselves to act more reliably than their partners, women wished to be in control of taking precautions and the majority preferred methods which were not dependent upon their partner's actions. On the other hand, most men they thought were only too happy to let women take on the responsibility for contraception. Women assessed their partners' attitudes thus: 78% of the men were thought to prefer the women to take contraceptive precautions, 20% didn't mind which partner took the precautions and 2% preferred both partners to use contraception. Again the reliability of the pill and its separability from the sex act affected their preference. But women were perturbed by a number of other reasons which they attributed to their partner's preference.

One of the concerns expressed related to the assumption of a woman's sexual availability to her partner once she was rendered 'safe' from pregnancy. This sometimes made women feel reluctant to use the pill:

'I prefer not to let my partner presume he can have sex with me when he likes and it's going to be okay. I don't like to be abused, you know.'

Another had to do with the consequences of sexual activities. If responsibility for contraception was assumed to be the woman's, the man did not need to think about the possibility of pregnancy:

'I've never known a man who likes taking precautions himself. They don't like the method, but also I don't think they like to think about the implications of the possibility of getting pregnant.'

As the man does not become pregnant, he can be disassociated from the consequences of sex and therefore from contraception:

'It's inclined to enable the man to totally forget he has any responsibilities whatsoever. It's no trouble for them. They don't have to know about it. They can just forget about it.'

The preference of men for women to take responsibility for contraception was thought to conveniently let men off the hook. As well as acting irresponsibly about contraception, men were able to abdicate from any responsibility for pregnancy occurring:

'Most men prefer the pill because it's easier and safe and it's no problem for them and they can blame me for it if anything goes wrong.'

'He prefers me to take the precautions because it's easier for him. And there's no responsibility for him if you do become pregnant.'

The problem for women was often that they had been concerned about their partner's irresponsible behaviour regarding contraception, with the consequence that they worried about the likelihood of finding themselves pregnant. The availability of female-controlled contraceptive methods which were highly reliable increased their control over the avoidance of unplanned pregnancies. However, it seemed to allow their partners to distance themselves from responsibility for pregnancy and contraception, and to focus their own concerns upon their sexual pleasure primarily. Their sexual displeasure with methods such as withdrawal and the sheath, combined sometimes with irresponsibility about obtaining sheaths, made it very difficult for women who felt their partners ought to take on some of

the responsibility for contraception:

'I decided to transfer responsibility to my partner for awhile. But it's not really working out as I've had to buy them all (sheaths) so far.'

The combination of men's irresponsibility about contraception, the fact that it is the woman who will become pregnant, the higher reliability and separability from sex of female-controlled methods, and the greater reliability resulting from having control over the use of contraception convinced most women to use contraceptive methods over which they would have a high degree of control.

Menstrual periods

Having a regular monthly cycle of menstruation was important to women for a number of reasons including being able to work out such methods of contraception as the safe period, as an indication of health, and as evidence that they were not pregnant. On the other hand, periods were often accompanied by pain or general discomfort or tension. In addition having periods could be embarrassing or interfere with sexual relations.

Most women welcomed the lighter, easier periods they experienced with the pill as a valuable side effect. Twenty per cent thought they would remain on the pill for this reason even if they did not need it for contraception. Fourteen per cent had been given the pill by their doctors during their teenage years because of painful or irregular periods. The likelihood of heavier blood loss and painful periods accompanying the use of the IUD was a major dissuasive factor in women's decisions about using it.

The relationship between menstrual periods and contraception hinged largely upon relations of sexuality. Sexual activities were for some women too uncomfortable to consider, or seen as too messy and embarrassing to engage in while they had their periods:

'Ah, no, we never do. I never have. I dislike it. I think I've done it once a long time ago. Plus I don't like the blood 'cos I'm fairly heavy, I suppose 'cos it's fairly messy too.'

'We don't when I have a period; I'm too bloody bad-tempered.'

'I hate it. It tends to stop the period, and then about 4 days later it starts again. Also I feel a bit sensitive and tender.'

For others, their interest in sexual activities was heightened just before or during their periods:

'Oh, yes, I feel randiest then, usually.'

'Quite often I enjoy it more. I just get terribly randy. There's something about it. Not always, but often I do. I enjoy it as long as my partners aren't upset. Sometimes I find they're a bit funny.'

Apart from the discomfort women felt, or the greater enjoyment they experienced, their attitudes to having sex during their periods was very much affected by their partners' perceptions of menstruation. As this latter quote suggests, this was frequently a problem for women.

Whereas women felt that menstrual blood should make little difference to their partners' sexual interest in them, they often worried that it would be distasteful to the men or found that it was:

'I'm afraid he might find it disgusting. He doesn't like the idea of menstruation or discussing it.'

'It doesn't bother me but I don't think he likes it very much. I think he feels it's rather unpleasant.'

Although women expected this discomfort with the idea of menstruation to become easier when they got to know their partner better, several were surprised to find that it became worse:

'He never used to mind. But now if we're making love and he withdraws and it's sort of bloody or anything, he goes "Bleagh". Or if I say I've got my period, he says "Oh, bloody hell" and gets a bit huffy about it. If I've got a tampon in and I have to go and take it out, I mean he doesn't like that at all.'

'Before we got married it didn't matter. But since we've been married, and I suppose the relationship is there as far as he knows, forever, he doesn't like it very much. He finds it restricts him in some way; it's messy or in some way impalatable.'

Those methods of contraception which minimized menstruation or helped to conceal the evidence of menstrual blood were found to aid in avoiding the problem of such perception of menstruation. It was therefore easiest from this point of view for women to use the pill. Its separability from the sex act was enhanced by the advantage of reducing menstrual blood. In particular, the non-interference of men's sexual pleasure could be achieved on a psychological level as well as a physical one, through the use of the pill.

Availability

The increasing availability of the pill and to a lesser extent, the coil and the cap, clearly affected the women's use of contraception from the mid-sixties. The ease with which the unmarried, in particular, were able to find and use contraceptive services improved markedly, judging by the difference in the reports women gave about their experiences, in the 'seventies. Most notable was the change in attitude of both women and service workers; requests for contraception increasingly became seen as legitimate:

'I used to be so embarrassed, but not now. Partly because I was younger and partly because the climate of opinion is different now. I used to feel that I was sitting in the nude with just my handbag. But now it's just like going for tonsillitis; you just go along.'

'It's just like going out to buy bread, a more accepting kind of atmosphere about it.'

There were variations in the type of service or clinic atmosphere which women reported as finding more or less conducive to obtaining contraceptive information and supplies. Doctors, too, were assessed as more or less likely to be able to offer information or assistance with contraception. Despite coming up against moral disapproval from service providers on many occasions, women themselves had found their own views and those of service workers to have markedly changed during the 'seventies. They had begun to think of contraception as their right.

The requirement of women to attend some form of family planning service to be able to obtain the diaphragm, pill or IUD of course made these methods more difficult than others to use. While a few women were able to use a friend's supply of the pill initially, all had attended family planning services within several months after first using it to obtain a further supply. Twenty-two percent of the women had found difficulties in obtaining the pill from their doctors. The reasons for this pertained either to moral disapproval regarding young and unmarried women's sexual activities or to medical views about the age or other health conditions which may enhance the risks of using the pill. Apart from these situations women tended to find the reverse was true - that their doctors easily prescribed the pill, but were reluctant to provide them with further information or other methods of birth control.

Forty percent of the women felt that it was difficult to obtain the cap, or diaphragm. Its decreasing popularity once the pill became available through medics who had previously not been involved in providing

contraception seems to have been accentuated by a decreasing faith in, experience with and knowledge about the cap on the part of family planning service providers. Women often found it difficult to obtain any information at all about the use of the cap or its reliability, particularly from general practitioners. While only 20% of the women had ever used the cap, 70% thought they might use it in the light of the relative advantages and disadvantages they had found with other methods.

The most difficult method to obtain appeared to be the IUD, or coil. Fifty-four percent of women thought or found that their doctors were reluctant to offer them the coil. The most frequent attitudes which they had encountered included that there was no need for them to change methods unless they were having serious side effects from the pill, that other methods were more difficult to use than the pill, and that the coil was not recommended for women who did not have children. These attitudes varied amongst doctors, some women finding their doctors quite happy to fit them with a coil whether or not they had had children or could not use the pill. In a few instances women had been asked at clinics for their husband's signature on a form before they would be fitted with a coil, which was always experienced as a deterrent.

Forty-two percent of the women thought that their doctors had a preference for a particular method; in all but three instances this preference was for the pill. Reliability was of course one reason for this preference but, in addition, the ease of handing out prescriptions, the speed of patient turnover, the assumptions about low health risks and few serious side effects, and the convenience of use were pointed to by the women. The importance of the doctor's preference was experienced in a direct way:

'Well, it's always up to the doctor whether he gives it to you.'

and in less direct ways as well:

'He never really talks about anything else.'

'They just assume that unless there's some reason why not, you should be on the pill.'

'If they just assume the pill's OK and they keep prescribing it, that encourages you to keep taking it. Whereas if a doctor pointed out that there were different methods and that nobody can be 100% sure about the pill anyway, it would probably put more people off.'

Next to the pill women in the study found their doctors to favour the coil, notably for women who had children or who were seen by their doctors to be unreliable, not so bright, or irresponsible. Women were incensed by such attitudes especially if they felt themselves to be acting sensibly according to their own needs:

'Because I'd gone off the pill and then wanted to go back on it after about two months, I think they saw me as very irresponsible. I thought I had a perfect right to go off it if I wasn't sleeping with anybody at the time...The fact that it wasn't a very long gap should have been immaterial..I think they were quite happy to put me on the coil because they sort of saw me as somebody who was 'at risk' or something.'

The extent to which women felt that their doctor's preference was problematic to them depended upon whether or not their own preferences coincided with their doctor's. It was when there was a clash between what the woman wanted and what the doctor she saw thought was best that the power differential between them was experienced most acutely.

Upon initial consultation with a doctor for contraception 84% of women reported that they knew which method they would like to use, 8% were thinking of a method and wanted the doctor's advice and 4% were advised to use the method by their doctor because of another health condition. In recent consultations, similar proportions applied.

Although the large majority knew what they wanted to use, there were many questions upon which they sought their doctor's advice. These included advice about which type of pill to use, what would be most suitable and safest for the woman requesting it to use, the possible side effects and the individual's health condition and risks. After using the method for some time, questions became focused upon side effects and whether to change the type of pill or change to another method. Despite frequent disappointment with the responses from their doctors, women tended to expect that their doctors should be able to provide them with information and advice on these matters, and to look to their doctors as experts.

Changing methods appeared to be more difficult than initially selecting one. This was in part because both women and their doctors were likely to view the pill as the easiest and most obvious method to use. Once using the method women grew to have increasing doubts about the side effects they were experiencing and the risks they were taking. However, it was at this point that women found their doctors to be relatively unresponsive to their concerns about the pill, continuing to emphasize the ease and reliability of taking the pill while dismissing the risks as rare if not minor. This brought home to women the way in which their initial decisions had often seemed so obvious at the time, but had not been the result of a careful or knowledgeable choice from amongst the existing contraceptive alternatives. As one woman explained:

'When I went to the family planning clinic, they said "What method of birth control do you want?" and as I hadn't any idea and most of my friends were on the pill I said "I want to go on the pill" and they said "Okay". I enquired about changing to the coil last year and was advised very strongly against it. They said I'd found a method that seemed to suit me and it would be silly to change. But I'd chosen that method randomly and with very little knowledge at the beginning.'

As discussed earlier, finding a suitable method was a relative matter for women and changing situations demanded flexibility in contraceptive use. From the point of view of service providers, however, it seemed that the method currently being used by the woman was assumed to be suitable, and the woman to be 'happy on it', unless serious side effects were experienced. Whether or not symptoms were interpreted as side effects, and whether or not they were regarded as serious, and by whom, frequently became contentious issues and affected which contraceptive methods were, in fact, made available to women.

This rigidity in the contraceptive methods advised or made available to women was exacerbated by the insecurity of knowing whether or not the back-up measure of abortion would be available should it be needed. Only 6% of women felt they could say their doctors would be favourable to an abortion if they needed one. The remainder did not know what their doctor's reaction would be or suspected it to be unfavourable. The importance of having such a back-up measure was made clear by the women's determination to somehow find, borrow or in some cases, steal the necessary money to gain access to an abortion if they decided it was required. Yet the uncertainty about the medical availability or social acceptability of abortion, and the preference to avoid confronting this situation if possible, meant that women were highly sensitive to arguments about the need to use a 100% reliable form of contraception. Despite the fact that such a thing does not exist, the proximity of the reliability of the pill made it appear the most suitable method to use. Therefore, unless there was evidence of some good reason why not, the most suitable method to use appeared to be the pill. Unless their doctors found, or could be convinced that such evidence existed, the advice women most commonly reported being given was 'it would be silly to change'.

Women who had decided which method of contraception was most suitable for them to use, but met with disapproval from their doctor, had several courses of action open to them. They could accept their doctor's viewpoint, try to change their doctor's opinion or understanding of their situation, or change their doctor. The latter option seemed to be the most likely to achieve change and most women initially or eventually changed their doctor, or clinic, when this situation arose. This was not too difficult for women in this study to do as they had usually moved geographically to attend their courses and had access to the university clinic, their own general practitioners and a range of local family planning clinics in the area to obtain contraception. Moving geographically was frequently a convenient time to change doctors or clinics in an effort to obtain the desired contraceptive method:

'The family planning clinic was suggesting after four years that you should come off the pill completely and change to something else but so far I keep changing family planning clinics. They said that at the last clinic and when I came here they said "The next time you come - " and I thought "No way, I'll have moved by then".'

However, it sometimes took women several years of contraceptive use and experience with different services to realise that doctors vary in their opinions about the relative safety of the different methods and in the range of contraceptives they were most likely to make available to women. Looking to their doctors as experts meant that women tended to accept what was made available to them - until they had experience of other doctors or learned of other women's experience with doctors:

'I went to the doctor to try and get an IUD fitted but he said I couldn't have one because I hadn't any children. But since then I've friends who had IUDs fitted and they haven't had any children. I tried to go to the FPA but they couldn't fit me in for another three months.'

Being able to use the chosen contraceptive method thus meant for women

learning to manoeuvre their way around the range of family planning services to find one which would make that method available to them.

This process was sometimes thwarted by rivalry between general practitioners and family planning clinics in a given area. Individual general practitioners were sometimes insistent that clinics should not provide contraception to 'their' patients, with the result that women found they might have fewer alternative contraceptives made available to them. If this meant that women were unable to use the method they wished they were likely to feel frustrated and infuriated with their doctor's attitude:

'Last time I went to my doctor at his insistence. Normally I go to the family planning clinic which I was happy with, but he went to them and said they weren't to take any of his patients. I managed to give another person's name so I wasn't cottoned onto for some time but eventually he did. It was very annoying. He insisted on doing it but didn't give any of the service the FPA gave...The only thing he had in fact done was to try and get me to come off the pill because I was over thirty. So I thought the service he offered was very bad.'

In this situation women were inclined to change their doctor or look to a family planning clinic in another area. Some women, however, felt unable to change their doctor because of other family members or other health reasons. Unless they were able to successfully insist upon being provided with their preferred method of contraception, they were thereby limited to what their doctor would provide.

A comparison between women's experiences with general practitioners for contraception and with family planning clinics revealed the latter to be favoured for making a greater range of contraceptives available. In addition, family planning clinics were appreciated for the specialized knowledge they were believed to have in the field, the greater number

and regularity of health checks they offered, the greater likelihood of being treated by a female doctor, the leaflets and information sometimes provided, and the acceptance and/or anonymity of attending for contraception. General practitioners, on the other hand, were preferred for their convenience of location and hours of service as well as for the possibility of incorporating contraceptive needs into general health care. The proportions of women currently using each type of service for contraception were nearly equal.

Looking to the future

The vision which women held of their future birth control practice changed with their increasing experience of contraception and family planning services, and the experience of other women whom they knew. At the same time, the alternative possibilities for planning births continued to be constrained by the need for 100% reliability, given the questionability of abortions being available. Hence, women remained reluctant to try new methods or engage in flexible arrangements unless they were in a situation where they would not mind becoming pregnant. They became increasingly aware of their contraceptive needs but were confronted by the lack of a safe and reliable method which was separable from the sex act and easy to use.

For many women the number of years ahead of them during which they envisaged requiring contraception confronted them with great unease. When they had chosen their initial or current method, it had seemed the easiest thing to use at the time. Planning to continue using the method over many years was quite different. Health risks became more central to their concerns, yet reliability and separateness from the sex act remained priorities too. Anger over the risks they often felt they were being forced to take with their health for the sake of sexual ease and

reliability was weighed against the independence they gained feeling fairly sure of being able to avoid unintentional pregnancies. But with the development of side effects over several years of using the pill or the coil, choices became more limited and the need to reassess decisions more acute. The need for greater flexibility in the use of one or a combination of several contraceptive methods, and in relations of sexuality, became increasingly clear.

The future was frequently viewed in terms of the likelihood of having children, and women therefore thought that this would provide them with a break in their contraceptive patterns. Even for those who did not foresee the situation in which they might want to have children, the option was considered a desirable one. However, it was often pointed out that the vague plan to have children or simply the expectation that they would was in practice put off year by year. The requirement of contraceptive reliability had continued beyond previous visions of what the future would hold, and perhaps was likely to go on in this way. This meant that women were sometimes using a particular contraceptive method far longer than they had originally planned, and could not necessarily see any finite period during which their needs would change.

Having children was as far into the future as some women envisaged their contraceptive use; others who either had had children or who were thinking about it closely or who had friends in a similar position could see that their need for contraception would not be dramatically altered. The spacing of children and limiting the numbers of children they would bear meant having to use reliable forms of contraception. Those with the number of children they wanted were very determined to avoid any further pregnancies as far as possible.

Sterilization was a method of birth control that a few women had considered as a current possibility, but the majority felt that it was a decision for some time in the future. While it was thought that it would be preferable for the male partner to have a vasectomy since it was an easier, lower risk operation than female sterilization, two issues emerged to make it appear unsatisfactory. First, it depended upon the woman being committed to one partner. That is, it would only be while she was with this partner that her problems about contraception were relieved. This was not to undervalue the benefit to women of the partner taking on such responsibility for birth control, but it did point out the fact that it did not completely solve the woman's need for contraception. Second, the partner's reticence or fears about his virility meant that women were hesitant about the effects on the men of sterilization. These were seen to be largely psychological, rather than physical reactions, but problematic nevertheless:

'I would have thought the operation would be easier for a man but I'd probably have it done because when we were discussing it he used to think it would affect his virility. I don't believe that myself but even if it's not true it's still going to have some psychological impact.'

'My husband's against vasectomy adamantly. He's just so squeamish. He can't bear the thought of anyone coming near him with a scalpel, particularly near his balls, so he just won't even contemplate that.'

Despite their concerns with their partners' views of vasectomy, many women felt that by that stage in their contraceptive use, it was time their partner should take on responsibility. Years of taking health risks with methods such as the pill or coil led to the hope, if not the expectation, that their partners would be willing to accept sterilization if and when the situation arose.

Another possibility which women looked forward to was the development of a pill for men. In this way the risks associated with oral contraception could be shared by the partners alternating periods when each would use it. Although several women pointed out the fact that it is still the woman who might become pregnant if the male pill was ineffective or the man inconsistent about taking it, it was thought likely to be useful in some situations at least, and therefore would be a welcome addition to the range of birth control methods currently available. Whether their partners would agree to use a contraceptive pill was something which women felt less sure about:

'As the only reliable method is the pill there's no choice. There's no reliable precaution a man can take, and therefore the question (who should take the precautions) doesn't arise. He did say he wouldn't take a male pill as it may be physically harmful.'

'With the pill it's up to me. He prefers the pill because of the convenience of the method. If there was a male pill he might think about it although he has an even greater aversion to taking tablets than I do. Perhaps he wouldn't.'

In addition to their possible reluctance to take on health risks similar to those the women currently took, concerns were expressed by some women about the likelihood of men's resentment of having to 'make the effort' or take such responsibility for contraception. Experience with men's fears about their virility and the fragility of their egos gave further reason for doubting the potential use which would be made of a male pill. The benefits which could be derived from the availability of oral contraception for men thus were seen to be marred by men's resistance to using it.

It was hoped that continuing research into contraceptive technology would produce improved versions of current methods, with fewer health risks and greater reliability. The ease of using injectable contraceptives appeared attractive to women for that reason, but raised many questions about side effects, health risks and the inability to stop the hormonal

release into the woman's body should symptoms appear. Interest was shown by several women in more accurate ways of determining when ovulation occurs, such as through electrical impulses or mucous changes, so that using the safe period might become more reliable. This was viewed as adding flexibility to women's contraceptive use, allowing women to alternate or combine use of different methods and thereby to meet their changing needs. The availability of early, safe methods of abortion was thought to be a necessary back-up measure, and the earlier it could be done the less traumatic a decision and experience it was seen as likely to produce. The need for a wider range of birth control measures to be made easily available to women was strongly emphasized, as was the requirement of a socially accepting framework of attitudes which would provide them with the possibility of choice and control over their fertility.

In this chapter the school as a source of information about sex and contraception is examined. The formal educational programme of schools provides a potential basis for a comprehensive presentation of the various methods of contraception: their physiological effect, factors which may interfere with their efficiency, modes of use, availability and practical guidance regarding how and where they may be obtained. As Busfield and Padden (1977) indicate, the gaps in contraceptive knowledge which people may have are many and varied, including general misunderstandings and confusion about specific items. Yet, if girls/women are to be able to decide upon and use a contraceptive method suitable to their situations, at the time when their need for it arises, these gaps need to be minimized at as young an age as possible. Although a school programme is unlikely to provide sufficient information for any specific individual, it could provide a useful formal basis upon which further information is gathered, shared, and applied as it becomes relevant.

The reality for women in this study was that schools were the least informative about contraception of any sources of knowledge available to them. This may seem surprising given the concern about teenage pregnancy, and the increasing role attributed to schools in providing sex education, since the early 'sixties. Although 78% of the women remembered having some form of sex education at school, only 8% received any information about contraception. This is not unusual; Schofield (1976), for example, found that most sex education in schools was centred on biology or hygiene, and 90% provided no information about contraception. This chapter could be sub-titled: where women did not learn about contraception.

Sex education at school is explored in detail despite its failure to offer contraceptive information because of the light it sheds upon sexuality as the context of contraceptive practice. The concern of schools to contain girls' sexual behaviour appears to pre-empt the concern to prevent teenage (unmarried) pregnancies, at least in so far as appropriate action towards pregnancy prevention is impeded. Analysis of this dilemma reveals that the failure of schools to equip girls with knowledge essential to increasing their control over their sexuality and fertility is not an anomaly; the self-protection and independence of women is not a priority within a male-dominated educational system.

Femininity and promiscuity

Recent feminist research on sexism in education has elaborated upon the ways in which sexual inequality is furthered in schools. Whether or not they fit with the realities of people's experiences or needs, expectations and attitudes are nurtured which concur with patriarchal stereotypes. Far from acting as an agent of change, or an equalizer of opportunity, the educational system has been recognized to enforce male supremacy.

Dale Spender argues:

'The books and materials used within our schools abound in crude and inaccurate images of women and men and are designed to indoctrinate children in sexual inequality. From the day they begin school children are confronted with images of human inequality and are exhorted to conform to them'. (1980b, p.25)

In her study of primary schools, Katherine Clarricoates (1981) clearly shows just how early and how thoroughly sexism is incorporated into the daily routines of school life. In teaching activities and in informal classroom situations boys tend to be highly rewarded and of central concern, while girls are more likely to be undervalued and relegated to subservient positions. Boys and girls are treated not only differentially, but hierarchically according to their sex. The encouragement in girls of

deference to boys and men is what is frequently referred to as promoting their natural femininity and the acceptance of a woman's role.

Femininity in sexuality, too, is based upon deference to men. With whom sex occurs, what sex is, and the purposes for which it is done centre upon this hierarchical relation. Yet it is not, as is often assumed, a relation characterized by male activity and female passivity. There is, in fact, little room for passivity on the woman's part; deference requires activity. Passivity is a privilege reserved for those securely powerful. When applied to those in a subordinate position, it may more clearly be defined as enforced immobility, as a mode of deference which acknowledges the vulnerability of the subordinate to the dominant.

To be feminine is to appear willing to please and defer to men. It is to portray oneself as innocent, ignorant and vulnerable. It is an act. Learning to be feminine suggests that girls are learning to be actresses, and learning to play the part implies a recognition of difference between the role which is being played, and that which is not. Feigning innocence implies experience, the experience of knowing at least how one should not appear. The achievement of a feminine image is thereby acquired through the presentation of sexual deference and vulnerability to men, through the avoidance of its opposite, and through the denial of possessing the intelligence with which to tell the difference. The activity may become tortuous in practice, but the principle remains wherever femininity is taught, supported or encouraged. It is this facade of self which characterizes the relation of subordinate to dominant, gaining favour by playing to the desired self-image of the more privileged.

Feminine sexuality involves women in an active relation to the desires and needs of the more privileged, men. Women learn that they are expected to engineer men's sexual satisfaction and feelings of potency through their appearance, responses and loyalty to men. Although a woman is directed to serve one man in particular, her husband, her capacity to acquire a husband depends upon revealing evidence of these qualities of feminine attractiveness to all men. Deference, responsiveness, vulnerability and self-denial are all part of the feminine service, and servility.

Promiscuity suggests a more self-interested approach to sex, and is regarded negatively in females. As discussed in the previous chapter, the imputation of promiscuity is the accusation that one is stepping out of line sexually. Evidence in girls of autonomous sexuality, exploring their own potential and interests in the sexual sphere, is generally regarded with horror and warnings of impending doom. Actions to contain these girls' behaviour is considered legitimate and laudatory. Sexual conformity is sought through the encouragement of feminine attributes.

The problem for schools, as for other institutions which support the status quo of male/female relations, is that femininity cannot be recognized to be an act. If feminine deference is not biologically natural, it is not necessary. Its desirability becomes open to question, to females at least. Once there appear to be alternatives, choices are possible; so, too, is change in that status quo.

It is always possible, of course, for girls to decide against femininity in favour of knowledge, experience and self-affirmation. Feigning ignorance may be rejected in favour of seeking and speaking knowledge. Deference and vulnerability may be replaced by self-defence, and even offence. A common form of prevention of this possibility is

couched in terms of 'protecting them from themselves'. It may involve the denial of alternatives or withholding information which may make alternatives appear available or preferable. Thus, for example, rather than having to rely upon girls feigning ignorance, they may be kept actually ignorant as far as possible. These measures create dependence and vulnerability by denying the possibility of self-defence. Femininity remains an act of deference, but one which is necessitated by powerlessness.

The contradiction for schools between the encouragement of femininity and the prevention of teenage pregnancy is that it is more likely to be the well-feminized girl who becomes pregnant. Morton-Williams and Hindell (1972) point out that it is more likely to be the sexually ignorant or naive girl who becomes pregnant, rather than one with experience of sexual activity. Withholding information from girls in order to ensure feminine naivety can thus be seen to be directly linked with girls being caught unprepared.

It is not that femininity is not about becoming pregnant; it is. The antithesis between femininity and pregnancy exists only until they become synthesized by the presence of a husband. Once femininity and pregnancy become joined in the service granted a man through marriage, they are rendered compatible. The problem of teenage pregnancy is not the age of the woman but a reference to the fact that she is unlikely to be married; if she is married, she is not considered a problem.

Promiscuity, the stepping outside of the permissible bounds of sexuality which protect the patriarchal social order, is recognized to be a threat to its stability. Femininity in sexuality, the appearance of women's deference, innocence and vulnerability to men, bolsters the status quo - except where it is actual and not simply an appearance. Actual naivety and vulnerability leave a girl unprepared to deal with the

fine balancing act required of her in attracting a male sexually whilst withholding sexual activity.

Sex education in schools has been designed largely to deal with this dilemma between the encouragement of femininity and the prevention of teenage pregnancy. Yet, it continues to be caught up by its commitment to male-dominant/female-subordinate social relations, and the ensuing threat posed by promiscuity. Michael Schofield points out that the reluctance to provide information about sex in schools has been the fear that once young people have heard about sex, they might want to try it out. Promiscuity is feared as a threat to social stability, and in the sex education which is provided:

'No pains are spared to see that only the conventional moralities are propounded. Every course, book and visual aid emphasizes the virtues of a loving stable relationship and condemns promiscuity'. (1976, p.20)

The argument for withholding information about sex on the basis that young people have not yet heard about it may seem absurd. In a society which employs sexual images openly in advertising, film, newspapers, magazines and television, they can hardly not be confronted with sexual ideology on a very regular basis. It is perhaps more understandable when it is remembered that it is primarily females who are feared to be, accused of and punished for promiscuity. Further, it is not sex per se which is feared, but that girls/women may take decisions about their sexual activities which do not accord with feminine deference and loyalty to men. It is particularly information which may be other than that which supports male-dominant sexual ideology which is withheld. That is, it is not so much the provision of any information about sex which is resisted, so much as the provision of information which might present girls with alternatives to femininity.

Dire warnings

The difficulty in introducing sex education into a situation which conforms to patriarchal divisions, enhances femininity in girls and prepares them for a life of servicing men, is that to openly discuss sexuality would reveal the nature of this educational project and threaten its success. On the other hand, to completely withhold information regarding the possibility of pregnancy from sexual activity has been recognized to be a major problem with regard to teenage pregnancy. The format for the subject of sex in schools has typically been one which concurs with this overall educational programme.

One approach has been to maintain a silence on information or positive aspects of sexual activity but to issue dire warnings to girls about promiscuity, venereal disease, pregnancy and other 'dangers' which follow sexual intercourse before marriage. This may be presented either from a religious angle or from a scientific one:

'Nobody talked about it at the convent. There was always a great fear of pregnancy looming. If a girl got pregnant, she left school. It was all hushed up and nobody ever talked about it as if pregnancy was such a terrible thing that you couldn't.'

'We had one lesson when we were 15 during which the doctor who came to talk to us didn't say at any point what sexual intercourse actually was and what it involved or tell us that it was a nice thing to do. She warned us very strongly of the horrors of VD - if you slept around, that is what you got.'

Either way, the project is to stimulate such fear that it is presumed the girls would be too frightened to engage in sex, or even contemplate the possibility. However, in encouraging femininity in girls, schools support that form of sexuality in which girls have little say over the matter, particularly when they are actually naive and unprepared to deal with boys' sexual advances. Stimulating fear in the presence of carefully maintained ignorance does little to ensure that girls manage to walk safely across the courtship tightrope.

Confusion may be added by the false appearance that the rules of sexual morality apply equally to boys and girls. Despite the presentation of a similar morality to both boys and girls, their actual behaviour will be treated very differently. As suggested earlier, sex may make a girl promiscuous, but it makes a boy a man. Moral guidelines become less a directive for males than an indication of the standards of morality they have a right to expect in 'good' girls (the marriageable kind).

Girls, on the other hand, are not only expected to conform to moral pronouncements about their own sexual behaviour, but they are held to be responsible for the sexual activities of the boys. It is the girls who are supposed to control themselves, and at the same time, not let the boys go too far:

'It was all about how girls should save themselves for marriage, but boys could easily get carried away, so you had to be the moral person for both of you; boys were like wild animals who couldn't control their impulses.'

Thus, while the boys are excused for their behaviour, and even acclaimed for their displays of aggressive, inconsiderate virility, the girls inherit the disapproval and blame.

Heads of schools, as parents and others who are seen to be responsible for the containment of girls' sexuality, are unlikely to wish the moral respectability of 'their' girls and 'their' school to appear blemished. To offer sex education to the girls would be to admit that they might be engaging in such unacceptable behaviour, and that their sexuality was not being properly controlled by the school:

'Somebody asked our headmistress if we wanted a speaker to talk about sex education and she said, "No, our girls don't need it." '

A concern that sexual activity should not be occurring may slide into belief,

pretense, or non-admittance, for the reputation of the school may be dependent upon the public appearance, at least, of the maintenance of sexual morality.

The appearance of moral respectability claimed by their schools, and the demands placed upon the girls, was experienced by women in the study as unrealistic and unhelpful. It left them without access to information about sex and contraception, which they were aware that they needed:

'At that age everybody is having sexual intercourse - or at least a great many people are - but at school you have to more or less pretend that you're not.'

'Most girls become sexually active before the age of consent and that's fatal 'cos the establishment's busy pretending it isn't happening, or shouldn't be. You can't go to doctors for pills or anything because doctors will tell your parents; even if the doctors wouldn't, you still think they might. And at school you can't go and ask anybody.'

There was little or no opening to discuss sexuality at school, and even less opportunity to raise questions about contraception. The subject was kept under lock and key, except for occasional pronouncements about what the girls should not be doing, what they should be preventing the boys from doing and the frightful events which would certainly follow should they do otherwise. This moral approach to sex education was experienced by women to have no redeeming features.

Female versus male teachers

Femininity in sexuality is a balancing act of appearing sexually attractive to males through feigning innocence and vulnerability, whilst controlling one's own sexual behaviour and that of boys/men. A good performance would seem to require a very clear idea of what one was trying to do, and a reference group in which continual progress could be checked

and reformed as the situation required. Talking about sexuality between women and girls, even within the context of male-dominant ideology, would thus seem essential. However, the potential of females discussing sexuality together to give credence to their own concerns and experiences and to begin to question that ideology constitutes a threat to the stability of male/female hierarchical relations. The inference frequently drawn from women becoming knowledgeable about sex and sexuality is that they are or may become promiscuous. This would suggest that the potential for change is clearly recognized and feared.

The contradiction between the need to talk about sexuality amongst women to achieve sexual femininity, and the implication that sexual knowledge amongst women is unfeminine and sexually unattractive, certainly makes life difficult for women and girls. It also presents problems for schools attempting to teach sex education whilst not undermining the status quo. One problem focuses on whether female or male teachers should be involved in giving sex education lessons to girls.

Who should talk about sex to whom affects women teachers as well as girl students. Both groups are defined and confined by what is thought properly feminine for females to know about sex. While it is assumed that a married woman does know something about sex, to talk about it explicitly or within a range of types of relationships might suggest either her own promiscuity or that she is encouraging promiscuity in young girls. A single woman, as her students, is regarded with moral suspicion if she even talks about sexual activity, for how would she know if she was not herself promiscuous. If a woman teacher suggests alternatives to patriarchal heterosexuality, particularly if she mentions lesbian sexuality either in terms of her own experience or as a possibility for her students, she will probably lose her job. As Stevi Jackson (1980) points out, even a suspicion of lesbian sexuality

161

on the part of the teacher can have disastrous consequences for her and hence, must be masked. Sex education for girls led by women teachers, despite its potential for change, is thus limited by the constraints imposed upon female teachers who wish to keep their jobs and indeed, who wish to continue teaching anywhere. Not surprisingly, women teachers were sensed as frequently embarrassed or hesitant about giving sex education lessons:

'It's a difficult area. I think it should be talked about without any embarrassment, which is something that most women staff have great difficulty in doing. And you always feel you know better than your teachers anyway: I remember feeling, "Aw, I know all this anyway".'

'When I was 14 we had a talk but we all felt we knew more than she was prepared to say anyhow.'

A woman teacher is as constrained by male-dominant ideology as her girl students in discussing sexuality. The institutional structure of the school which surrounds them, limits the possibilities for sex education, since anything a female teacher says may be taken in evidence and used against her.

Whilst it is considered to be a masculine virtue to be knowledgeable about sex and a male prerogative to talk about sexuality, it is highly unusual for a single male to talk to a group of females, particularly a group of adolescent females, about what sex is. Sex is more generally talked about by men in a group with other men, or in a one-to-one situation. When men talk to women about sex it is more likely to be a personal sexual relationship or as a display of bravado. Despite the male-dominant content of sex education lessons, the male teacher would not be in a comfortable position of dominance over a group of female students on two counts: first, because of the potential of such a group to give credence to their own experience and thereby, to challenge the dominant sexual ideology; and second, simply because of the rarity of the situation and the fact that he would be highly outnumbered. Male teachers were, in fact, experienced as being extremely embarrassed when the subject of sex was broached in lessons.

What sex is, as has been discussed in the preceeding chapter, is something men do to women. Women's response is significant to sexual activity primarily with regard to the enhancement of male sexual desire and capacity. Femininity depicts the woman's concern for the enjoyment and sexual satisfaction of the male, and masculinity evokes the man's privilege to exercise his sexual desires and to have his needs met by women. The ways in which sex is generally discussed reflect these male-dominant/female-subordinate relations, and affirm them. The vulnerability of girls to boys' and men's sexual inclinations is thereby emphasized. When presented by a male teacher the situation at once becomes imbued with his sexual privilege as a man, and the consequent threatened danger to the girls. His authority as teacher, and expert in sexual knowledge, compounds his dominance while the girls' age and student position add to their vulnerability. The recognition of this sexual relation with its danger to the girls has led to the firm prescription that male teachers should not use their privileged position for their personal sexual gratification.

The male sex education teacher is thus in an awkward position. Although teaching content which espouses male privilege, and being in a relation to female students which positions him as authoritative and sexually knowledgeable, the inherent danger to the girls demands that he deny or desexualize this relationship. At the same time, the potential of a group of girls to challenge the male-dominant ideological content of sex education adds to his imbalance. Although, probably an irreconcilable situation, attempts were made by male teachers to desexualize lessons, usually through an emphasis on biology:

'Reproduction, that's about as far as it went, and even then (he) had to turn the lights out when he was talking about it. He showed slides, and when he was talking about it he had to have it dark.'

'We had human biology given by a gentleman who went very red from his forehead down, until he was a bright cherry red down to his collar. There was absolutely no instruction on the mechanism whereby sperm got from one place to another or anything like that.'

As these quotes suggest, the focus upon biology is one common way in which attempts are made to desexualize sex education. It was the most frequent format for sex education in school reported by women in the study.

The biological approach

Clearly approaching sex education through biology has become a very popular form of talking about sex in schools (Harris, 1974; Schofield, 1976; Jackson, 1980). The potential of this approach is perhaps to minimize the restrictive or fear-provocative warnings thought to be necessary as an accompaniment to the introduction of sex education to the young, as a means of prevention of sexual activity. To talk about sex in biological terms is to detach it from behaviour, to distance it and to present it as just another scientifically objective study of 'the facts', in this case 'the facts of life'.

Women's experiences of this approach, however, suggest it too was found to be hampered by the tensions in talking about sexuality, discussed above. Usually, sexuality was incorporated into a course of biology lessons; otherwise it was presented in special sessions earmarked health education or sex education, or in a one-off special class or talk. One major problem seemed to be that sex was rarely mentioned. Rather, the only discussion of the subject was in relation to reproduction and in most instances, reproduction seemed to be discussed except for anything to do with sex.

Animals were more frequently discussed than humans and often, it appeared, instead. Even the animals which were discussed tended to be

remote from humans although a fairly impressive range was reported including worms, fish, frogs, chickens, rats and rabbits. Where the discussion moved to the human, it appeared as a continuation of the mechanistic reproductive framework in which other species were presented:

'We started off with the reproductive lives of worms and moved on to human beings. It was very limited. It certainly didn't involve emotions or feelings. It was all very sterile - just bodily functions which take place.'

Despite the relatively progressive step of introducing some information about sex, or at least reproduction, in schools, women found that it was not particularly relevant to their sexual concerns; too often, talking about 'the birds and the bees' was literally just that.

Discussing sex in this way may successfully remove the implication that the school is encouraging sexual activity amongst pupils, but in doing so it would seem to defeat the purpose of informing and preparing the young to deal with sexual relations, and avoid pregnancy. Even in sessions specifically oriented to human sex and reproduction, the subject was felt to be dehumanized and therefore, difficult to relate to personally:

'You went through it as if it was just an inanimate object really, which wasn't quite the right idea I'm sure.'

'Conception and fertilization were explained in diagrams in such a remote way that you could never think of it as being a human thing at all, like frogspawn or something.'

This depersonalization not only removes the school from active involvement in pupils' sexual behaviour, it presents sex and reproduction in such a way that it appears that there can be no active involvement by the pupils themselves. Reproduction just happens instinctually and sex is nothing more than an extension (the first stage) of this inevitable process. There is no element of choice, no decisions to be made, no difficult situations to deal with, no emotions - it all simply happens naturally.

No doubt few actually believe this to be the case. It contradicts the experience of conflicts about sexual behaviour as well as the apparent need for moral warnings as a preventative against such behaviour occurring. Nevertheless, it affects the way in which sex and reproduction are viewed, linking the two as one process and presenting them as natural and inevitable (after marriage). Michael Schofield indicates that this approach left pupils with 'a vague notion that sex was simply doing what comes naturally' (1976, p.21). What comes naturally has been presented to be reproduction; sex is merely the first stage of the process. By implication, even where sex is not explicitly mentioned, what is natural sex is that form of sexual activity which will initiate the reproductive process. Natural sexuality is thus heterosexuality, and heterosexuality alone, culminating in penile penetration and ejaculation in the female vagina. Moreover, male but not female arousal is indicated to be necessary to sex, since penile erection is a prerequisite for reproduction.

On the other hand, if what one is trying to do is to prevent pregnancy, it would logically follow that it is only this form of sexuality in which one should not be engaged. Sex education could potentially be used to inform pupils of other possibilities. As Stevi Jackson has argued:

'If one of the reasons for giving sex education is to reduce the risk of unwanted pregnancies it might be useful to inform girls that, since nature has endowed them with separate reproductive and sexual organs, they have a "natural" means of contraception at their disposal...

But few schools are prepared to take such an approach.' (1980, p.140)

To educate girls in this way, or even to encourage them to explore such possibilities for themselves, would directly counter their training for femininity. Sexual knowledgeability, independence and the awareness of sexual choice is considered inappropriate to women's feminine sexuality, unattractive to men, and a challenge, no doubt, to male sexual privilege. The denial or omission to present the biological separation for girls of

their reproductive and sexual possibilities, and the implication that sex is simply the first stage of the reproductive process, presents girls with both an image and a logic of sexuality in which dependence upon males appears to be a necessity.

The definition of sex which is employed is heterosexual, and characterized by male action, needs and desires. Reproduction, too, is described in terms of male dominance and female receptivity. Jackson (1982) suggests that such equations illustrate the inbuilt coercion in our notions about how sex is organized. Ruth Herschberger's (1948) poignant alternative description of reproductive biology as 'encapsulation' by the female clearly illustrates the social construction of biology and its male-dominant orientation. A concise example of how all these elements are brought together in a seemingly factual account of sex and reproduction was reported by the following woman:

'A biology teacher, a man, said conception occurs when a man puts his penis in a woman's vagina. That was it.'

Sex and reproduction are equated, the event dependent upon the actions of the man, and the relations appear natural and inevitable; no other definitions or descriptions are presented. As Dale Spender (1980a) points out, these descriptions indicate how male dominance and female mutedness are constructed through the language which defines our reality and structures our thought.

Marriage and motherhood

An alternative approach to sex education which can be accused neither of encouraging promiscuity nor of reducing human relations to biology, is to project it into the future. In this way, sex education can be incorporated simply as a preparation for the lives which await girls when they grow up.

A significant problem with this angle however, is that while sex is presented as confined to marriage and directed largely to the goal of motherhood, it is unlikely to be seen by adolescent girls as relevant to their situations:

'We had a film about having a baby, but that was too far on because none of us was interested in having babies.'

While such a film could likely have been made more relevant in context of a wider discussion about sexual relations and choices about having children, it usually appeared to have been presented instead of talking about sexual relations.

The sexism of preparing girls for an apparently inevitable future of marriage and motherhood has been a major theme of feminist writings and campaigns, past and present. Indeed, the extent to which education has been opened to girls can be seen to have resulted largely from feminist struggles of the nineteenth and twentieth centuries. However, the way in which this sexism may be perpetuated despite its presentation as a science or as sex education is demonstrated in the following description:

'At 16 or 17 we had this film. It was more a propaganda film about the family - it had absolutely nothing to do with the realities of sex. It didn't mention contraception.

It was stereotyping, getting you to play your role in this society. It was all based on: Mommy was going to have a baby and Daddy, whom she was married to of course, was so delighted. It was all seen through the eyes of this 14 year old girl, with somehow symbolic pigtails, who was knitting for this coming sister or brother.

And you saw Mommy trotting happily along to the doctors - these beaming, all-male doctors. They poked about, never anywhere that could be remotely embarrassing, and sort of looked at her tummy and said, "Ooh, what a big tummy", and prodded it. Whatever that was supposed to tell you about sex, I do not know.

In the end you didn't see anything of the birth. All you saw was her waking up in hospital, Daddy arriving with a

bunch of flowers, and her sitting pridedly clutching this baby, while the matinee coat was slowly being completed.

It was the domestic science teacher that was showing the film. It just shows. It all comes under one of the domestic sciences. You learn to cook for him; you have his babies. It's so obscene, the whole thing.'

As indicated here, marriage and motherhood are in effect, whitewashed. The 'happily ever after' presentation allows for no conflict or doubts or version of reality which might discourage girls from such a course of action in the future. The ideal is set up as something which they should want and ought to be able to attain; if they 'fail' to achieve it, the problem stems, by implication, from some inadequacy in themselves.

Again, as in this example, sex is not explicitly discussed. It is assumed to follow naturally from marriage, and to be but the first step to the joyful picture of parenthood presented. This emphasis upon marriage and motherhood affirms heterosexuality, and heterosexuality alone, as natural and as the route to success and happiness for women. The possibilities of alternative courses of action or future directions are firmly omitted.

Motherhood is portrayed as a necessary part of the fulfilment of every woman's life, but this image is highly qualified. It is only within marriage that such fulfilment is possible. That is, the joy does not lie for women in having children per se, but in having children for some man within marriage. Outside of marriage, motherhood is denoted a state to be pitied, a result of irresponsible or irrational behaviour or a tragic event. No sensible and concerned mother would wilfully impose social illegitimacy upon her children and hence, it is thought, would do all in her power to find a husband. As Sally Macintyre has shown, (1976), the differential assumptions of motherhood as instinct for married but not unmarried women highlight the social construction of the myth of motherhood.

In supporting the equation of marriage and motherhood, this form of sex education acceptably encourages femininity in girls, and prepares them to fit within a patriarchal form of family life. As no other possibilities are presented, there appears to be no choice: either one finds a husband, bears his children and lives happily ever after or one doesn't and suffers ever more. It would be surprising if girls did not 'choose' the former as their goal.

Contraception

In context of the preceding discussion a fact that would appear on the surface to be surprising becomes understandable - namely, that contraception was rarely included in the sex education experienced by women in the study. It was, however, the aspect of sex education that women felt they had most need of at the time. A total of 4 women (8%) had been taught anything about contraception at school and only one of these women thought the topic had been covered in an adequate way, although they all felt that even a minimal lesson on contraception was better than nothing.

The difficulties which seemed to arise about contraception reflected tensions regarding the encouragement of promiscuity and independence in girls. For example, dire warnings were transmitted rather than practical advice and assistance. Even where it was implied that contraception was possible and advisable if sexual intercourse took place, practical information was withheld:

'There was nothing about contraception. They said be careful and really we shouldn't; we weren't told how to be careful.'

Nor were women told how to find out more either in terms of written material or through advice centres. It appeared that the admittance that girls might want to know how and where to get contraceptive information would be viewed as though it were commiseration in their promiscuity.

The biological approach extended to contraception in only two cases, despite its disinterested scientific veneer, and its popularity as an approach. In both cases it was limited to those who were studying for an A-level in Biology.

The marriage and motherhood format of sex education was unlikely to give rise to a discussion of contraception since the assumption employed is that sex does, or at least should occur only within marriage, and then is directed primarily towards having children; for example:

'We were told how intercourse happened and advised that it was something you only ever had in marriage and then you wanted babies, so I don't remember anything about contraception.'

By assuming what girls should do and informing them that this is what they do or will want to do in the future, the fact that they may be doing otherwise remains invisible - at least until a pregnancy occurs.

What to do if you find yourself pregnant was not part of the sex education with which the women were provided. Abortion methods were discussed in biology lessons in one instance. In two further instances it was presented as sinful. In most cases, however, it was never mentioned at all. The possibility of pregnancy, as practical guidance regarding being pregnant and how to decide what to do about it, appeared to be thought outside the scope of what was or should be necessary information to young girls.

The single exception to the lack of an adequate sex education programme experienced by the women was reported quite differently than most. Despite finding the school a less than completely easy forum for discussion about sex and contraception, a combination of outside speakers and general discussions provided a series of informative sessions. Information about conception and birth given in the third year was followed in the sixth by contraception, abortion and sexual relations. The main criticism in this case was that this important information had come far too late.

Although women had doubts about the appropriateness of schools to teach sex education, the timing of the sessions, the attitudes which were conveyed and the form it should take, all felt that some information should be provided through the schools. The major need which most women felt should have been met by a school education programme was practical information and assistance in obtaining contraception and abortion. Because of the serious difficulties which were recognized regarding discussions about sex at school, it was seen to be a crucial matter that girls should be given advice about where to go to seek advice, information and contraceptives. Advice about 'how you did get pregnant', 'methods of contraception' and 'where and how it's available' and 'how to go about getting an abortion' was thought to be the most urgent, the most practical and simple enough for schools to be able to provide. Where some sex education had been provided it was generally the least likely to be the most required - practical information and assistance in obtaining contraception.

The importance to individual women of this general lack of education about contraception depended upon the other sources which she did or did not have. For instance, if sex and contraception were discussed openly at home, then the lack of education at school was less important than if sex was shrouded in secrecy at home. Alternatively, if the woman was given leaflets or other information when attending contraceptive services, or if she came across informative magazines, leaflets or books, or if she discussed sex and contraception with her friends, the influence of the school was or became less important. Over the course of years many of these other factors intervened but often in an accidental or fragmented way. The improbability of having the appropriate information at the time when it was required tended to be the rule rather than the exception in women's experiences. The school is one potential source where the necessary information could be acquired at a sufficiently early age to be of use when it was first required. In 100% of cases in this study, schools failed to meet that potential.

This chapter explores the various sources of information where women did learn about contraception. The most informative were media sources, leaflets and books, female friends, and mothers. Doctors, male friends, partners and fathers were found to provide relatively little information about contraception. Written material and women friends appeared to act together as the major means of acquiring contraceptive knowledge. Discussions between friends often stimulated further reading and written material would be discussed with friends and experiences compared with what was read.

Few women found that they had sufficient information about contraception at the time when they first required it, that is, at the time of first sexual intercourse. Most had expected not to need it before they were married and once they found that they did, were reluctant to seek out further information and help for fear of disapproval. As one woman expressed it:

'I think the old morality dies hard; women are still reluctant to seek information because they're still reluctant to have labels pinned on them as somebody who does sleep with someone. Particularly when you're young and romanticize ideas a lot about sex, you may feel it's alright to sleep with a boy out of love for him but it is very hard to seek out information about contraception. I've known girls who have been anxious about appearing "easy" merely because they were being careful.'

It was most often the women's own experience of sexual relations, and their resulting fears about the possibility that they might be pregnant, which confronted them and emphasized to them their need to learn more about methods of preventing pregnancy. It was at this point that they began to talk with girlfriends and to read magazine articles, and generally to break through the barriers of silence about sexuality and contraception which had surrounded their lives until then.

Media sources, leaflets and books were found to provide general introductory information about contraception which was helpful to women in several related ways. However, this material was, apart from feminist sources and books and handbooks about contraception generally, limited by the tendency to provide generalizations rather than detailed discussion, particularly regarding side effects, long-term effects and dangers to health of the various methods available to women. Reliability of the information which was offered was seen to be subject to a number of possible forms of bias, which resulted in some confusion about which information to believe. This latter problem of biased information was enhanced by the former problem of the brevity of information available, since without some detailed knowledge about the consequences of using a particular method of contraception it was difficult to assess the extent to which a source was presenting biased information. The significance of this information, or lack of information, can be seen in relation to the decisions which confront women about the contraceptive methods they have used, do use or might use. For example, assessing whether they are experiencing symptoms which are related to the contraceptive method used, requires the knowledge of what side effects might possibly occur with the method in question; of this, more in the following chapter.

At home

The situation at home was most similar to that at school where sex was rarely talked about. Concern about girls' sexual behaviour appeared to be dealt with on the basis of 'the less they know, the less likely they are to do anything'. Frequently this would be accompanied with dire warnings as to the consequences which would certainly befall promiscuous girls, including pregnancy and VD, but especially the fact that no man would ever marry them once they had 'lost their virginity'.

This attitude reveals the male dominant perspective which confines women within a structure of servicing men in marriage. A woman who has no experience of sexuality apart from her husband, is considered to be every man's right in selecting a wife. A double standard applies: sexual experience makes a boy a man, but a woman promiscuous. For men, sexual experience is regarded as a normal part of being male, having a male sexual urge, and expressing it. Not so for women; sexual experience is tied up with marriage and dependence upon catching and keeping a man. A woman who does not protect her virginity to give to the one man who will marry her for it, is downgraded in the marital stakes; her prospects are impeded once she is reknowned to be used/soiled/cheapened. It is deemed to be a woman's responsibility to use her sexual attractiveness to interest men in marrying her, but to ensure she does not 'indulge' until she has secured a marital commitment; after this she may enjoy sex in so far as it pleases her husband and keeps him committed to their marriage.

The containment of girls' sexuality is taken to be evidence of successful parenthood. Mothers, by example, are supposed to imbue

in their daughters an orientation to servicing and pleasing men, to heterosexuality and to finding and keeping a husband. Fathers are held responsible for the development of femininity in their daughters, especially a 'healthy' attitude of deference to male authority, being 'the first man in her life' (Sutton and Friedman, 1982). The relations of power between the parents support the likelihood that such attitudes and curtailments will be conveyed to girls. Fathers have an interest in the benefits of services and deference gained from their daughters as well as their wives, while mothers may fear retaliation, ridicule, and rejection of themselves or their daughters should they 'fail' to conform to these standards.

It is not surprising, therefore, that most women who were engaging in sexual activities outside of marriage, did not tell their parents. Such an admission would imply that the parents had failed as parents, for they had not successfully ensured that sex would take place only within the confines of servicing a husband. The attitude predominant amongst women in the study was: 'what they don't know won't hurt them'. Even in those cases where parents were less 'strict', as little as possible about their daughter's sexual behaviour would be made public. Such secrecy significantly affected the choices which women felt they had about their living arrangements, relationships, and possibilities for having children. Not wishing to hurt their parents or embarrass them in front of relations, friends and neighbours was an important consideration in taking decisions about their own lives.

The influence of parents was strongest during teenage years when learning about sexuality, beginning to have sexual relations

or to consider the possibility of doing so. This meant that they either dare not engage in sexual intercourse, or else, did so secretly and anxiously, dreading that a pregnancy would occur and their parents find out first, that they had been having sex and second, that they were pregnant. Contraceptive decisions, too, were made anxiously and fearfully, lest their sexual activities became known. This could mean that no contraceptives were used which might be found, that doctors were not approached lest parents would be told, that for fear of pregnancy the most reliable methods were used regardless of side effects, that working out what to do sexually and contraceptively was shrouded in tension about what parents might say or do if they knew.

Where parents were aware of their daughter's sexual activities, their own disapproval seemed to prevent them from discussing the practicalities of contraception. Once again, dire warnings or more overt threats, took precedence. It appeared that it was not until sexual activities were known about for some months, or even years, that contraception became an acceptable topic of conversation. This meant that parents were not normally involved in early decision-making about contraceptive use. As the daughter's behaviour came more within conventional morality (she married, or formed a marriage-like relationship), or parents came less to view themselves as responsible for her sexual behaviour, contraception tended to be discussed occasionally. By then, the daughter had usually been using some form of contraception, or had tried several methods and had reached her own decisions:

'I discussed it with them when I'd already formed my own opinions, so really I was using them as a sounding box; I was decided already. I was just confirming my own opinions so I don't think they affected me that much.'

Once discussions about contraception had become acceptable, women found that from time to time over the ensuing years, they would discuss contraception with their parents. Sometimes these were general conversations about the pros and cons of different methods or media reports; other times, they pertained to personal decisions and were found to be quite helpful.

Mothers versus fathers

Half of the women in the study reported that they had discussed contraception with their parents at some time. Some of these discussions had occurred late on, others were very brief; in nearly half, however, some involved and informative discussions had taken place. Most of these discussions which were identified to be sources of information, and where they were seen to be personally relevant to the needs of the women, were those situations where the mother was either the main or the only source of information on contraception. In a few cases both parents were considered to be helpful in learning about contraception, particularly in those instances where sexuality had been openly discussed throughout their lives, and where the parents were considered to be broad-minded about the matter. Where father was the only source of information about contraception, the discussion was not felt to be helpful.

The instances in which fathers were cited as taking a significant part in discussions about contraception were relatively few. Most women found that their fathers did not talk to them about contraceptive methods. One woman suggested that although her father professed not to believe in contraception, his actions appeared to contradict this view:

'My father thinks that sex is for procreation although it's totally hypocritical 'cos they've only got me and I've seen Durex in the house so I don't know what they were for.'

Another felt that although her father had tried to talk to her about contraception, he ended up bragging about his virility:

'My father tried to discuss it with me. I say tried because, well, he tried to discuss it with me, when I was about 16, and he sort of ended up trying to impress me with his magnificent sexual potency, you know how they do. That was about it really.'

One exception to this generally uninformative approach of fathers was one woman whose father was a chemist. He had given her a general chat about contraceptive methods which was fairly brief and not personalised for 'by their standards I was and am promiscuous.'

Mothers were an important source of information about contraception, and support about sexuality generally, in a way in which fathers were not. Although 50% of the women received no contraceptive information from mothers or fathers, of those who did 96% involved mothers in discussions including 56% of cases which included mothers only. The research of Greer Litton Fox in America suggests that the mother-daughter relationship is the most significant in providing sex education in the family and that it appears to be due to the efforts of the female parent that intentional sex instruction occurs at all (Fox and Inazu, 1980). A number of reasons for this arose from this study.

One reason seemed to be the fact that mothers have the same problems relating to contraception as do their daughters. Therefore they could offer advice and guidance on the basis of their own experiences. This sometimes led to a debate about the pros and cons of different methods as well as informing daughters as to the existence and possibility of obtaining contraception:

'My mother thought the pill was a good idea. She definitely preferred the pill to nothing at all, but she also has great faith in the sheath because it worked for her and she thought if the risks of the pill were too great, then I should use the sheath, or abstain.'

Sometimes, too, emphasizing her own experiences appeared to be a way to discuss and inform daughters about contraception without having to admit that the daughter might be engaging in sexual intercourse:

'We discussed it as relating to her, but not what I should do because it was assumed that I wasn't going to do anything of that sort for a number of years.'

Mother and daughter, being women, have a similar relation to contraception and the possibility of pregnancy throughout their reproductive years. This is an important basis for sharing information about contraception. That mothers should be seen to contain their daughter's sexuality outside of marriage may be qualified, whilst not denied, by this shared experience.

Another aspect of the shared experience between mothers and daughters which may affect the possibility of their communicating about contraception is their shared social experience of being women within a patriarchal social structure. Although this

experience may mean that mothers know very little about contraception themselves and/or that they feel it would be unfeminine and embarrassing to talk openly about sex and contraception, it may also make them aware of the importance of their daughters learning more than they knew. In some cases this was dealt with through the use of books:

'My mother found difficulty talking about it so she gave me a book, and then we discussed things as they came up in conversation.'

'We tried to discuss it but we both got very embarrassed so she gave me the books to read.'

In other situations it was clear that mothers were trying to take a practical approach to the needs of their daughters and provide them with contraceptive information, despite and perhaps because of reservations about their sexual behaviour:

'She had always told me: "If you've ever got any problems, sexual problems, don't hesitate to go on the pill just 'cos it would offend me." And when I did go on the pill, I think it did offend her, but that was after I'd taken the jump so she accepted that.'

In a few instances mothers appeared to present their daughters with encouragement in making their own decisions about sexuality as well as information and support regarding contraception and abortion:

'My mother had an extremely open-minded attitude to sexual relations generally. Equally I know I could go to her for the money and the support if I needed an abortion. She's extremely supportive; I mean, total trust.'

Given the patriarchal context in which both mothers and daughters live, instruction in contraception and support for daughters is rather a brave move on the part of mothers, since evidence of their daughter's sexual behaviour is taken to be proof of their own failures as mothers. It may arise from a recognition of the needs of women to protect themselves through a practical understanding of contraception and its availability. These needs are common to both mothers and daughters and may indicate a concern of mothers that daughters have the information and means to protect themselves from pregnancy, which they did not have themselves.

The awareness of living within a patriarchal family structure as women is a particular form of this shared social experience. Mothers and daughters may collude for mutual support and protection within the family. For example, one woman found that her mother occasionally turned to her for support in her contraceptive decisions:

'My mother said things like: "I've gone back on the pill, but don't tell your father - he doesn't like it."

In another situation, mother and daughter decided together that they could not tell father about the daughter's abortion in order to protect another woman in the family:

'We were worried about my younger sister because his reactions were really extreme. He would never let her out, and it would always be thrown at her.'

An alliance between mothers and daughters seemed to be one way in which women provided support and protection for each other and countered the subservient position of women in the family, particularly as was mentioned in several instances, where the husband/father was prone to physical, verbal or other punitive outbursts

in reaction to evidence of sexual or contraceptive non-conformity to his will, by his wife or daughters.

Friends

The influence of friends and discussions between friends tended to become more important as sexual experience was gained. Before this time the women felt themselves to be more influenced by their interaction with their parents and the schools they attended. For those who had experienced some teaching about sexuality and contraception the subject was generally less mysterious and prohibitive than for those who had not. Whether or not they had been taught about sexual relations and possibilities of contraception, at 14-15 years their attitudes and understandings reflected those of their elders; by 16-17, their understandings had altered to a great extent (for some this occurred at a later age). Discussions with friends, generally other girls who were experiencing the same things, about relationships with boys and when and where sexual activity was acceptable or not, began to feature much more centrally in their learning than previously.

For example, at the age of 14-15 most women felt that sex was not something to be discussed. This reflected the attitudes about sexuality which surrounded them at home and school that sex was not to be talked about, let alone engaged in. The implication being, as discussed earlier, that any knowledge about sex might make it possible or even encourage the young to engage in such activities:

'It was all sort of hush, hush and don't talk about it, so we didn't really.'

'I was very secretive about it and thought it was dirty. I certainly knew nothing about love and sensuality and sexuality.'

Secrecy is often associated with naughtiness and unclean activities. Often, too, uncleanliness is connected with the woman herself, her vagina and particularly her menstrual blood:

'I was very uptight about the whole idea of sexual relationships. My view of the pill was that it was a licence to promiscuity and all those other terribly naughty things. And at school you weren't supposed to talk about that sort of thing very much. For example, I remember a girl asked me if I had a tampax and I was so amazed that anybody would dare to say the word "tampax" in public.'

This atmosphere of secrecy, naughtiness, and uncleanliness surrounding young women and influencing their awareness of their own bodies and sexuality was seen to be anything but helpful. Although successful in ensuring ignorance about sexual relationships, sexual activities were not prevented from taking place. It was often only after sexual relationships were taking place that women became aware of what sex involved, began to discuss it with their friends and partners, and began to see the need to protect themselves with contraception.

One major problem which this secrecy surrounding sexuality presented was being prevented the opportunity to learn from women who were older and/or who had experience of sexual relationships. As a result even when girlfriends did begin to talk to each other it was difficult to know how to discuss sexuality:

'We did talk to each other but not many of us knew much of what we were talking about. One thing we were probably doing was trying to find the words to say things to each other and find out what other people thought and what other people were doing. And I suppose a lot of it was to get information, factual information, about what it was really like to make love, but there wasn't much forthcoming at that age really, not the people that I knew, anyway. And the people who did know seemed to prefer not to mention it.'

Trying to find the words to say what one wasn't sure one should be saying was obviously no easy task. Jokes and innuendos about sex and who might be engaging in sexual activities were exchanged, but with little serious sharing of feelings and ideas:

'We giggled about it but nobody had any experience so there was no one to talk to; we didn't know what to talk about.'

'There was a lot of fallacy. We were all into keeping up a sort of front that we'd done everything. I don't know that I was entirely aware of what intercourse was exactly.'

Knowledge about sexuality was rarely gained through more experienced or older women sharing their understandings and feelings. What information women did have before they began to engage in sexual activity was either in terms of reproductive physiology (of animals, mainly) or romantic images of marriage. Girls in the same situation were unable to break through this silence precisely because they were in the same situation; they had as little knowledge and experience themselves or they felt that sex was not something to be discussed.

Two-thirds of the women had their first experience of sexual intercourse by the age of nineteen. Although at the age of 14-15 most believed what they had been taught about sexual morality, their opinions went through a fairly rapid transformation from the age of

16-17 onwards. From this age they began to reassess their moral ideas and expectations regarding their sexual restraint:

'At 14 I was very prim and proper; I didn't think you should have sex before marriage.

By 16 I'd changed my mind.'

Often this change occurred after, or during a change in their sexual behaviour. It was frequently their own experience of sexual relations which confronted them and emphasized to them their need to know more. This experience for some included sexual intercourse and for others included a range of sexual activities 'leading up to it'. It was at this point that women often became frightened about how little they knew or understood about sex and contraception, although they remained at a loss to know what to do about it:

'I didn't sleep with people at that age, but you certainly went in for the heavy petting bit. You were quite aware of what you weren't doing and what you were doing or what it was leading to, but that's all you knew.'

'When I was 14 I knew practically nothing, very very little really. I knew in theory how it happened but just couldn't imagine such a ludicrous thing happening in practice; it all seemed so crazy. Then when we were 15 and having sex it was so much a hit and miss attitude really, so totally irresponsible, basically just not realizing the risks, you know, just true ignorance.'

'I knew you were up shit creek if you didn't use it (contraception), but that's all I knew. I didn't know what you would use, how you would get it, methods of using it. I didn't know anything that was any use to me.'

The preparation they had had to deal with this situation was either minimally helpful or positively unhelpful. Prescriptions from premarital 'purity', dire warnings about the evils of promiscuity, secrecy and mystification about sexual relations, withholding of contraceptive information lest it encourage sexual activity, descrip-

tions, and drawings of animal reproductive physiology - all these approaches to their sexual education were found deficient. When the need for practical information about sexual relations and contraception arose, the women did not have it. Moreover the implications as to the 'immorality' of their behaviour created a great deal of confusion as to what they should be doing, with whom they could discuss it (if anyone), what would happen to them if they continued to have sexual relations, what would happen to them if they did not, how to protect themselves from becoming pregnant, what to do if they did become pregnant, and so on.

It was at this stage that women began to break through the barriers of silence about sex by starting to talk to each other about their experiences, their feelings and their fears. Uncertainties as to how they should behave sexually, or allow their partners to behave, featured centrally in their discussions:

'It was on the level of how far you went, sort of thing, and what was an acceptable way to behave. And so you'd test other people out by saying this happened, even if it didn't really, or if more than that happened, just to see what their response was so you got some idea of what you ought to be doing.'

'In the sixth form we talked a lot, mostly about saving ourselves for our husbands, although we didn't want to stand in judgment of anybody who slept with somebody.'

'It was just the sort of wee girly chat: "What did he do last night?" "Do you think you should have let him?"'.

'Basically my knowledge is trial and error. The year I got into sex, experimenting myself, my friends and I talked about it the whole time.'

These discussions seemed to be an attempt to reassess moral standards and guidelines for their behaviour. Because what they had been taught no longer appeared to be appropriate to their situations, these young women were primarily concerned to work out what would be appropriate. The discussions were practical, being concerned mainly with what to do/not to do, how to do it, with whom, when, etc. There was less discussion about the pressures and implications of sexual relations in their lives.:

'I think we were trying to work out how it was done, and generally about having relationships with boys - not really the emotional aspects, or what marriage would do to you as a woman. It was mostly discovery at that point.'

'We talked a fair amount about what we were doing, but not about the kind of pressures we felt or actual serious discussions about problems.'

Because these young women were talking to each other on the basis of their own as yet limited experience of sexual relations, it is not surprising that the range and depth of their discussions were also limited. The guidelines which they received through their homes, schools, and the media were found overall to be irrelevant to their situations and they therefore learned by trial and error.

The information about contraception which they had was also learned by trial and error. By 16 onwards, contraception began to be a topic of conversation between friends, but few had received much education about contraception, least of all how to obtain and use the various methods available. Discussions were limited by the restricted information they had available to them:

'We talked about contraception. Really we'd only heard about the sheath, rhythm, withdrawal. The pill seemed something for grown-up people to take, very much older, because it was difficult to get hold of them.'

'Mostly we would talk about Durex. I knew there were other things, the pill, but I thought you had to be very old to go on them, at least 19. I didn't know about the coil or cap so I didn't think about that.'

Although these women were aware that contraception existed, their knowledge was superficial; it didn't include, for example, knowing which contraceptive methods were available to them, where and how they could be obtained, whether they could obtain contraception without their parents knowledge, how to use them, or how reliable they were. As Joan Busfield and Michael Padden point out, knowing that it is possible to prevent pregnancy by the use of contraception is not sufficient; it is also necessary to have the knowledge at the right time and to know how to control births through using contraception, which itself requires a knowledge of the different methods, how to obtain them and how to use them correctly (1977, p.235). Despite concern about the risks involved, fear about the possibility of being pregnant and a desire to protect themselves contraceptively, these women often did not have a sufficient knowledge of how to meet their contraceptive needs:

'When I first started having sex, everything was very haphazard. I found out then as much as I could about abortion, even before I really knew about contraception. I even went to a clinic to check it out; I was that worried. I knew about the pill, but in very vague terms. I thought I was too young to go on it. I'd no idea about caps, or coils. We used withdrawal or the sheath, since they were the most easily available. I knew they weren't absolutely effective and you can easily get caught out. I felt quite anxious about it.'

How old one had to be before it was possible to use the pill, how to get hold of it and where to get advice about it, without the fact of having obtained it or having asked about it being conveyed to parents, were major worries at this age. Any contraceptive information, advice or supply which was available only through medical services ran the same risk of detection and therefore was frequently considered to be too dangerous. Hence, although they were beginning to have sexual relations and to talk together, sharing what information they did have, the women had neither the information which they required to meet their contraceptive needs nor an easy avenue for finding it. Since the access to knowledge about contraception had quite effectively been kept out of their reach before they required it, lest it encourage them in 'promiscuity' they did not have it when they did require it.

As with the change in their views on sexual morality, the women's knowledge and use of contraceptives, especially the more reliable methods and the more reliable ways of using the various methods, came about through their own experience. Some had been offered information and advice by mothers or elder sisters, but for most this information had not been passed on by more experienced women. The major impetus for seeking out advice and supplies from medical services and thereby, taking the chance that parents might be informed or that disapproval might be imposed upon them, was their own experience of the risks they were already taking - either through becoming pregnant, becoming frightened that they might be pregnant, or learning of a friend or sister who had become pregnant whilst using the same approach:

'It just happened. I got worried and thought I was pregnant. I went for tests, but I wasn't. and then I started using contraception.'

'When my sister got pregnant, that's when I decided I'd better start taking contraception seriously'.

'We used withdrawal and safe period. It was convenience and ignorance and there seemed no real alternative. I thought it wouldn't happen to me. Then a friend got pregnant using the safe period, so I started using the sheath.'

'We used nothing the first few times. I think I obviously got scared, a lot of good it did me. Then I used foams for a few months. I was very ignorant. Someone advised me and I think the advice was wrong. I found out I was pregnant.'

The experience of becoming pregnant or becoming aware that one might be pregnant seemed to shock women into an awareness of their need to actively seek information about contraception and to take steps to obtain contraceptives, even in the face of likely social disapproval. It is understandable that it would indeed take such a shock to change their approach; actively seeking and using contraception is contradictory to the appearance of sexual innocence and femininity. The contemptuous and punitive tones with which the label 'promiscuous' may be applied to young women who appear to be knowledgeable about sex and contraception, is effective in silencing women and preventing them from seeking information.

The exclusion of women from information about their own bodies, and the means to care for themselves and each other, is not new. Rather it is an established pattern which has enforced women's dependence upon men and upon male-dominated access to information. The rationale for such exclusion of women has been the patriarchal view of their difference from men. For example, Lorna Duffin points out that the nineteenth century exclusion of women from entering the profession of medicine was based upon men's view of what they thought women were, or at least, ought to be. For females to acquire knowledge of anatomy and physiology was considered indecent since, as Duffin succinctly puts it, 'Femaleness involved purity. Purity involved innocence and innocence meant ignorance.' (1978, p.46).

It is within this context of the ideology of femininity which is taught to girls and encouraged as they grow into women, stressing their supposed purity, innocence and ignorance, that their lack of contraceptive information and preparedness must be understood.

Beginning to talk to girlfriends about their sexual activities and contraception was experienced by those who did so, as a relief and reassurance that their actions and problems were not unique. Similarly, talking about which contraceptive method to use, how to obtain them and the problems encountered was found to be very useful. Even for those women who did not begin to share their experiences with other women or exchange information with others until several years after they had been using contraception, discussion was broached initially with apprehension, but the resulting exchange was found to be informative. This is not to say that there no longer existed confusion and problems as to a lack of information, or conflicting understandings. The 'facts' about the various contraceptive methods, their reliability, side effects and health hazards continued to be negotiated. However, despite their early exclusion from knowledge about sexuality and contraception, the women increasingly found that other women were a supportive and informative resource. As one woman expressed it:

'Once there isn't this atmosphere of judgment and you're doing wrong, sort of thing, you can talk more freely about it. This means that you're more willing to talk about different methods and different problems about sex than you would have done before. My friends are my educators. With close friends we discuss it on an intimate level'.

Women friends as a source of information about contraception continued throughout the years since the subject was first mentioned between friends. There were some stages when friends were more important than others, notably when a given method was becoming unsatisfactory, when another method was sought, or when contraception was the subject of press headlines.

Friends were cited as one of the two most important sources of information on contraception; the other source was reading material. Often the two would go together: discussions with friends would lead to seeking written information, and articles would often be discussed with friends.

Sharing experiences of contraceptive methods, family planning services and written material formed a major part of the knowledge friends gained from each other. This included information about where to get information, seen to be a particular problem before having had much experience themselves. Later, it became important to share what they suspected to be side effects and the reactions they had had from their doctors when seeking advice about this. Also friends were central in reassessing alternatives in the light of their mutual, perhaps unexpected, experiences of contraceptive methods and services, and of sexuality. Once it had become relatively common for women to talk about contraception and to feel able to 'admit' to their sexual experiences, this contact was frequently widened to include discussions with other women at work, in the neighbourhood, and so on and thus the benefits of sharing with other women were extended to incorporate more than close friends.

Sharing experiences was sometimes seen in context of the position of women in society, and led to further questions about women's rights. The experience of living within a patriarchal society was discovered to be relevant to the problems experienced in sexual relationships and contraception. The double standard of sexual morality, the denial of information about sexuality and contraception, the legal control over access to contraception and abortion, the mystification and control over women exercised through the medical profession, the concern of governments and research bodies with population control, the profit motive of pharmaceutical research - all these became seen as important information relating to concerns with contraception. These understandings led to

a profound change in attitude, particularly with regard to the right to control their own bodies and their fertility:

'My attitude to contraception has changed in that I'm a lot more aware of it and what it means now. I now feel it's a primary right to be able to have it, which is something that I wouldn't even have considered when I was younger; it wouldn't have entered my head.'

For some these new understandings came directly through their involvement with the Women's Liberation Movement; others were not directly involved but found the new insights which were vocalized by feminists, and the countering statements of those who disagreed, to be the subject of many discussions. A few were involved in feminist health groups, set up specifically to explore the situation of women in relation to health matters, the existing alternatives for women and the possibilities for change. Such groups were experienced as providing much useful information and support:

'I think the whole of my contraceptive education has been helped enormously by the fact that practically all of my friends are in the Women's Movement. It's been through self-examination groups, and we've all been very conscious of questions of health and contraception and abortion, and female autonomy within those fields. It's definitely the most important influence and the way I've learned the most.'

Feminist groups have stressed the importance of understanding 'sexual politics'; in sharing information and experiences with contraception, sexuality has been seen to form a necessary and revealing aspect of the discussions. The difficulties which have inhibited discussions about contraception often have been those which relate to sexuality: first, the problems of finding the words to express feelings and experiences that women have been told either do not exist or at least, should not be spoken about; and second, the sense of loyalty to the man involved if they were to share with other women the 'personal' aspects of the relationship (especially anything negative) might be

construed as disloyalty. These problems were not limited to feminist groups; they were repeated in various ways by the women in the study. While women talked to their friends more often about contraception than they did with anyone else (including their partners and their doctors), they found it less easy to talk to each other about sexuality.

Throughout this discussion on the importance of friends as a source of information about contraception, the reference has been to women friends. This is because most of the women specified that it was their women friends with whom they shared information and experiences. Christine Farrell (1978) also found that it was mostly female friends who provided information about sex and birth control. There were instances where women reported having useful discussions with men friends about contraception, but these were said to be relatively rare. They seemed to occur where the friend in question had a particular understanding about contraception as part of his occupational standing. In general, men friends as men partners were found to have a more limited knowledge about contraception than women.

Partners

Although men were generally found to know less about contraception than women, they were relied upon for their wider experience and knowledge in the early stages of the women's sexual experiences. However as women gained experience, learned more about contraception through other women and through reading, the assumed greater knowledge of their partners was found to be largely mythical. This is not to say that partners were not an important influence affecting which contraceptive method the women used; it is however, to suggest that as a source of information, men were found to have little to offer.

The unpreparedness with which women first engaged in sexual relations coupled with the romantic image of dependency upon males for protection, meant that most women relied upon their partners to use some form of contraception, at first. The guidance of young women towards sexual and contraceptive ignorance and away from self-protection, in the name of femininity and purity, left them little alternative but to embrace the hope that someone else would step in to look after their concerns. The sexual double standard allowing the males the sexual experience denied females, and indeed, making a virtue of it, suggested to the young that these more experienced males were bound both to be more knowledgeable and to protect their novice partners in sex:

'I was very under-informed in sexual relations. I always thought I was never going to have sex before I got married. You were supposed to save it until you found the right man, though I always wanted to marry someone with enormous sexual experience who was going to teach me all those beautiful things.'

The fact that sex was engaged in before marriage meant that even greater dependence upon the partner occurred, for the risk of being labelled promiscuous prevented many from seeking out other sources of sexual and contraceptive information. It was difficult, therefore, for women to assess their own contraceptive needs and decide upon the best method from the range of contraceptives which were available to them:

'When I first started making love at all, I was entirely influenced by my partner because he had more experience than I did. So consequently I really only got his opinions.'

Over half of the women interviewed said that they had originally taken little part in the decision as to what, if any, contraception would be used. As they explained, they 'left it to the bloke' since they didn't know much about it themselves. The result was usually that withdrawal was used, if anything, with a few using the sheath; for some 'either withdrawal or the sheath'

would be used 'depending on the bloke'. For the woman, the situation was filled with tension and worry about pregnancy, but uncertainty as to what could be done about it; as one woman described her experience:

'Basically it wasn't a very good period because as I say, I wasn't very sexually aware. It was all very tense and unenjoyable, and this withdrawal thing wasn't very good either really. I wasn't very conscious about the whole thing, and also because of ignorance, so I just went along with him. I mean I was very close up about these matters; I was brought up with a guilty conscience towards these things if ever I indulged in them. And at that time I couldn't talk to my partner about it and he didn't suggest anything else, so there was always tension about it - probably not knowing what else to do.'

This initial dependency upon partners to take responsibility for contraception concurs with the education for femininity the women had experienced.

However, as with many aspects of this training, especially those which stress the superiority of men's knowledge and their capacity for protecting women, it is not necessarily in accordance with the reality of women's lives.

Once women began to learn more about contraception, primarily through reading and talking with other women, they relied less upon their partners. Realising that they had been risking becoming pregnant, and wanting to be better protected, they sought both more reliable methods and more reliable information. Consequently, the importance of partners as a source of information changed dramatically over the first years of women's sexual experience:

'In the early days my partner's attitude was very important to me, but as time has gone on it's declined in importance. I want to know I'm using the safest method.'

'My friends are more important now. I do discuss it with him, but I think I know more about it than he does.'

Although partners were influential with regard to the qualities looked for in a contraceptive, their co-operation in using the chosen contraceptive method and their satisfaction with the method being used, they came to be

regarded decreasingly as a knowledgeable source:

'I'm an expert compared with most men that I meet.

It's unusual to meet a man who's actually read anything.'

'I think men don't tend to know so much about contraception as women anyway, so from that point of view. I don't think they've influenced me that much.'

The question of who decides which contraceptive to use and the basis on which these decisions are made, between a woman and her partner, is discussed in more detail in chapter five. Notably, the desire to be in control of the decisions and/or the use of the chosen method for many women developed along with their increasing knowledge and experience of contraception. This growth in understanding included the recognition that their earlier expectations of the greater wisdom and protective qualities of their partners were not borne out by their own experiences and were, indeed, unfounded. Access to contraceptive information, and an exchange of information and experiences between women, thus contributed significantly to an awareness of the unsatisfactory nature of feminine dependence upon men, at least in this aspect of their lives. It encouraged women to turn away from a reliance upon their partners to protect them, to increasingly depend upon their own judgment, and to turn to other sources for informed contraceptive advice.

Doctors

Women in the study rarely found their doctors to be a source of information on contraception. Although 94% had consulted with doctors to obtain contraception at some time, and most of these over a period of several years, 82% had discussed contraception with doctors only very occasionally or never. When contraception was discussed, the women found that although they received some advice, they had received little information. Often they were confused by the conflicting advice given by different doctors and felt that they had been given insufficient information upon which to make their own decisions.

The relationships between women and their doctors, and the influence of medics upon the women's decisions and actions is discussed in more detail in the two chapters which follow. Therefore, it is perhaps best to limit this discussion to the major patterns and the few exceptions which occurred with respect to information. In general women felt that they received minimal information from their doctors, and even this was usually dependent upon the woman's initiative. Often it had to be at their insistence, and persistence. Frequently, the information they did receive was felt to be glib, patronizing and the woman's concerns not taken seriously. Pressures on the doctor's time, lack of interest, and a medical attitude of doctor omniscience and patient ignorance, particularly female, were the commonest reasons offered by the women to explain their doctors' behaviour.

The giving of advice rather than information was considered to be an unnecessary and unhelpful approach to women who were consulting a doctor about contraception for the first time. At this stage in their contraceptive use women felt that they could have usefully benefitted from information on the range of contraceptives available so that they would have been able to make a choice. They had felt nervous about going to the doctor (who might either moralize about their sexuality or report to their parents or both) and too innocent of contraception to know the right questions to ask. Women just took what they were given, which was usually the pill, without understanding the decision they were making. Nor were they usually given information about the potential side effects, long-term effects, how long they should think about staying on it, what to do if they became uncomfortable or unhappy on it, what else they might consider using and so on. Women felt they had little choice over the contraception they used, or basis for making decisions about when to change methods and what else to use. As one woman described her experience:

'When I first went for contraception I was automatically put on the pill. I didn't really get advice about different methods which would have been useful then. I didn't consciously know I wanted advice and not get it, but I was pretty ignorant about other methods. It would have been good for me; I could have chosen then. All they really told me was to be careful of the first two weeks.....

....Any time I've been, they've never really talked to me about any other methods. I think they should have. I suppose there are leaflets and that, but you seem to get the impression that the pill is the only method, and unless you really ask for something else, you don't really get told.'

Women who were looking for a general discussion of different methods at any time with their doctors, found it hard to come by. It seemed that doctors gave advice about problems which arose, usually in terms of whether it was anything to worry about or not, whilst they were more reluctant to offer information about the particular problem, the particular contraceptive method, or the range of contraceptive methods available. Women who had tried to tap this source of information often came away disappointed. Many felt despondent about the possibility of having an informative discussion with their doctors, except where the woman felt the problem or question was, or could be presented by her as one which the doctor would find relevant:

'It's very difficult to have a general discussion; if you approach a doctor it's got to be from a very specific angle which they're prepared to discuss up to a point. If I was trying to (find out more about contraception), I wouldn't look to the medical profession to do it. With doctors you're encouraged to think things aren't problems, and if you think they are, well that's too bad.'

Although women generally regarded their doctors to be well informed (unless personal experience suggested otherwise), they felt that they had very limited access to information from this source. What they did receive was advice, but this often contradicted either their own experience or the advice given to them by other doctors. Because they were given little information which might have explained why the advice was given, women remained confused as to what to do for the best and became sceptical of

of medical advice. This was considered to be a serious problem since women felt that they needed to be able to obtain medical evidence in an accessible form in order to make their own decisions about contraception:

'The thing is I'm very dependent on their information, which they're extremely reluctant to provide, to take a decision myself. I think doctors assume that they could not make you understand if you don't have medical knowledge, and they just don't think of ways of putting it - in comprehensible explanations. They assume we're going to be ignorant and stay ignorant and they're going to know it, even the nicest amongst them.'

Dependency upon the medical profession for information and difficulty in gaining access through doctors has been widely recognised in other aspects of health care. Monopolization of knowledge has been shown to be one means whereby a profession maintains its status and its control over those who are dependent upon it. As Joyce Leeson and Judith Gray point out: 'The control of women's fertility both in terms of contraception and abortion is still regarded by many doctors as legitimately theirs.' (1978, p.92) Control, argues Barbara Seaman (1969), is achieved as much by what doctors don't tell women, as what they do.

As with other aspects of contraceptive services, family planning clinics were experienced as better than general practitioners, and women doctors better than their male colleagues in providing information. Preference for the services provided by the family planning clinics was based on a number of related factors including being staffed largely by women doctors, women's problems being taken more seriously, wider understanding of contraception due to specialization, and some attempt being made to provide women with information about contraception. Although clinics varied in the quality of their services, women found that information about contraception was fairly consistently provided in terms of leaflets. Again the majority of the information was about the pill, but leaflets about alternative methods were obtained by several women on request. Not all women were

satisfied with the quality of information provided by the leaflets but all appreciated having at least some information available to them. These leaflets are discussed further in the following section.

Greater accessibility to information and preference for family planning clinics and women doctors were mutually reinforcing. Women preferred those services because they were more likely to be listened to with serious concern and, therefore, the information which was offered to them was thought to be more reliable than information given them in a situation where they felt their concerns had been treated dismissively. Similarly, doctors who provided information, as well as advice, about contraception were seen as more competent and their advice taken more seriously. Conversely, it was more likely to be general practitioners and male doctors who provided little information, were dismissive in their advice, and who were thought by the women in the study to know little about contraception and women's problems; women were less inclined to take their advice seriously. Some actively sought out family planning clinics or women doctors; others felt for various reasons 'stuck' with their existing doctor, but unsatisfied with the service provided.

On the whole, then, women found that their doctors provided them with little information about contraception. This was seen to be unsatisfactory because it was felt that doctors had information which women required in order to make knowledgeable choices about contraception. Despite variation between clinics and individual doctors, it was more likely to be family planning clinics and women doctors who provided women with some information. These services were regarded as being more competent and were preferred. However, for the most part, the women's experience was that of receiving advice without information which would explain it. The result was much conflicting advice, and insufficient information with which to assess the difference and decide which advice should be taken, if any.

Media sources, leaflets and books

These sources of information about contraception will be discussed together because of the similarities between them qualifying the information provided as either helpful or dubious. Media sources were most often the source of early information, particularly magazines and newspapers, whilst leaflets and factual books came to the women's attention only after they had some experience with contraception and contraceptive services. Media sources were more widely known; 100% of the women had encountered contraceptive information through media sources whilst 74% had read about contraception in either leaflets or books.

Of the media sources women's magazines, including feminist publications, were the most popular. Ninety per cent had read about contraception in these magazines, and the majority of these women described them as the most helpful media source in the provision of such information. Newspapers were the second most common media source where contraceptive information was found, 78% of the women having read about contraception in newspapers; this course, however, was deemed to be less reliable than other media sources due to what was seen as the sensationalist approach employed by newspapers. Contraceptive programmes on television were viewed by 46% and heard on radio by 32% of the women in the study.

Leaflets on contraception were encountered by 56% and books by 40%. The majority of leaflets read were those acquired through attendance at family planning services; the rest were through a range of sources, including leaflets distributed through their university and manufacturers' advertisements. Leaflets were in general considered to be helpful as an introduction to contraception, but to be very limited in providing detailed discussions. Books were found to be better in this respect, but more difficult to find.

Media sources were particularly important to the women when they were first thinking about sexual relations and becoming aware of contraception. For many women the information and ideas presented through the media were found to counter the moral attitudes about sexuality which they had been taught:

'The media is an important influence on your sexuality - what is considered to be the new modern way of life. I think the social climate is more conducive to doing things you want to despite friends' and parents' disapproval than it was 10-20 years ago.'

Information from these sources were often the first understandings which women gained into the details of what sexual intercourse was about. Magazines, however, tended to focus more on contraception while the detailed descriptions of sexual intercourse was found mainly in novels:

'Most of my sex education came from novels, before my practical base. I was extremely shy and sort of thought that female organs were a thing not to be mentioned. I think that although my mother had told me when I was young how babies are made, I actually found out the whole real bit from novels which I read quietly in the corner in a plain brown cover.'

Reading was found to be vitally important. Considering the background of withholding information from girls and pressures against girls and women talking about sex, discussed earlier, written material which could be read away from the gaze of disapproving eyes became one of the few sources available. It was the most frequently mentioned source (86%) of where women had learned the most about methods of preventing pregnancy. As a source of information, reading was rivalled only by female friends (60%); often these two sources complemented each other with articles being discussed between friends and discussions with friends provoking an interest in reading more about contraception (48%).

Reading about contraception was seen as very important in this

period of first learning about what methods existed, which ones were reliable, and how to use them. As with sexual relations, little information had been offered to women before they found themselves requiring contraception. The probable insinuations of promiscuity which would accompany any public questioning into the subject, meant they were reluctant to ask:

'It's easier to digest something written, than to go and question it when you're young. It's very difficult to talk to other people then.'

Finding the information helped them to have an idea of what they could use and to a lesser extent, where and how to obtain it:

'A lot of the magazines I read when I was younger, such as the sort of glossies for young girls, were doing a lot of stuff on contraception and abortion. It told me about methods I needed to know. I was really very ignorant.'

'In the past embarrassment had prevented me from talking about it and therefore, reading magazines and that was how I learned. But there seems to be a lack of information, even there, of where to get more information.'

Other women only came across these sources of information after they had sexual and contraceptive experience of their own, and had learned about contraception through other sources; yet, they felt that had they had access to these sources when younger, it would have been most helpful:

'In magazines you get other people's experiences and general information which by the time I came to read, I knew most of anyway. But when I was younger, 16 or 17, it would have been very helpful indeed. There was nothing around at that time when I was contemplating it.'

The same was often said of leaflets, particularly as they were of a general introductory nature but were available mainly through contraceptive services, which meant that they were unlikely to be used by the women until they had some experience and information about contraception.

The information provided through media sources, leaflets and books were helpful to women in a number of related ways. They offered lots of information of a general nature on the existence, availability, range, reliability and ease of use of contraceptive methods:

'Some of them (magazines) have been extremely good, the method of presentation of the general information. Those articles that are good not only give the information but back it up with how to find out more and where to find it out, who to go to, etc., and those who take a much more scientific attitude towards it.'

'Some of the articles in women's magazines, both Spare Rib and radical feminist magazines, and also Woman's Own and things like that, have been helpful. They give general information on what's available and the pros and cons.'

Particularly those articles which appeared to recognize that the same method or the same type of pill would not suit everyone, were found to be useful:

'I think the thing that impressed me most about most of these articles was the fact that they stressed that if one pill doesn't suit you, another might, that you shouldn't therefore wipe all forms of the pill off the slate because one hasn't suited you, which I was very glad of after that Minovlar episode.'

A range of opinions was felt to provide an overall picture of any particular method, and of the acceptability of the various contraceptives available:

'One book I read was very interesting - a collection of essays on the different methods to use - because they made it clear that they were all speaking from their own point of view. For example, they slated the IUD in one essay and said that was their own opinion but that other doctors think differently. People don't usually write like that.'

Articles which were written by women about their experiences, or articles about the experience of women with the method being discussed, were seen as a basis for comparison with their own experience, in much the same way as talking with other women would be:

'Lately I read this piece in The Sunday Times about a woman who'd been on the pill and had been depressed as well. And she wrote this piece about how she felt and I thought that just described how I felt, and it seemed to me the fact that they'd published it, it probably described the way a lot of other women felt as well.'

'There was a section on abortion, and since I got the book just after I had mine, it was interesting to see what other women had felt.'

Leaflets and contraceptive handbooks were found to be especially helpful in providing practical information about using a contraceptive method:

'That leaflet on the cap was very helpful in telling me how to use it and that it wasn't going to be the awful palaver that I imagined it would be.'

'They told you all the things you could expect about having a coil put in.'

Information about new research findings and new contraceptive methods becoming available or being studied were more likely to be found in media sources:

'I find television programmes are very interesting: new things coming onto the market, a once-per-month pill, a pill for men, things like that.'

'I can't resist these articles in newspapers which quote new statistics. When confronted with something that gives me more information, I always read it.'

In these various ways media leaflets and books were found to be useful to women in learning and making decisions about contraception. The limitations of these sources tended to be the generalizations rather than

detailed discussions, particularly regarding side effects, long-term effects and dangers to health of the various methods, and the brief, yet jargonistic style with which they were often presented.

Many women felt there to be a problem about the standard of information in media sources, leaflets and to a lesser extent, books. This information they felt was primarily designed to provide a brief introduction to methods of contraception. Introductory information was sometimes found helpful at an early stage of learning about contraception, as discussed above. However, the presentation and language used, particularly in leaflets, often was felt to have defeated the purpose of supplying information:

'There's very little literature that is readily available at an easy enough level to understand, that's not full of technical jargon, but on the other hand, is not so superficial that it doesn't tell you anything.'

'I don't think they were deliberately dishonest, but they (leaflets) were so watered down as to be fairly useless.'

Although recognizing that it was perhaps difficult to devise a leaflet or article which would be useful to everyone, given the variation in what might be known about contraception, an over-simplistic or over-mystifying presentation was found to be insensitive to women and to result in a very limited type of provision:

'One (leaflet) was handed out at college. It was very terse, concise and not very helpful. I thought if you didn't know about it, it was useless; if you did, it was equally useless - a waste of publication really.'

'Leaflets on the whole are pretty disastrous. I think the presentation on the whole is fairly bad. There seems to me to be two modes of presentation: one for complete morons and one that's the sort of pseudo-scientific - like writing it down in the same jargon you have to fill your tax form in, which is no use whatsoever.'

The solution to this problem was seen to be the provision of more information, explained clearly, with greater regard being given to the many problems which women encounter using contraception, and the future problems they might expect to encounter, as a consequence of using the contraceptive methods available:

'I'm familiar with the range of what's available and I prefer certain methods. But there's the medical background: what does it do to you to take oestrogen over a period of 4 years? What does it do to you to walk around with a coil inside you for a period of years? That's why I say I'm not very well informed because I don't know what that means. I'd like to know what it's going to do to me when I'm sixty. I know that kind of information isn't available, but I think there are probably pretty accurate medical predictions about what's going to happen. The kind of articles you read tell you what is best and why, but that doesn't tell you in detail what are the consequences of using this particular method.'

'A lot of information seems to be very sort of superficial and I think for most women, it will tell them what they already know. I think it must be presented in a more serious fashion. This applies to television, radio, magazines and everything. If it was more detailed, more serious, went more into the problems and other things, it would be a lot more useful to a lot more people.'

The need of women to know more about the consequences of the contraceptive methods they are using is evidenced further by the difficulties they encountered negotiating side effects, discussed in the following chapter. The potential of media sources, leaflets and books in providing such information would appear to be great. The major concern which remained for the women with information from these sources was the confusions surrounding the possibilities of biased information.

The question of bias

Concern about information being biased gave rise to uncertainty as to whether or not to believe the assertions being made about contraception. As with the sexual attitudes and morals, what was first learned tended to be believed until newer information or experience caused them to rethink the situation:

'If it's new information, you're not sure whether it's true or not; you just take it until you read something else that puts forward other ideas.'

If other ideas were never, or only rarely, encountered through other sources the tendency was to go on believing what was first learned, or first thought to be the most authoritative source. This was especially so where one idea was frequently repeated:

'It's a reinforcing thing really; the more times you're told the same thing, the more you believe them.'

and when it coincided with a decision being taken:

'It's always nice to be told you're doing the right thing after you've done it.'

The most frequent example of information providing reassurance was in relation to taking the pill. The possibilities of ill effects have raised doubts in most women's minds regarding the advisability of taking the pill, especially over a long period of time. However, the majority of information and advice which the women had received had suggested that such ill effects and risks were minimal. Given the other advantages of the pill, particularly its reliability, ease of use and separateness from sexual activity, women hoped the assertions about its minimal risks were true:

'Its a reinforcing effect rather than a direct influence. You always wanted to read things which said it was okay, to reinforce the taking of the pill.'

'I read newspaper articles to make sure my pill doesn't
crop up. It's reassuring.'

On the other hand, reports and assertions contrary to the minimal-risk,
reassuring ones, sometimes provided women with information which prompted them to
rethink what they thought they knew:

'I read the reports on tests that have been going on.
It's given me a lot of my dubious information and made
me think again.'

'Sunday Times articles are quite good in giving me
information about the pill. It's one of the things
that made me think about coming off it.'

Some women felt that media sources in particular put too much stress on the dis-
advantages and risks associated with contraceptive methods, at the expense of
emphasizing the importance of reliability:

'Mainly I've found them frightening 'cos the articles they
publish tend to be on the disadvantages. I think they
concentrate too much on that rather than the obvious advant-
ages or on the obvious necessity of needing a reliable form
of contraception.'

For most women, coinciding with the length of time they had been using contraception
and reading about it, there were more and more conflicting bits of evidence which
arose. The problem then became which reports to believe:

'I have some difficulty with them: some reports are
very anti-pill and some are very pro-pill, so it's
difficult to know what to rely on.'

'I'm sure there are different opinions on this but
I'm influenced just by this one opinion I got from one
paper. I'm biding by it. They seemed to be based on
scientific findings and like a doctor's opinion, I tend
to take it without doubting it too much. I do take
several opinions if I can, but then you find there are
several different opinions and you go back to yourself.'

The difficulty, however, of going back to sort out one's own ideas about the best
thing to do, was not having enough information on which to base decisions.
Because there seemed to be more advice than information offered, and the information
which was offered tended to be of a general introductory nature as well as possibly
limited by its bias, the result was more likely to be confusion than clarity.

The bias of an article or report could take several different forms and women found some of these forms easier to distinguish than others. One major form of bias was related to the purpose associated with the publication of the information. For example, if the purpose of the information provided was to sell the particular contraceptive or to sell the newspaper or magazine, then the information was likely to be viewed sceptically:

'Anything that's being pushed by the manufacturers - well, you're going to get all the marketing things.'

'I read a leaflet put out by the manufacturers of a type of sheath which claimed it was more reliable than I think it is, and also a leaflet about a spermicidal foam which claimed it was reliable if used on its own. I wouldn't have thought that. That was drug company stuff; the Family Planning Association leaflets were fair, but not the drug company ones.'

'You've got to be quite choosy. There have been some I've read that have been downright misleading, especially those who just want to put on their front cover "Sex Survey" or something so that people will go out and buy it; that happens all the time.'

Another purpose which gave cause for concern to some women was whether the information provided was geared more to the needs of the contraceptive service, particularly the doctors, than they were to the education of the women serviced:

'The family planning leaflets tend to gloss over the side effects. I think they just give them to you to cover themselves. It's just really important to know, even to know the worst; they might discover some awful side effects, but at least you'd know. But women would probably change then and drive doctors crazy. They want to get you on one method with as little fuss as possible'.

The tendency of newspapers to sensationalize the news reported to sell the newspaper was a further purpose questioned by the women. They were interested in the up-to-date information found in newspapers, but were often sceptical of the 'scare story' approach:

'Newspapers are often very sensational about different methods. I wouldn't put much faith in what I'd read in newspapers - about anything, much less contraception.'

'I remember just after I came off the pill with cramps, they had this big article in the Sunday Times about people having leg cramps and dying of thrombosis. And I thought it was really irresponsible and a load of shit. It did worry me but I knew I shouldn't have been worried by that because I know things like that just exaggerate headlines.'

Where the purpose of an article or news report could be fairly clearly identified as being one which had little to do with providing information to women to assist them in making decisions, any conclusions drawn were likely to be discounted or queried. Other forms of bias were less easy to decipher.

Bias was questioned in several different aspects of the information offered: the range of methods, whether all sides of an argument were presented, the moral slant surrounding the information, who had written it and what they were trying to prove. At times it was difficult to distinguish what the bias was; other times it was easier:

'I haven't known the significance of some reports, particularly where something is written in medical terms. My doubts have not been because of their overt bias but because of my ignorance of what their bias is. Quite often, though, you are able to tell the difference between people trying to give information about a piece of medical research and people trying to be moralistic.'

Moralistic attitudes that women did not agree with, particularly those which emphasized the promiscuity of pre-marital sexual activity, the wickedness of abortion and the preference of women's traditional 'role', was a form of bias which tended to discredit or at least render suspicious any information offered:

'If I come across an article in Cosmopolitan or something like that, I'll read it, but usually there's so much garbage about women in them I can't bear to.'

'The sort of magazines I read all implied that you had a steady boyfriend and that you were going to get married and you were going to have kids in the long run, so they never mentioned things like sterilization.'

'I read about abortion in one of these crummy girls' magazines which were doing these awful stories - where a girl about to go to the abortion clinic sat down on the park bench and then, instead of going in, rushed home to keep the baby.'

The moral slant which appeared in an article about contraception was closely related to the presentation of information, who had written it and what it was thought they were trying to prove. Where moral views regarding sexual behaviour, marriage and family were seeming to be pushed, especially if there were views conflicting with what the women believed, the bias was fairly easily identified; in apparently 'factual' presentations of contraceptive information the bias was not as clear, although some distinctions were noted.

One distinguishing characteristic which was related to the perceived bias in a report on contraception was whether or not all sides of an argument were presented. This was as true for statistical information as for general discussions regarding the advantages and disadvantages of different contraceptive methods:

'I dispute most of their figures. They're just pulled out of the air, so I read them with a pinch of salt. They say 98% of this happens, but they don't compare it with what other people do (who are not on the pill). I find them very biased and you can normally guess before you get to the end what sort of person has written it - somebody selling the pill or somebody totally against it.'

'Sometimes when they stress the efficiency of the pill and hardly mention the hazards, I feel as if they are pushing it.'

'I would'nt rely on them to make up my mind about anything. A good example is the coil; if you read a lot about the coil you tend to get the view that it's 100% safe and a pin-prick. Actually I do know someone who had one fitted

with no pain at all, and that's what comes over in articles, Yet three women I know have pains, etc. and a lot of women have discomfort. You must doubt them.'

Similarly, bias was sometimes perceived in the concentration of information on one or two methods to the exclusion of information about a range of different contraceptives which were available. Women found that most of the articles and leaflets they had seen focused almost exclusively on the pill, and to a lesser extent, the coil:

'They tend to concentrate on the pill or the coil and disregard the others as inappropriate or unsafe. I've heard very little about the cap. With the pill you sometimes get coverage of side effects, and the coil, but even then I haven't read exactly how they work, exactly what they do to you.'

'There's a distinct lack of frank informative articles which discuss all methods. There's so much written about the pill; everything else gets pushed into the background, so people don't think about having a cap, coil or sterilisation.'

Books, contraceptive handbooks and feminist self-help health guides (handbooks and magazine articles) appeared less biased than other sources. They were found to provide a greater range and depth of information. They were, however, more difficult to find. These sources were less likely to be found in waiting rooms, handed out via contraceptive services or found in shops. Those women who did manage to encounter them usually found the information to be more detailed and useful than they had discovered elsewhere:

'I've found that books are especially useful. The things that you can find in certain books are not always available in other ways, such as I read in a book, and this is apparently true, that if you're on antibiotics then the coil isn't as effective as it should be. I'd never been told that by anybody, neither my doctor or the family planning clinic. But that sort of information I think you can find out.'

'Something like Spare Rib or Women's Voice discuss things that aren't generally discussed, and problems that aren't generally considered problems by the medical profession.'

'Women's Report is very good and women and health books, like Our Bodies, Ourselves. They give you the kind of detail you can't seem to get anywhere else. Handbooks too - although some I've seen I'd have doubts about, mainly 'cost they're out-of-date.'

It appeared that the more in depth the discussion, the more likely different viewpoints would be presented for comparison or enough information would be offered to allow women to draw their own conclusions. It was this type of discussion, detailed and comprehensive, which women found to be most helpful.

Most sources of information about contraception encountered by the women provided an introductory type of discussion, focusing mainly upon one or two methods of contraception, with little emphasis upon the consequences of using them or the debates surrounding their use. Women, therefore, often had a limited range of information and this they felt, impeded them from drawing their own conclusions. They found themselves having to rely upon the author/s or the piece having presented a fair and balanced account. The question of who had written the report and what they were trying to prove gave rise to suspected bias. Reports written by doctors and/or obtained through family planning services were least likely to be criticized:

'If it's written by a doctor I tend to believe it.'

'The figures were fairly qualified on the pill so you didn't really see too much, but I suppose I thought they were written by somebody who knew what they were talking about.'

'I haven't had any doubts about the family planning leaflets simply because one tends to assume that being a body like that, they're going to be less biased than somebody who is picking up statistics for a book.'

Once women began to read differing accounts by doctors, or articles that compared or debated doctors' views, it was less possible to believe them purely on the basis that they were written by a doctor. Awareness of differences of opinion among doctors did not necessarily give women sufficient information to draw their own conclusions, but it made them more aware of the need to consider the evidence themselves and to look to a range of sources

for information. Further, it confronted them with the fact that there is conflicting evidence on the subject:

'I don't know if you remember but recently in it made the front page, a woman on the pill had died of a heart attack. She was quite a young woman but she had been on the pill for 15 years, and the doctor put it down to the pill. He was advising all women who'd been on the pill for 10 years that they ought to come off it. Every day after that there were other doctors writing in saying it was nothing to do with the pill, and they supported the pill. I was quite concerned about it but at the same time I just thought that obviously the doctors who said it wasn't the fault of the pill had probably got just as much evidence on their side as well. You've got to be aware of the possibilities though.'

Other sources of information tended initially to be regarded with greater suspicion of bias than medical ones. If the information was found to accord with the experience of the reader and with that of other women she knew, the credibility of the author/source of the information improved. This was particularly noticeable with feminist sources of information. Women who relied upon the fact that an article was written by a doctor to give credence to the information in it tended to be very sceptical of the evidence put forward by feminists:

'There's a lot of sort of Women's Lib. literature out at the moment written by different people and they tend to quote statistics, you know, in the middle, particularly the American writers do, and of course you have to be aware of that, because there may have been a particular statistic about a particular area where she was writing and it may not necessarily be true for the whole of America or it may not be true the next day, you know. And the very fact that she quotes where she does, she is obviously trying to prove a point as well. So I think there is definitely a certain bias in these statistics.'

Other women, particularly those who had experienced difficulties which were either dismissed in the advice given or written by medics, or were subject to conflicting medical viewpoints, found that feminist sources provided information which was more relevant to them:

'They've been helpful about side effects on the pill. It mightn't have crossed my mind that lots of women have side effects on the pill. Doctors ignore it. They do. I think it's important that women get an idea of solidarity - that you're not a single neurotic, lurking alone.'

Yet for those who felt that they should decide about the pros and cons of different contraceptives on the basis of as much evidence as they could find, there was considerable reluctance to rely upon either feminist or medical sources to select the evidence for them. To some extent, of course, it was necessary to select which sources were looked to for information, albeit with a critical eye. In this respect feminist sources were very important since they tended to take the experience of women and 'women's right to choose' as their starting point:

'I'm quite selective I guess. I read the ones I feel are on my side.'

'They've given me a lot of information I just wouldn't get anywhere else, so I tend to go back to those sorts of things (feminist magazines). I don't think I would have got that sort of information from the medical profession because it wouldn't have been regarded as particularly significant.'

There were some drawbacks to relying upon feminist sources for information, such as their tendency to raise issues that led to further questioning. Often their different slant on discussions about contraception added new dimensions which could be confusing or disturbing:

'The politics of sexuality which is presented is good, but can make it less helpful in a way. Like with the pill - some people like it in terms of controlling their sexuality and some dislike it.'

'It's made me feel worried about possible ill effects that I hadn't even contemplated might happen to me. You get to feel that everything's carcinogenic and everything can potentially kill you a bit quicker than anything else. But I think there's an alternative to feeling like that - more information, good quality information.'

As pointed out by the woman in the latter quote, more detailed and reliable information would help to provide women with the basis for comparing and criticising reports they encounter. It might also lessen their dependence upon who was writing the report and the concern about what they were trying to prove. As with other forms of bias, the more information women had on which to base their judgments, the less they felt the need to rely upon someone else's viewpoint.

'More information, good quality information' can be seen to be necessary at all stages of women's contraceptive use. Protecting themselves contraceptively and choosing and changing their method of contraception to suit their varying situations depends upon such information being made available to women. In addition, information about symptoms which may be related to the method of contraception in use is necessary for women to distinguish side effects and decide what to do about them - whether to look for another form of contraception or whether the discomforts they may be experiencing are less serious. Without the information to make these decisions, women are placed in a position of extreme dependency upon the advice and practices of their doctors. The complications of this dependency in negotiating with their doctors is the subject of the next chapter.

The processes of negotiation between women and their doctors were most clearly revealed in the practice experienced around the detection and treatment of contraceptive side effects. It was here that the relations of differential power and knowledge were felt most acutely by women in the study. 'When something went wrong' in the normal course of contraceptive use, questions began to arise for them about the taken-for-granted assumptions of the adequacy of existing contraceptive methods and/or services. The attempt to delineate the problem and to locate a solution confronted women with the need to reassess these assumptions and to negotiate with their doctors the suitability of their contraceptive use.

These negotiations centred upon several key questions about the symptoms which women experienced and reported to their doctors: first, is the symptom related to the contraceptive method used? second, is it serious? and third, what should be done about it? The first two questions were usually interdependent, and both bore relevance in decisions about what actions should be taken. For example, where a symptom was recognized to be related to the contraceptive method used, but not thought to be serious, little was likely to be done about it. Or, where a symptom may have been viewed as serious but not related, treatment was often geared to the alleviation of the symptom but not necessarily to the prevention of its recurrence. The answers found to these questions were therefore highly significant to the continuing contraceptive actions of the women involved.

The assessment of these questions, and their answers, hinged upon the relationship between women and their doctors. Medical dominance was accentuated by male dominant perceptions of women resulting in frequent conflict between women and their doctors. The latter's control of the prescription pad, authority as expert, and privileged access to information appeared to significantly influence these negotiations, and their outcome. As Margaret Stacey has aptly suggested,^{*} the result begins to be revealed as processes of subjugation. The inequality in the positions from which either party negotiated was protective of the medical privilege to decide what is serious, and to whom. (*Personal communication)

The extent to which women were involved in negotiations about side effects emphasizes the importance of these processes. Only 6% of the sample had never used either the pill or the coil as a contraceptive method. Of the remainder, 85% of the women had experienced symptoms which they thought were likely to be related to either of these two methods of contraception. Further, it needs to be pointed out that women were reluctant to connect symptoms with their contraceptive use unless they became recurrent or continued for some time; that is, they were unlikely to relate the two until they felt that they had substantial evidence. This finding was contrary to the frequent medical expectation of 'over-reporting by oral contraceptive users' resulting in 'a substantial degree of bias' in the identification of adverse conditions related to pill usage (see, for example, The Royal College of General Practitioners' report, 1974). The implication that women's awareness of possible side effects or regular contacts with the doctor to obtain .. contraceptives leads to excess reporting, and may thus be largely discounted, was not substantiated by this study. Rather women appeared to ignore or tolerate their symptoms and only reported them to their doctors when they had gone on for some time or increased in severity. Further, they were more likely to report symptoms which they felt their doctor might take seriously than

those that they thought probably would be dismissed.

Consulting doctors

The advice, practices and attitudes which were conveyed to women by their doctors informed them of the likelihood of being taken seriously should contraceptive complications arise. In some cases women felt they knew from their first consultation about contraception with the doctor whether it would be worthwhile going back if problems arose; in others, they learned when the situation of experiencing what they thought might be side effects did arise. The extent to which women considered that their doctors understood their medical histories, regularly checked their health status, were prepared to listen or discuss symptoms they experienced and refrained from imposing moral opinions upon them influenced the degree to which they valued these consultations.

Expectations regarding what their doctors would or should do in providing contraceptive services included guidance about what to expect in terms of the possible side effects, the health risks involved and if using the pill, the type of pill which was likely to suit the individual woman best. Few received such guidance. Information received from their doctors was rare and most women considered that the decision about which type of pill to use was arbitrary. Health risks tended to be dismissed as almost negligible and side effects as minor, except where the woman's age or experience with disease appeared to be viewed by their doctors as incompatible with use of the pill, or coil. Nevertheless, concerns about the limitation of their own contraceptive knowledge and the access of their doctors to detailed medical information led women to look to their doctors as experts. Experience with different doctors and varied medical opinions raised doubts about this general level of expertise amongst medics. Cynicism increased with experience of negotiating with doctors.

The sense of not being taken seriously by their doctors was a predominant feeling amongst the women. Dismissiveness, disinterest, and lack of time were frequently said to characterize their doctors' reactions to their questions or reports of symptoms. The medical privilege to make available or withhold contraceptive methods meant that women were very acutely aware of the importance of their doctor's understanding of, or at least, agreement with their contraceptive preferences. To gain this approval women had to be concerned with their doctor's opinion of them. The attempt to convince her doctor that she was a rational and responsible human being, and not 'a neurotic female', was not always an easy task for a woman.

When medics cast suspicion upon the reliability of the statements made by patients, they protect their own views from challenge or change. Further, their legitimacy as the appropriate decision-makers in contraceptive or other health matters is thereby reinforced. It is a form of legitimation frequently used by dominant social groups to safeguard that position over subordinate groups. The medical prerogative to reference an individual's physical or mental state as unhealthy is a powerful means by which an individual's rationality or reliability may be brought into doubt. Whether an individual is portrayed by a doctor to be weakened, diseased, over-anxious, sickly, hysterical, pathological or neurotic the result is the same - the individual appears as incapable and hence, unreliable.

Feminists have pointed out that these adjectives have been applied most often to women, regardless of their state of health or illness. Dale Spender (1980) for example, has argued that the consistent devaluation of women in a male dominant social order constitutes women as a muted group; this in turn reinforces male blindness to the experience of women. The medical profession has been recognized to have played an infamous role in defining

women to be intellectually incapable, lacking in physical stamina, periodically polluting, sexually dangerous and emotionally unreliable solely on the grounds of female/lack of male biology (Oakley, 1976; Duffin, 1978; Ehrenreich and English, 1979; Scully, 1980; Elston, 1981). That women in this study experienced all of these attitudes in their consultations with medics over several years of using contraception was therefore not entirely surprising. However, the frequency with which women reported their symptoms being treated dismissively, the difficulties they encountered trying to talk to their doctors, and the consequences for their own comfort, health and contraceptive use called for a closer look at the processes involved. Negotiating side effects highlighted these relations of medical dominance and female mutedness in response to the questions: is the symptom related to the contraceptive method? is it serious? and what should be done about it?

Is it related?

Knowing what to expect in terms of the possible side effects of the contraceptive method used by a woman was information which she rarely received from her doctor. Little more than what might be expected in the first few weeks, such as nausea or painful breasts with use of the pill, was likely to be offered. Apart from this, the usual advice received by women was the instruction: "Come back if you have any problems". The first problem which women therefore had was not knowing what sort of problem was likely to be considered a problem related to the contraceptive method in question.

The impression which most women received from their doctors was that there was no need to worry about side effects. Women were often uncertain whether this meant there were few side effects of the contraceptive or whether it was a suggestion to the effect that they 'needn't worry their

little heads about it' but should leave it all up to the doctor. The health risks which were conveyed to women as being serious, but rare, appeared to have been seen to be largely unrelated to possible side effects. The most notable exception to this was evidence of increasing blood pressure with use of the contraceptive pill.

The assumption that there are few side effects of the pill, and that these are unlikely to be connected with risks to health, which are themselves rare, has been supported by medical studies, most notably the Royal College of General Practitioners' study based on data from 46,000 women in Britain over eight years. Critical analyses of this study, however, revealed many of the ways in which the adverse effects of the pill came to be underestimated in the study (see, for example, Rakusen, 1974, 1978; Beral, 1976; Seaman and Seaman, 1977). The conclusion of the 1974 RCGP Report advised that the evidence of many adverse reactions reported by women including migraine and headache, vaginal discharge, depression, chicken pox and other virus infections, and loss of libido were subject to substantial bias in reporting, and thereby should be largely discounted. The adverse effects being largely discounted, and the health risks appearing as yet unproven, the implication pointed to by the study was that the estimated risk of using the pill was one that 'a properly informed woman would be happy to take'.

Yet, information which may be insufficient to prove a definite relation between the pill and a given disease or health risk does not deny that the link exists, or that there is evidence to suggest it may be likely. It simply remains impossible to say definitely one way or the other (Walsh, 1980). What is clear in this situation is that use of the pill by women continues to be in an experimental stage. This points to the need to avoid sweeping generalizations about the safety of the drug, and to alert women and their doctors to careful monitoring of all symptoms experienced (Seaman and Seaman, 1977).

The danger of assuming women are likely to over-report their symptoms (which then may be largely discounted from the estimated risks related to the contraceptive method is that new or contrary evidence is not recognized. The low-risk, few side effects perception is confirmed by a self-fulfilling prophecy. If women are assumed to have 'other reasons' for complaining of symptoms, it then appears that women are themselves to blame for complaining.

This process was expressed by women in the study in terms of busy doctors who had no time for fussing females:

'Obviously such a lot of people are unaffected by the pill that doctors with their workload tend to think of women coming in as being fussy and stupid.'

Experience of doctors' reactions to their complaints of symptoms as women complaining about nothing at all tended to dissuade women from mentioning symptoms until they had become persistent. The invalidation of being told that a reported symptom was 'nothing at all' frequently left women feeling more confused and unsure what action to take after the consultation with their doctor than before it. In some cases, women found themselves wondering whether they had imagined it all, or whether they had in fact asked the doctor about it:

'It was as if I was imagining them. It was really absurd. You'd think that they would touch you or act as if you were complaining of something...It's almost as if they can't hear you. They go on with the same sentence that they've been saying. And you say something new that you think really ought to change things and they somehow manage to evade it as if you hadn't said it. It's really weird; they somehow manage to sidetrack you so that you forget that you've asked it, and you only remember later.'

Repeated experience of this process of invalidation in negotiating with their doctors led women to have less trust in their doctors' expertise and advice. If their symptoms persisted they were likely to

look to other sources of information, or to other doctors or clinics where they thought they might receive better care.

Women reported that they had learned most about contraceptive side effects, as other aspects of contraception, from written material (mostly magazines) and from talking to other women about their experiences. Few had learned which side effects were likely to accompany, or might possibly be related to the contraceptive method they used, from their doctor. Yet, some found they were expected to report their reactions to the contraceptive to their doctors. This seemed to suggest that what were likely side effects were known for the symptoms were to be assessed as reactions to the contraceptive. On the other hand, women's reports to their doctors of symptoms were frequently dismissed or invalidated:

'I've complained before of what I thought might be side effects of the pill and they very much pooh-pooed it, saying "You're getting neurotic about it, hearing a lot of stories, whereas in fact it doesn't do this". Every time I go to the family planning clinic they say "Oh, it's nothing, it's nothing." When I told them I'd been on it for six years and wanted to know whether I should take a break off it, they said "Well, it's a mild one so it doesn't particularly matter. As soon as you have any side effects, then it's time to start thinking about coming off it".'

Such advice was not experienced as at all reassuring by the woman in this example, for she had over several years been reporting symptoms which included cramps, migraine, depression, loss of libido and thrush. It became extremely difficult for her to follow the advice offered. As each time she asked about a symptom she thought was a side effect, it was seen as unrelated to the pill, she was unable to ascertain whether what she was experiencing was in fact an indication that it was time to start thinking about coming off it.

Part of the process of learning how to negotiate with doctors to receive contraceptive health care involved women in assessing which symptoms a particular doctor, or doctors generally, were likely to see as possible side effects. This information was gathered through the media, through discussions with other women, and through trial and mostly error with their own doctors. According to the reports which women gave it appeared that one of the most important factors which would distinguish those symptoms which were seen as side effects from those which were not was whether it could be measured independently by the doctor. That is, if the doctor was not dependent upon the woman's word for evidence of the symptom, but was able to use measures such as bacterial cultures, weight scales or blood pressure levels, it seemed more likely to be recognized as a side effect. Less tangible symptoms including mood changes, headaches, loss of libido, cramps, and other pains and discomforts, were more dependent upon women's descriptions and less likely to be seen as side effects. Women learned with experience which symptoms it was possible to discuss usefully with their doctors:

'It's very difficult to have a general discussion. If you approach a doctor it's got to be with a very specific angle which they're prepared to discuss up to a point. When my vagina was very sore and irritated it took a lot for me to go to the doctor. When it proved not to be an infection they thought it wasn't a problem. If it's not an infection, you're all right and if you're uncomfortable, well that's too bad.'

'I began to develop a strong reaction against alcohol (1-2 glasses of wine; never occurred when off the pill). As soon as I had a drink I would have such a headache, I could hardly see, but the doctor just laughed and said "That's probably the drink". He just told me not to worry.'

'Since I had that worry and he was so dismissive I'd say I wouldn't discuss problems with him. But if I was putting on a lot of weight or something purely physical - I know that sex drive is physical, but something he sees as physical, then I could discuss that with him.'

The problem which this presented for women was that if the only symptoms which were likely to be recognized as possibly related to the method of contraception used were those which could be measured independently by the doctor, then what should be done about those symptoms which did not fit? This query was sometimes solved by coming across a doctor who did recognize the symptom which the woman experienced, or learning from other women who had experienced the same thing and who had found a way of dealing with it. However, there was much frustration with doctors and anxieties about symptoms which occurred in the processes of negotiation and learning about side effects.

Symptoms which did become recognized as real, but did not fall into the category of being easily measurable by the doctor, tended to be related to other factors than the contraceptive used. That is, while it seemed to be accepted that the woman did experience the symptom, it was more likely to be put down to 'other reasons' than being a side effect of the contraceptive. These reasons pertained primarily to either normal characteristics of womanhood, or to behaviour which was seen as unladylike. In the first case, that of normal womanhood, women inferred from their doctors' statements that it was nothing unusual for women to experience, or think they experienced untoward symptoms:

'I've tried to talk to them but you never seem to get anything but put-off replies like "Females always have a certain amount of infection in their vaginas".'

(Thrush) 'They seem to think it's so general among women - if you take what they prescribe it'll go away; if it comes back take some more and that's that. I don't think they take it too seriously.'

Vaginal discharge and discomfort seemed to be regarded as natural for women, despite the women involved knowing it was not. Next to their genital state it was women's mental state which was indicated to be normally unhealthy, again regardless of the women's own assessment of

what was normal or abnormal for them. Emotional excess and mood changes were more likely to be seen as side effects of being female than they were related to the drugs a woman was taking:

'His attitude was just "Don't be so silly". He said it (loss of sex drive) was purely emotional. I knew that it wasn't, but he wasn't interested in that.'

'I went along to the doctor for some Valium or something (for depression) and said I was taking the pill. I got the Valium but no discussion about the pill. He just gave me the pills (Valium) and that was that.'

'He just tended to fob it off (headaches and depression) as "Women!" and "Don't worry about it, silly girl".'

Those who encountered these perceptions of women when consulting with their doctor about symptoms found it difficult to negotiate any further. Any denial or challenge of their doctor's view seemed to be discounted on the same basis as the symptoms were - that women were typically over-anxious and mentally unreliable. Not surprisingly, women often concluded that they simply could not win, nor their symptoms understood, and gave up discussing difficult-to-measure symptoms with doctors.

Behaviour which might be construed as unladylike, or unfeminine, appeared to provide doctors with a second reason to discount symptoms reported by women as being side effects of the contraceptive method used. References to sexual promiscuity on the part of the woman were frequently pointed to as the cause of symptoms, and in some cases the symptoms were deemed to be the woman's 'just deserts' for her immorality:

'He was implying that if I had sexual relationships with more than one person, then I couldn't help but pick up thrush and vaginal infections - just assuming that because I wasn't married, I did that.'

Sometimes it was quite easy for women to reject their doctor's view of their unfeminine behaviour, as in the above example, but other times it was more complicated. Particularly in relation to women who had experienced an abortion, doctors' judgments about symptoms were confusing as views

of women's sexual morality, irresponsibility, risk of pregnancy, and physical or emotional after-effects of the abortion appeared to be closely interconnected:

'They've always seen the various bouts of frigidity I've had as being sort of psychosomatic and related to my past experience (abortion)...But recently when I went to the new clinic they immediately said "Well, you've got thrush and that could account for all your difficulties in having intercourse". Thrush has been quite a recurrent thing; I don't know if that's a side effect or not.'

'Ever since the abortion they just treated me as a patient, as somebody with problems. I just wanted to go normally on the pill, but every time I went back I had to discuss everything in relation to the abortion.'

Pre-marital or extra-marital sexual relations, having more than one ongoing sexual relationship, having an abortion, or even putting off pregnancy for too long within a married relationship were examples of the types of behaviour which could be put down as 'other reasons' for symptoms occurring. The implication of such a pattern of diagnosis seemed to be that women were unhealthy, or potentially unhealthy, when they acted outside of the normal behaviour prescribed for 'good girls'; improper behaviour was thereby likely to give rise to untoward symptoms.

The image which emerged of women from these reports of medical assessment of symptoms was unflattering, contradictory and extremely unhelpful to the women involved. Genitally and mentally unhealthy by natural predisposition or by unfeminine behaviour, or both, this characterization of womanhood was at times as confusing as it was revealing of patriarchal attitudes within the medical profession. Barbara Ehrenreich and Deirdre English (1979) have suggested that it has been the hormonal link between women's reproductive systems and their brains which has served to justify medical ideology as being backed by scientific validation. Traditionally, they have pointed out, women's gynecology has

been regarded as ruling their psychology, by the medical imagination, and both have been considered to provide sufficient pathology to support the expanding fields of gynecology and psychotherapy, or even 'gynecology as psychotherapy'.

The situation which resulted for women often seemed to be one in which they were completely unable to ascertain whether the symptoms they reported to their doctors were in any way related to the contraceptive method they were using. Medical reactions which asserted their ill health to be normal for a woman, and denied their protestations on the same grounds, invalidated any contributions women offered to the negotiations. The paradox which this view of women then posed for the practice of health care and the negotiations surrounding contraceptive side effects was probably impossible to resolve. Whilst a woman's word could not be trusted, medics remained dependent upon women's reports of their symptoms in their diagnoses and treatment.

This paradox reveals that the patriarchal medical ideology which may be employed by doctors in their treatment of women patients inhibits their perception of possible contraceptive side effects. Whether symptoms are explained by reference to the inherent unhealthiness of being a woman or to behaviour construed to be unwomanly, the result is likely to be a failure to recognize symptoms as possible indicators of ill health which could relate to the use of contraceptive chemicals or appliances. If it is not recognized that a woman's symptoms might be related to the birth control method she uses, it is more likely that side effects which might otherwise be avoided or treated will continue to provide discomfort, and perhaps may develop into a serious risk to the woman's health. Further, to deny that the symptoms which women report experiencing are possibly related to contraception, on grounds that women are likely to have 'other reasons' for reporting symptoms, is to prevent the development of an increased understanding of what women do experience using contraception.

It is to preclude the gathering of further evidence as to what the patterns of side effects are, or might be over a period of several years of use. The necessity that this understanding be gained is made the more urgent considering the acknowledged ignorance into the long-term effects of methods such as the pill or coil, the high proportion of women on a world-wide scale who use them, and the length of time over which women have and will continue to use them.

Is it serious?

Whether or not a particular symptom was identified as related to the contraceptive method, the question with which women primarily felt concerned regarding the symptom/s experienced was: is it serious? Three possibilities arose in negotiating an answer. First, the symptom could be simply a discomfort and not a risk to the woman's health; second, both discomfort and a risk to health could be involved; and third, discomfort could be minimal while a significant risk to health was present. The importance of distinguishing which of these possibilities was likely to apply in specific cases derived from the consequences for action indicated by the various assessments. The question confronting women who experienced symptoms was initially: is this something to be concerned about? and then: if so, what should be done about it?

In the first case, where a symptom was thought to indicate simply a discomfort and not a risk to health, determining what should be done about it tended to depend upon how much of a discomfort the woman involved felt she was able to or should endure. This decision was of course closely tied up with what the woman considered to be the alternatives to the method she used, and to her awareness of what could be done about it. In this her doctor was a very important source of information and provider of alternative contraceptive methods or type of a given method (notably regarding different brands of the pill). Negotiations between women and

their doctors hinged largely upon whether the symptom was thought to be related to the contraceptive used. If it was recognized as a possible side effect, several options were open: tolerate it, change the type or brand of the contraceptive, change the method of contraception. If it was not recognized, then toleration or treatment of the symptom was possible while the source of the discomfort may not have been identified. The majority of the symptoms women experienced appeared to be perceived by their doctors as not very serious, regardless of whether they were recognized as possible side effects of contraception or not. As a result, there was little negotiation about what to do about the symptoms. The predominant pattern of women's reactions was to tolerate the discomfort, perhaps reducing the severity with other drugs or treatment, for months or even years until they reached a point where they became 'fed up feeling like that'. Once that situation was reached, and the woman had changed her view of the seriousness of the discomfort and/or her willingness to put up with it, she either stopped using the method without consulting her doctor or she became more insistent in her negotiations with the doctor about finding a solution or alternative.

In the second instance, both discomfort and a risk to the woman's health were identified. It was possible to decide the symptom was something to be concerned about, regardless of whether it was identified as a likely side effect. However, unless some source of the symptom could be seen women felt very much at a loss when trying to decide what should be done about it. They remained extremely dependent upon their doctor's advice, having insufficient information with which to negotiate, let alone decide what they would do. Other sources of information sometimes revealed the likelihood of whether the symptom could be a side effect, and women thereby increased their participation in negotiations and decision-making. If the symptom did come to be recognized as a likely side effect, the care usually became clear for finding an alternative form of contraception - providing other methods were known about and made available.

Finally, where there was no symptom, or one of minimal discomfort, and yet a risk to the woman's health was pointed to by her doctor, it was not necessarily clear to women that there was something to be concerned about. Without evidence about the link between the woman's age or physical condition being shown to indicate the risk implied by the doctor in using her preferred contraceptive method, women frequently suspected that the risk suggested was a matter of opinion. As women were aware of varied medical opinions regarding side effects and health risks with the pill or coil, even if they were not knowledgeable about the detailed differences in viewpoints, they were concerned to find out several opinions before accepting that they were unable to use their method of choice. Negotiations, where no or minimal symptoms were experienced, were therefore usually carried out with more than one doctor. Often a doctor could be found who would agree with the woman's own view or at least who would allow her to use the contraceptive she chose. After repeated requests with more than one doctor, or if she was presented with evidence indicating the health risk suggested, a woman was likely to accept that the method was incompatible with her state of health.

The answer to the question: is it serious? was thus closely connected with the previously discussed question: is it related to the contraceptive method used? The problems which arose in practice in negotiating both questions were similar. In addition, even where it was recognized that the symptom experienced was possibly related to the form of birth control, it had to be negotiated in terms of how great was the discomfort or the health risk involved in the light of the available alternatives.

Serious, but not related

The most common indication women received from their doctors regarding the severity of their symptoms was what, if anything, was done

about them. Treatment of any kind suggested that something did need to be done, and provided validation for being concerned about and reporting the symptom. However, it did not necessarily provide women with the information as to whether the symptom was likely to be a side effect of their contraception. As a result they remained uncertain whether an alternative method was necessary to prevent the symptom recurring, or to relieve it:

'She gave me an internal and said I looked sore, and had thrush. They sent me to a special clinic 'cos I didn't want to consult my own doctor about it... First, they gave me pessaries. When I went back they said "The initial infection's cleared up but now you've got another infection" and gave me oral antibiotics. That brought on a bad throat and ear infection, so I went to the ordinary doctor's and they gave me some drops and it cleared up...I don't think the (vaginal) infection is completely gone now 'cos I have a heavy discharge. I don't know if it's the pill causing it or not. The doctors haven't said anything.'

The woman in this example had received treatment for the initial infection and for subsequent ones which followed that treatment. Yet, she had been given no guidance as to the possible relation between her symptoms and the contraceptive pill which she had been using for several years. Although she considered her discomfort to be serious enough to look to finding out what to do about it, to attend various doctors repeatedly for treatment and to consider the possibility of finding alternative contraception, she thought that if it had been to do with using the pill she would have been advised medically. As with many other women, she considered that if the symptom was not mentioned by the doctor/s as a possible side effect, then it was supposed that the doctor/s thought it was not.

One approach in negotiating side effects was to ask the doctor directly whether the symptoms experienced were possible side effects;

another was to simply describe the symptoms and 'see what the doctor says'. Doctors were found to prefer the latter. Often women felt that their doctors would not inform them of suspected side effects until they became seen as sufficiently serious to warrant changing the brand of pill used, or changing the method of contraception to another. Negotiating how serious the side effect or risk to the woman's health was usually not explicit either; women deciphered their doctor's meaning according to the treatment prescribed.

The major difficulty for women in these negotiations was knowing what to do about the symptoms they experienced. Despite being serious enough to receive treatment, when they were not explicitly acknowledged as possible side effects, women did not know whether to think in terms of alternative contraception or to look to other aspects of their health for the potential cause. If the discomfort was manageable with treatment or if it occurred only occasionally, it tended to be classed by the women as 'just one of those things'. If it was recurrent or became a significant discomfort, it was then experienced as a problem. In this situation, women felt they were very dependent on their doctor to provide them with information about the likely causes and solutions. It was here where much agitation arose, for women rarely found that they received the information which they required:

'They don't offer information. They don't offer any information, and it's quite difficult to know how to formulate questions to get any kind of information out of them...The trouble is I'm very dependent upon the doctors to be able to take a decision myself, and on the information they provide.'

The apparent reluctance of the women's doctors to provide them with information was responded to with feelings of frustration or annoyance, or both. Either they felt that their doctors did not understand what was happening to them, or that the medics considered women incapable of understanding. Over time they became less trusting of their doctors, less

inclined to attempt to negotiate with them, and more inclined to look to other sources of information and experience which would assist them in taking decisions.

Related, but not serious

When symptoms were related as possible side effects, women felt themselves to be in a better position to weigh up whether or not this was something to be concerned about, and if so, what should be done about it. Changes in the condition could be noted, reported, discussed and negotiated with the doctor/s involved on a regular basis. However, it required that these side effects be taken seriously, and regarded as a serious discomfort and problem for the woman, if the negotiations were to lead to some success in dealing with them.

It was not always clear to women on what bases their doctors made decisions about how serious symptoms were to be regarded. As with the negotiations surrounding whether a symptom was to be seen as related to the contraceptive used, women found their doctors tended to view those symptoms which they were able to measure independently of women's reports as most serious. Tangible symptoms were thus taken more seriously than 'vague and subjective complaints' (The RCGP Report, 1974, includes headaches, migraine, mild depression and changes in libido as good examples of this category). Despite the objectivity supposedly added by those symptoms accessible to medical techniques, women encountered great variations in the particular symptoms which were considered to be serious by doctors.

A central distinction which women discovered was frequently employed by their doctors had to do with assessing whether the symptom was primarily a discomfort or whether it constituted a risk to health. The former was more likely to be deemed a side effect, and the latter referred to as a danger or a risk. Despite the variations between doctors

concerning the specific symptoms which were thought to be serious, women found that few of their doctors regarded the dangers or risks involved to be more than miniscule. This was perhaps because risks tend to be estimated in terms of life-threatening or fatal illnesses. Women who perceived the symptoms they were experiencing as serious discomforts, or potentially detrimental to their health and fertility, found this attitude most disconcerting:

'They seem to think that if something isn't really, really serious - if it isn't going to kill you - then it isn't an important side effect, when it is! Somehow they maintain such a distance and say "Oh, yes, well, you do get a certain amount of side effects when you're on the pill. Just keep on it and if it's still there in another few months..." I just thought "Well God Almighty there I am having to sleep with my legs on top of a pillow they're so sore when they're lying flat - there's something wrong.'

The lack of concern which it was thought such attitudes conveyed about women, their comfort and their health was compounded when moralistic or punitive sexual ideas were also detected:

'So I went to the doctor and the first thing she said was "Are you on the pill?" and I said "Yes." "Oh, well, that's why then. If you go on the pill you expect to get these things. I'm not going to treat you. There's nothing wrong with you."'

At times, then, it appeared that symptoms were dismissed on grounds of not being a life-or-death crisis and at others, that they were being dismissed as deserved retribution. Either way, women felt the disregard of the seriousness, or potential seriousness, of their symptoms hampered the possibilities they had to negotiate a successful solution.

In individual consultations it was of course difficult for women to challenge or change the institutionalized power differential of the doctor-patient relationship. The alternative courses of action open to women were limited by the information and especially the availability of

contraceptives over which the medical profession maintain a monopoly. That is, a woman who had doubts about her doctor's attitude or practices could a) remain silent and take action only with regard to the alleviation of her symptoms where possible, b) stop using the contraceptive in question, c) become more insistent or in some way convince her doctor that something be done, or d) change her doctor and begin the process of negotiation again. Neither of the first two alternatives were able to provide a satisfactory solution if the woman wished to use a method of contraception which was obtainable only from a medical source. The third and fourth alternatives were frequently employed by women in the study, and in some cases met with success. One woman who became more insistent explained:

'His attitude was "never mind". It wasn't in fact until I missed another period, two months later, that I said "Hey, look, you know, I want to go on another pill" and he gave it to me then. But then again a friend of mine who'd missed several periods and whose doctor said "Don't worry about it", she ended up having to come off the pill to try and get her periods back again. So I was pretty determined that I wasn't just going to accept that attitude.'

Another woman met with success through finding a different doctor with whom she was more able to negotiate in a constructive manner. The validation and information which she received from the second doctor enabled her to make up her own mind about the health risks which she was prepared to accept:

'He just gave me this speech on how "Going on the pill is no more dangerous than going on a holiday for two weeks on the Norfolk Broads". He didn't give me any advice about what type of pill would be best, just "We'll put you on this". When I went back because I was having trouble, he just automatically said "Oh take this; have this instead" and didn't even discuss it with me. The next time I started having trouble I swapped over to the woman doctor because I felt that he was an idiot and didn't appreciate what was happening.'

Changing doctors or clinics was the most frequently tried alternative. It was not always successful, nor was it always possible. However, experience with several doctors tended to give women an increased awareness of the varied opinion and manner amongst doctors; this in turn increased their understanding of what they might expect and what help could be offered to them. Learning what was possible in negotiations with some doctors made them more insistent in their negotiations with doctors generally.

What should be done about it?

What should be done about side effects was limited and made possible by what could be done about it. That is to say, it was the relative context of alternative contraceptive methods, their reliability, risks convenience and availability in which women took decisions regarding how much of a discomfort and/or health risk they were willing to put up with in their current contraception. The availability of related forms of treatment, too, affected whether side effects were found to be tolerable. Medical assistance and regular checks also influenced what was seen as permissible symptoms. All of these factors were mediated by the information women had in terms of alternative methods, possible side effects and service provision.

One way in which women tried to assess whether their symptoms were related to their contraceptive method was to discontinue using it for a period of time. Usually this was a few months, depending upon the individual woman's situation. With the pill this was not a difficult thing to do as it was easy for women to stop using it after one cycle and begin again when they decided to do so, providing they had leftover supplies of the pill when they had ceased using it. With the coil this procedure was more complicated and necessitated further negotiations with the woman's doctor. Unless she and her doctor agreed on the plan to

discontinue using the coil for a time, this action could become problematic as one woman explained:

'I had this idea, a crazy sort of idea, that maybe the coil wasn't helping (backache). Sort of a fantasy but I had to have it out just to see; so I did. The doctor was annoyed with me for having it out for no reason. She sort of laughed at me for saying I wanted it out because of my back. I knew logically it was very silly but I just had to have it out, and I thought you should be able to anyway. And she was more or less saying that I was costing them money but the coil doesn't cost very much. I'm sure it's more expensive to be on the pill for for twelve months.'

When I went back to have it put back in I went to a different clinic and I didn't tell them I'd had one before because after my experience at the other clinic, I didn't want them to think I was chopping and changing too much.'

The dismissal and invalidation which this woman experienced in her negotiations made it more difficult to test out her hypothesis. Regardless of the outcome of such testing, and in this case the woman found her symptom was not related to the use of the coil, the woman's decisions become increasingly complicated by medical reactions of this nature. Not only does she still have to come to a decision about what should be done about her symptom, she has also to work out how to deal with her doctor.

Being able to decide upon what should be done about symptoms depended upon ascertaining whether the symptom was related to the birth control method and whether it was serious. As discussed in previous sections, women found themselves having to learn which symptoms were likely to be seen as serious or as possible side effects by their doctors. Those symptoms which medics could measure easily or which they could treat gave women the clearest ideas about whether it was something to be concerned about, and whether they ought to be considering an alternative form of

contraception. Negotiations about other less tangible symptoms were frequently confounded by medical views about the normal unhealthiness of women, particularly those engaging in unladylike behaviour. This was a particularly notable aspect of contraceptive negotiations as the women who attend their doctors for birth control are presumably healthy rather than sick patients.

Women who wish to use a method of contraception which is available only through medical provision are forced to negotiate with their doctors about the method they prefer, the side effects and health risks involved, and the changing reactions they experience over time. As with the selection of which contraceptive to use, negotiating side effects and what to do about them is not a static decision. It is a process which varies with the woman's situation, information, assessment of the alternative contraceptive methods and the doctor or clinic she attends, in the light of the varying or accumulating symptoms she may experience. Suitability of methods is thereby a changing phenomenon, requiring flexible and observant negotiations. Further, it is, in the end, the woman who must take decisions about which method is most suitable at a given time as it is she who must use it and she who is at risk of becoming pregnant. The power differential between women and their doctors, based on the medical monopoly of information, authority and provision of the most reliable contraceptive methods, is contradictory to the requirement that women take informed decisions about which form of birth control to use. This conflict provides the basis upon which negotiations about side effects take place.

Medical ideology regarding what women are and how women should behave became evident to participants of the study during their consultations for contraception, examinations and in negotiating side effects. Perceptions of women as normally unhealthy, unhealthy for misbehaving, unhealthy when taking decisions about contraception contrary to medical advice, or perfectly healthy (except mentally) when complaining of symptoms abounded in the women's reports of their experiences with doctors. It appeared to be women's mental and genital condition predominantly which gave rise to medical doubt. Patriarchal stereotypes of women expressed in terms of health and illness portrayed women as inferior to men and prescribed their gender 'role' as subservient to men.

The conflict which women experienced between themselves and their doctors became most evident when some symptom or event occurred which countered the taken-for-granted assumptions about contraception. The power invested in medics to decide what patients need and whether and which treatment should be given placed women in a dependent position despite their lack of sickness. The medical monopoly of information, authority and prescription pad enabled doctors to impose their own understandings of what is best for women upon women. The problems which this presented for women in negotiating side effects, for example, were discussed in the previous chapter; these included distinguishing whether symptoms were related to the contraceptive used, whether they should be regarded as serious and what should be done about them. The ways in which doctors used their professional position to impose their views of women on women derived from their medical privilege; the specific views which provided the content of what was decided as best for women centred upon conceptions of male dominance and female subordination.

The focus of this chapter is upon the stereotypes which, in the experiences of women in the study, provided the content of that patriarchal vision. In the course of their contraceptive consultations women lived the effect of male dominant views of women put into practice. The difference between male doctors and female doctors in their power to enforce, and their likelihood of imposing patriarchal stereotypes upon women raised important questions for the potential of changing these practices.

Patriarchal stereotypes

The stereotypes which were experienced by the women could be divided into three related aspects. The first was an image of women as uninteresting, intellectually weak, over-emotional and unreliable: an inferior species of human being. Second, women were regarded to be ruled by their biological capacity to reproduce and care for children; their emotions and desires (conscious or unconscious) were deemed to centre upon this life project. The third stereotype encountered was the portrayal of women as sexually dependent on men. This assumption of heterosexuality did not directly relate to women's sexual satisfaction; rather it was seen to provide for men's sexual fulfilment and by proxy for women's.

The women's experiences of such stereotyping on the part of their doctors is certainly not unique. Other studies indicate that this experience with doctors is widespread amongst female patients (Chesler, 1972; Seaman, 1972; Frankfort, 1973; Macintyre, 1976; Corea, 1977; Barrett and Roberts, 1978; Oakley, 1980). In recent analyses of medical education (Scully and Bart, 1973; Weaver and Garrett, 1978; Weiss, 1978; Scully, 1980), medical perceptions of women (Graham, 1977; Elston, 1981) and advice to women (Ehrenreich and English, 1979), these patriarchal stereotypes appear with tedious regularity.

The first aspect of stereotyping could be seen in many areas of the women's interactions with their doctors. In seeking information and advice about which method to use, negotiating side effects, undergoing examinations and assessing alternatives to a contraceptive method which had become unsuitable, women confronted their doctors' views of women as ignorant, unreliable and highly emotional. Repeatedly, women spoke of their doctors as regarding them to be 'irrelevant and stupid and that was basically it'. Increasingly women came to feel they were not being taken seriously when viewed in this way, and they began, too, to question the competence of their doctors when they were so treated. This image of women has been discussed in some detail with regard to seeking information and negotiating side effects in the preceding two chapters, and the consequent problems for women in taking contraceptive decisions indicated to be substantial. It was the most commonly mentioned form of stereotyping and the severity of the problems it presented was varied, ranging from minor irritations to major encumbrances in using contraception.

Women's biological capacity to bear children appeared to be used as a form of explanation for the symptoms they experienced when using contraception as well as for the occasions when they did not use contraception or when it had failed to protect them from pregnancy. It was most noticeable in reference to women who had voluntarily experienced a termination of pregnancy. As one woman who had experienced a loss of libido when using the contraceptive pill explained:

'She says it's probably related to my termination - "What you really want to do is have a baby. Until you've had a baby you'll obviously feel guilty about not having had that baby. Until you've had a baby and realize how wonderful it can be, you won't get rid of your guilt." She was very caring, very pleasant, but I'm not sure I agreed with her. I don't find it particularly helps to talk to doctors anymore.'

As well as an explanation of symptoms, women's potential for becoming pregnant was sometimes offered to them as a solution to the symptoms they experienced. Women's reactions to this suggestion of pregnancy as a solution to their problems ranged from laughable in its absurdity:

'He suggested I get pregnant (endometriosis), but then everybody on the ward was told to get pregnant for one reason or another. One woman was told to get pregnant to clear up her acne.'

to strange and puzzling:

'She suggested a different pill (headaches), a one-hormone pill, and said "Why don't you get married?" That was really strange. She was suggesting that if I got married it wouldn't matter so much if I got pregnant.'

'He thinks I should get pregnant. It seems to crop up regularly, whatever's the matter with you when you go to see him.'

to annoying in its dismissiveness:

'When I asked her how to avoid cystitis she said "You'll just have to wait a couple of years till you have a baby and your vagina stretches". I could have punched her.'

Despite the fact that these women had looked to their doctors for advice or assistance in finding a solution to their problems, pregnancy was in extreme opposition to their intentions and they were therefore often shocked by their doctor's suggestion. The problems had arisen in relation to contraception and their desire to avoid pregnancy. To then be confronted with pregnancy as a solution seemed to them rather misplaced, to say the least.

Third, women frequently experienced in their doctors' advice and practices the patriarchal stereotype of women as sexual dependents of men. This stereotype had two themes: one, that women were themselves asexual or at least, less sexual than men and two, that women's sexual pleasure was

or should have been derived from the giving of sexual satisfaction and/or children to men. Very clear examples of this arose when women reported to their doctors a loss of sex drive associated with their use of the contraceptive pill. This complaint seemed to be regarded as an impossibility in many cases and put down to over-emotionality, reading too much (about the pill) or the unconscious desire to become pregnant. Where it was recognized to exist, it was unlikely to be thought of as serious or something to be concerned about (an improbable reaction were the patient a man).

The portrayal of women as sexually dependent upon men was largely prescriptive and predominantly employed with regard to marriage. Women who were not married but were engaging in sexual relations were easily identified by their requests for contraception; thus they could readily become victim to moralistic attitudes and punitive practices. While women who were married sometimes experienced moral judgments about their continuing avoidance of pregnancy and childbearing using contraception, this stereotype was conveyed for the most part through medical assumptions about the unserious nature of the symptoms they reported as they were 'likely to stop using it soon to have children'. Women who were not married or who were known to have extra-marital sexual relations were more susceptible to medical moralizing about female promiscuity:

'He'd keep you in there three-quarters of an hour telling you what a loose young woman you are.'

'I asked him about the different sorts of pill because he was going to put me on Minovlar which is different to the one I'd been on before. He didn't say much about it. He started talking about the morality of girls going on the pill when they were single.'

In general the women felt their doctors were less likely to impose their moral views about women's sexual behaviour now than they were five to ten years ago. Yet, this more liberal approach was frequently found to be only

superficial and restricted to the appearance of women being in a monogamous marriage-like relationship. There was still the lingering medical doubt, many women felt, about whether women had or ought to have the right to control their own fertility and sexuality:

'There always seems to be something there between the gp and the patient: that they're asking for something that they really ought not to be asking for, if they're a woman.'

The implication of the patriarchal view that women's sexuality ought to be confined within marriage and controlled by the one man whose pleasure is presumed to dominate her own, appeared to be that outside of marriage women's sexuality was out of control. Medics' perceptions were often expressed through their assumptions that their patients' sexual behaviour was uncontrollable, that they were sexually available to any number of men and that the medical opportunity to apportion blame and bring them into line was one which ought to be employed:

'Particularly with vaginal infections (thrush), I've had some very nasty interrogations about my sex life which seemed to assume I would go to bed with anyone who asked me.'

'After I'd been raped I had to go to the special clinic to see I hadn't got VD. In fact they found I had got some infection and I had to go regularly to the clinic and have a check-up...And he said to me "Is it clearing up, Miss A?" and I said "No, it doesn't seem to be" and he said "Well, what can you expect?" I mean, he was saying something about my morals there and I found that nasty.'

It was interesting that this stereotype frequently emerged when women attended their doctors for diagnosis and treatment of vaginal infections. The danger to men of women's sexuality being out of control may have been more evident and immediately threatening in these situations or the supposed polluting powers of women's vaginal secretions were accentuated or the

infection may have been taken as proof positive of the woman's wickedness and thereby, as justification for denigration or punishment. Given the women's dependence upon the medical profession for examination, diagnosis and treatment, ample opportunity to impose this patriarchal stereotype upon women arose.

Whichever aspect of patriarchal stereotyping women experienced in their doctors' attitudes and practices, the hoped-for assistance they had sought was found to be less than satisfactory. Decreasingly did women rely upon their doctors' opinions and advice. These perceptions of women did not accord with the problems which women encountered, the decisions they took or the sexual morality they applied to themselves. The faith which they had in the medical profession waned in direct relation to moralistic judgments and disrespect encountered.

Male versus female doctors

Fifty-two percent of the women in the study stated a preference for a woman doctor while only 8% preferred a man. The remaining 40% expressed that it did not matter to them which sex their doctor was, most adding the proviso, as long as s/he was understanding and competent. However, the pattern which emerged from their descriptions of their experiences with doctors was that these qualities were most often found in women doctors.

Several reasons were suggested for this preference and experience of women doctors as 'better' than their male colleagues. Women were found to be less likely to employ patriarchal stereotypes than were men doctors. Notably, it was the second stereotype discussed above, the view of women as determined by their biological capacity for reproduction, which women doctors were most likely to use. The images of women as inferior to men,

and as sexual dependents of men, were much more often experienced in the practices of male doctors.

Female doctors were discovered to be more interested in their women patients than were male doctors. They were said to listen more carefully to what women patients said, to be more supportive of the patient's views and desires, and to be more constructive in their approach:

'Women are generally more sympathetic. Not in the sense that they listen to you moaning, not slushy sympathetic, but they listen.'

'She was the first woman doctor I ever had and certainly was the most thorough. She was the only one that actually discussed the whole issue of the pill or the coil or anything else in any great length and actually went out of her way to give me some leaflets and books and things. She's the only one. It's very unusual; usually it's a matter of getting rid of you as fast as possible because it's not particularly important.'

Many other reports of women doctors echoed this sense of their giving more time, greater consideration and recognition to the problems encountered by their patients. Women doctors were not always as sympathetic and sensitive as their patients would have liked, but they were significantly better than were men doctors in the experience of the women.

'Women's problems' were found to be taken more seriously by female than male doctors. Menstrual regulation, period pains, vaginal infections and irritations, loss of sex drive, cystitis and other similar problems were felt to have been dealt with more sensibly and competently by women doctors. This was a significant feature for women who were consulting doctors about contraception and related 'women's complaints'. The attitudes encountered in male doctors often revealed to women that they were of little assistance with such matters:

'I asked him what I could do about my periods which do bother me but they all say "Go on the pill." They just beg the question. I think male doctors are not interested in women's problems. They're gynecological problems, quite an important specialty, but I think it's something that men are not very sympathetic about. They tend to let women get on with it.'

Dismissiveness, disinterest and a lack of understanding were commonly noted in male medics' approaches to gynecological symptoms, particularly around menstruation. The contradiction pointed to by the woman in the above example, that gynecology has become an important field of medicine and yet, male doctors appear unsympathetic and disinterested in 'women's problems', has been identified historically as well as contemporarily. The development of gynecology as a specialty within the medical profession has been shown to derive from the exclusion of women as healers, hostility towards women and disdain for their sexual organs; perseverance in gynecology despite this attitude to women and their bodies centred on the competition between men for individual success (Barker-Benfield, 1977; Ehrenreich and English, 1979; Scully, 1980).

Finally, women doctors were experienced as more gentle - physically, verbally and emotionally - than were their male counterparts. Whether in medical examinations, discussions of symptoms or in giving contraceptive advice, female doctors were found to be more tactful and more sensitive to the women's difficulties and concerns:

'I prefer women to examine me. I think they're more gentle. Also they tend to be more tactful, quieter.'

'A woman doctor, I don't particularly mind (vaginal exam). It's difficult with men, so uncomfortable the way it's done. In some clinics I've experienced the doctor has been very rough, keeps yelling at you to "Relax. It's not hurting." when it's killing you.'

This sense of gentleness made women feel easier with their female doctors and more inclined to discuss problems and possible solutions with them. They were also less likely to feel intimidated by their female medics, and therefore, felt more able to ask questions and express doubts. As a result of all these aspects of their experience with male and female doctors, women grew increasingly over time to view their women doctors as more competent to care for their contraceptive health concerns.

Although this was the dominant pattern amongst the women, there were some exceptions. The most common exceptions involved male doctors who were more gentle and considerate than the women had learned to expect or had previously experienced, and female doctors who were disapproving, dismissive or 'cold'. Of the four women who expressed a preference for a male doctor, one explained that she found it easier to talk to a man, another that she had never had a woman doctor and two had experienced women doctors as 'colder sorts of people':

'The females tend to be fairly - I don't know if aggressive's the right word, but they seem, perhaps it's a kind of inversion, that they've had to fight in a male world and therefore don't want to show the more human side. The experience I've had is that they're colder and they're almost trying to prove they're sort of hard and tough as the men. I think as a generalization I'd prefer to have a male who doesn't seem to have so many hang-ups.'

As suggested by this quotation, women doctors were working within a profession which has discriminated against women since its inception. Recent feminist research has elucidated the diverse forms of sex discrimination in a medical system controlled by men, where high value has been placed upon personal qualities usually associated with masculinity and training/ job demands have been oriented to male needs and based upon a lack of domestic responsibilities (Lorber, 1975; Carpenter, 1977; Elston, 1977a,

1977b; Walsh, 1977; Leeson and Gray, 1978; Young, 1981). These accounts have clarified many of the ways in which the odds have been stacked against women within medicine, while the men have been able to afford to relax in the structural cradle of a male-supportive profession. For female doctors to try to be as 'hard and tough as the men' would not be surprising; indeed, they would likely need to be twice as tough to achieve half the recognition of their male colleagues in this situation. Yet, when this was experienced by women patients as harshness or coldness, it was felt to be as unhelpful as these qualities were when experienced with male doctors.

Ann Oakley (1976) has argued that current medical practice cannot simply be distinguished by women doctors who are sympathetic to women and therefore 'good' and unsympathetic males who are 'bad' doctors. The historical development, structure and ideology of medicine as a patriarchal institution will have influenced the practices and attitudes of female as well as male doctors. Despite sex discrimination within the medical profession, women doctors as well as men have derived their professional and individual status from a system of health care which has actively perpetuated male dominant/female subordinate social relations; their promotional prospects, too, remain dependent upon their support for the status quo. In this study it has been clear that female doctors were found at times to be dismissive, patronizing, disrespectful and to employ patriarchal stereotypes of women as inferior, determined by their capacity to produce babies and sexually dependent upon men. Yet, women doctors were on the whole experienced to be significantly 'better' than men doctors in all these respects. Although women in the study were by no means always satisfied with their women doctors and reservations were expressed about the potential of such a professional structure for meeting women's contraceptive health needs, female doctors were preferred for their manner and their competence. Having learned to value male qualities over female, to expect doctors to be men and men to be more competent, this preference

for women doctors was one which developed gradually over several years of experience with both male and female doctors.

This preference showed itself most acutely in the women's reports of vaginal examinations. It was here that the sex of the medical examiner could exacerbate or diminish the effect of the notions of feminine gender which may have been expressed by the doctor involved. The research of Susan Ackerman-Ross and Nancy Sochat (1980) revealed that women's preference for a female doctor was strongest when the complaint was of an intimate nature and involved complete undress or extensive bodily probing; it was less important for concerns of the level of a sore throat. The sexual aspect of the doctor-patient relationship, specifically the male-doctor-female-patient relationship, was one of which the women in this study were very much aware.

Male-doctor-female-patient

The polarity of experience between having a male or a female doctor was never more pronounced than when the consultation was experienced as bearing sexual connotations. This was most likely, but not limited to situations of undress or vaginal examination. It appeared that unlike female doctors, male medics were able to reaffirm the patriarchal stereotypes they employed through heterosexual practices which symbolized and perpetuated relations of male dominance and female subordination.

In earlier chapters it was argued that sexuality is of central significance to the maintenance of patriarchal relations. Symbolically it differentiates between those who belong in each sex group or class. For the male, sexual organs are akin to a badge of office while for women they represent vulnerability and service to the male, in patriarchal terms. The sex act is defined in relation to male pleasure and conquest of the

female vagina. Female satisfaction is deemed to be derived from that of the male and in affirmation of male views, interests and desires; this is not a reciprocal relation. As regards the consequences of sexual activity, these are primarily borne by the female who 'falls' while the male's status is read as achievement, who is at risk of becoming pregnant and whose life will be most affected by the requirements of childcare. Individual sexual relationships are both the product of these norms and practices, and the reproducer of them. Patriarchal sexual hierarchy is at the same time a delineation of sexual acceptability and a confirmation of the political order.

Heterosexual political relations may be expressed through genital sexual activity or through a variety of socio-sexual gestures and verbal innuendos. Michael Korda (1978) suggests that 'intimacy' is implied in gestures men use with women to isolate and exclude them from the power and authority reserved for men; in consequence it becomes an advantageous technique in confirming women's inferiority and subordination to men. Other forms of innuendo such as sexual joking may be used in the same way. While it is often defended by men as merely a bit of fun, it is experienced by women as neither funny nor trivial. The recent research of Ann Whitehead (1976), Laura Evans (1978) and Audrey Middleton (1981) reveals that sexual joking and other similar gestures are experienced by women as embarrassing, demeaning and intimidating, and identifies such activities as forms of sexual harassment.

Sexual joking was one form of affirmation of sex and gender hierarchy experienced by women in their relations with male doctors. One woman, for example, explained that she found her doctor's approach to her to be 'typically male':

'He was so determined to be what he thought "liberated" it was dreadful...He felt he could make crude jokes because I was on the pill. I disliked the implications in his mind that went with it. It was like he could say anything in front of you because you were a "whore": "screwing around, ho ho". '

Far from finding her doctor's jokes 'liberating', she felt uncomfortable, embarrassed and demeaned. Implicit in remarking upon the woman's promiscuity was the acknowledgment of the sex and gender hierarchy between them, which confirmed the male doctor as part of the privileged sex and the female patient as vulnerable in her subordinate position.

When sexual joking or other forms of acknowledgment of the heterosexual politics of the male-doctor-female-patient relationship accompanied the gynecological examination, women felt the situation to be highly intimidating. The sexuality of a male doctor performing a vaginal examination upon a female patient involved not so much a direct fear that actual sexual intercourse would occur as an awareness of the vulnerability of women to male dominant sexual ideology and practices. This awareness was heightened by the disparity between the woman's state of undress and the doctor's protective clothing and instruments. Joan Emerson (1970) has argued that despite attempts at medical redefinition of the sexuality involved, the reality of a gynecological examination always remains precarious. As one woman succinctly explained:

'Objective medical practice apart, he's still a bloke and you're a woman.'

Attempts to deny or redefine the relationship varied amongst doctors, but neither allusions to objectivity, scientific rationality nor sexually-disinterested professionalism were sufficient to obscure the sexual conflict during vaginal examinations.

The women's responses to internal exams done by male doctors ranged from 'just bearable' to undignified, humiliating and degrading. The intrusion they expressed seemed little to do with 'feminine modesty' as is often suggested; rather, it was related to the experience of their powerlessness in the situation:

'The reason I put up with it is the feeling that it's for my own good and I ought to do it. I absolutely hate it. It's the fact of having a male doctor and I feel an enormous loss of dignity lying there with my legs splayed open and bits of metal being shoved into me.'

'I'm not very happy about them. Well, you're in an awkward position anyway. They put you in the most unladylike position they can, you can imagine, for the ordinary internals. They put you in this big seat, you know, with your legs apart, sort of naked from the waist down. It's a position in which you're totally powerless to do anything. And even if you can sort of get at people verbally, which I'm not very good at, it doesn't seem to carry much weight in that position.'

The combination of the powerlessness enhanced by this procedure and the dependency upon medical advice that they ought to be done, and done in this way, usually left women feeling unable to refuse or object to internals. Emerson (1970), too, suggested that women have strong negative reactions which belie their acquiescence, maintained through medical manipulation of the scenario and the fact that the staff 'act as if they have every right to do what they are doing'.

The normal setting for the gynecological examination does little to deny and much to emphasize patriarchal images of women and corresponding sexual practices. A remarkable similarity emerges between the imagery of pornography which depicts the sexual subordination of women to men and the scenario of the vaginal exam. Women are objectified in male-dominant fantasies; they have no will of their own beyond the desire to please and assist men. Pornographic magazines, for example, present women

as both available to men and appreciative of men's interest in them. They usually appear naked or scantily clothed, helpless, willing, vulnerable and submissive to male intrusions upon their bodies. As George Frankl (1975) points out, this view of women is, for men, part of 'normal heterosexuality': 'the man's power and the woman's admiration and gratitude' are fundamental to the patterns of men's sexual desire.

During the vaginal examination women appear similarly. The normal routine has the woman partially or completely naked, draped with a sheet which does not impede her doctor's view or accessibility and which he may or may not remove as he wishes. She is usually placed flat on her back, or leaning back, with her legs raised, bent at the knees and separated; sometimes she is strapped into this position. In this submissive posture the woman is left waiting until her doctor is ready to perform the examination. The speculi which are used to permit his entrance and visibility of her vagina and cervix are notoriously long, large and uncomfortable. Yet, she is expected to respond with pleasantness, cooperation and grateful appreciation of his skill, knowledge and expert understanding of what she needs. She is to return for a repeat performance when he sees fit.

Aspects of this power relation were present when a female doctor performed the examination, but because of other reasons why female doctors were preferred and because of the political nature of the relations between men and women, they were not experienced as sexual. Having a male doctor made all the difference:

'I feel intruded upon by male doctors. I'd like to tell him to mind his own business. I do feel it's very much a sexist thing, very much male doctors doing things to female patients. It doesn't come over the same with women doctors.'

Some male doctors were found to be better than others; some were gentle while others were rough, some showed consideration for the woman's experience while others did not. Nevertheless, this did not change the scenario of the vaginal examination. The simulation of the sexual subordination of women to men incorporated into the setting and procedures of the exam left women feeling extremely vulnerable. It was not that they felt actual sexual intercourse would take place, but the socially sanctioned rights of men to do things to women which were both intrusive and unpleasant was confirmed to them. While they were grateful for those doctors who were a bit more considerate of the woman's position than were others, the powerlessness they experienced and the impossibility of either knowing or determining how they would be treated during the examination was highly intimidating.

The combined effects of the social barrage of imagery of women as sexually subordinate to men, the practices of normal sexuality and the incorporation of ideas about the violation of women into normal medical procedures is to affirm women's powerlessness and male omnipotence. During the gynecological examination itself, Emerson (1970) argues, the woman is supposed to react in a manner which supports the doctor's view and concern with his potency:

'Her role calls for passivity and self-effacement. The patient should show willingness to relinquish control to the doctor. She should refrain from speaking at length and from making enquiries which would require the doctor to reply at length. So as to not point up her undignified position, she should not project her personality profusely. The self must be eclipsed in order to sustain the definition that the doctor is working on a technical object and not a person,' (p. 83, my emphasis)

Once again, the similarity of this description to what is taken to be an appropriate sexual response for women in response to men's concerns with their potency cannot be dismissed. Ehrenreich and English (1979)

illuminate the medical definition of 'mature femininity' to rest upon sexual submissiveness; further, the pelvic exam provides medics with the opportunity to assess whether a woman has 'accepted her femininity':

'In the doctor's imagination, the pelvic exam simulated heterosexual intercourse. Thus the examination could be used to evaluate a woman's sexual adjustment.' (p.249)

In addition to the possibility of evaluating women's maturity in this way male medics are presented with the opportunity of encouraging and/or enforcing women's submissiveness through the gynecological examination. At the same time, their own feelings of potency may be reassured.

Medical attempts to deal with the sexual conflict of the situation did little to change the political relation between male doctor and female patient. Various forms of denial and protection for the doctor emerged from the women's reports. One example consisted of the involvement of a female 'chaperone':

'He wouldn't examine a woman without a female nurse present. I found that more embarrassing than him doing it on his own because it meant all kinds of things about his kind of -: either he thought he couldn't be trusted or he thought I couldn't be trusted not to scream rape or something. I found that very disconcerting.'

Rather than cancel out the sexual tension of the gynecological exam, the use of a 'chaperone' confirmed that it existed and protection in the form of a witness was necessary to minimize the danger involved. As the sexual subordination of the procedure was the same with or without a witness, the protection offered was less for the female patient than it was for the male medic. As suggested by the woman in the quote above, the doctor was providing protection for himself either from his own sexual propensities or from possible accusations by his female patients. Ann Oakley (1980) and Diane Scully (1980) have noted similarly in their studies that the use of a female nurse as 'chaperone' is designed for the male doctor's

protection. For women in this study, the presence of a 'chaperone' during vaginal examination indicated that the sexual nature of the male-doctor-female-patient relationship was very much in their doctor's mind.

Other efforts to deny or veil the sexual connotations of the situation included distancing, objectification, technicalization and dehumanization. It appeared that in order to lessen the sexual conflict in the relationship between male doctor and female patient, the existence of one or both parties had to become invisible. Usually it seemed that it was the woman who was rendered invisible by removing recognition of her as a human being as far as possible. By transforming a woman into 'a lump of meat' the likelihood of any relationship between doctor and patient seemed remote, and thereby, so did a sexual relationship:

'It's okay, I think, when they just treat you like a lump of meat. I don't expect it to be very sexual then and it's not. It's a strange kind of thing.'

As long as the atmosphere of the examination kept up the facade of the woman as an inanimate object, the male doctor could appear as just getting on with the job. His potency remained visible, while the consequences for the woman being examined did not. Elaborate manipulations of language, positioning, protective clothing, timing and personnel were used to destroy the pregnant potential:

'It's very weird, this farce that's kept up: "This is very sterile; there's nothing sexual about it." It's a false reality which is kept up, the language which is used.'

The dilemma which this placed women in was clear: either they were invisible (as were their feelings, problems and needs) or the sexual conflict in the situation was recognized:

'It's a situation that has got sexual overtones but they have not to be there, so it's a real conflict situation. It has to be completely mechanical or it's really difficult. I hate it when they treat you just like a body, but when they have some rapport with you then there's the difficulty...'

The protection which this dehumanization offered was primarily oriented towards the doctor involved. Women did find it easier at the time not to have to recognize their powerlessness and sexual vulnerability, but it was the doctor whose interests were maintained by this. While the woman remained invisible through all the elaborate manipulations involved, no voice of objection could be heard from her. Emerson (1970) has argued that if the reality of the situation is not highly controlled, the patient may become a threat. If the experience of the women in the study were voiced, and heard, the legitimacy of this patriarchal relationship would be shattered.

Female-doctor-female-patient

The expression of a strong preference for women doctors may be explained in part by the relief of escaping the sexual politics of the male-doctor-female-patient relationship. The wish to avoid seeing a male doctor could be presented as the desire to have a female doctor. Yet the preference for women doctors needs to be viewed as well in terms of the positive attributes which a woman may bring to the situation and the potential for change which the female-doctor-female-patient relationship encompasses.

One obvious advantage of having a woman doctor was the shared physiology, its related possibilities and difficulties, amongst women. This provided for a 'privileged access' to information about women's experiences and symptoms:

'No matter how sympathetic a man is there are certain things he just can't understand first-hand, like periods and things, so I'd prefer to have someone who did have experience of these problems.'

This exclusive relationship was in some cases made more specific, as in the preference of a few women for female doctors who had experience of

childbirth and ante-natal medical care:

'I'd prefer a female doctor who's had children and knows what it's like to be on the receiving end.'

The predilection for a doctor with first-hand experience of what the patient is going through has emerged too in other studies which indicate doctors to be more sympathetic to patient illnesses and treatments they themselves have endured (see, for example, Wadsworth and Robinson, 1976; Davis and Horobin, 1977). The quantitative extent of the commonality of women - their physiology, their experience of healthy problems (as opposed to less frequent illnesses) and their endeavor to control their fertility - emphasized the significance of this factor with regard to women's contraceptive health care.

The shared social experience of being a woman in a patriarchal society, often referred to by feminists as women's shared oppression, provided another reason for the preference for women doctors. Not only were female doctors in a position to understand what it's like to live in a woman's body, they were also in a position to understand what it's like to live in a society in which women are socially and politically subordinate to men. Whether as employed workers, family members or public citizens, sexual discrimination was of central significance to both doctors and patients. Thus women doctors were thought to be more inclined to appreciate the experiences and problems of women than were male doctors:

'No man, no matter how sympathetic he may intend to be or feel he is, can grow up in this society and not end up discriminating against women, refusing to take their ailments seriously. I think there's always an element that women are secondary people and they aren't the main species going; their ailments are also secondary. And they have stereotype visions of women - that women have nothing better to do with their time than dream up illnesses to get attention.'

While women doctors may or may not have taken the view that women ought

to be more than secondary people, they were in a position to be able to understand what it meant to be placed in men's shadow and to be expected to service men's needs. In the experience of women in the study, female doctors were less inclined to accept and employ patriarchal stereotypes of women, and they showed greater interest, sympathy, understanding and support than did their male colleagues.

The potential for change in women-doctors-women-patients relations derives from their shared oppression as women in a society which discriminates in favour of men. All women share an interest in seeing through patriarchal stereotypes and in overcoming male domination/female subordination. Thus, Ann Oakley (1976) argues, 'patriarchal ideology potentially receives its most fragile support within the framework of the female-doctor-female-patient relationship' and it is here 'where the break with with patriarchal ideology is most likely to occur' (p.55). While this alliance may appear to be a necessary condition of change towards sexual equality in health care, it cannot be said to be sufficient. The professional privileges of female medics place them in a position of dominance over patients from which they may impose patriarchal judgments and standards upon women patients, and the internal hierarchy of the medical profession provides constraints against those medics who might challenge the male-dominant status quo. In the words of one woman in the study:

'A lot of women doctors seem to have sort of swallowed the whole medical dominance ethos which is so much a male thing. Somehow women doctors who've swallowed that whole lay as much crap on you as the male ones do sometimes, which really shouldn't happen, but it does sometimes.'

Women doctors may willingly employ patriarchal approaches to women's health care, they may be placed in a situation where they find it difficult or impossible to do otherwise or they may unwittingly do so. The stereotypes of women's subordination to men may be so closely incorporated into what comes to be taken as medical knowledge that it appears as indistinguishable

or natural.

The propensity of women doctors to accord with the patriarchal gender ideology of the profession to which they belong is countered by their own position in the sexual hierarchy. The sexual politics of the female-doctor-female-patient relationship is not one which is based upon the affirmation of sexual rights and privileges. Sexual domination over women is not a factor in affirming one's womanhood; women do not learn to expect sexual subservience from other women; women are not supported by ideological, legal and physical sanctions which perpetuate their dominance through sexual relations. In consultations and examinations the relations between women do not centre upon sexual dominance and subordination. Rather, the experience and position of the female doctor as sexual subordinate, as female patient herself, as a woman in a patriarchal medical institution confront her with the oppression of women at first-hand. The position of women doctors is sexed - i.e. they belong to a sex class. The authority and dominance of their professional position is undermined to the extent to which they are regarded as women. Their capacity for changing patriarchal relations, too, is dependent upon the extent to which they regard and are regarded to be in the class position of women.

The alliance between women doctors and women patients must be a feminist one if the male-dominant structure and ideology of the medical care system is to be seriously challenged. For the potential in the relationship between women doctors and patients to be reached, argues Phyllis Chesler (1972), both must actively consider the insights of the women's liberation movement. A recognition of the position of women relative to men and of the political challenge of women united is essential to overcome the divisions and competition between women to gain approval

from men. Mary Howell (1979) points to the contradictions inherent in being both feminists and professionals. As a woman doctor she reveals the compromises and frustrations encountered in striving to achieve feminist goals. Within the context of male-controlled institutions, she elucidates, some of these contradictions and dilemmas are irreconcilable, these must be confronted if feminist principles are to guide our efforts for change.

For women as patients the dilemmas are fewer but the consequences greater. Having less power to decide upon strategies of health care than their doctors, they are to a large extent at the mercy of those who are in a position to offer or withhold prescriptions or treatment. A feminist alliance with women doctors is helpful in the validation of women's experiences, the greater distribution of information, the understanding of women's needs and in challenging patriarchal stereotypes of women. Yet, the existence of the women's self-help health movement reveals that this has not been enough to effectively challenge the medical practices which perpetuate the subordination of women. The analysis of health care practices and the formulation of alternatives which continue to develop in feminist health groups are aimed at the increasing control of women over their bodies and their lives. While these groups may incorporate and gain from the skills and knowledge of female doctors, they are generated on the basis of the shared strength, information, skills and visibility of all women organizing together around their experience of health and health care. It is this awareness of what it is like to be on the receiving end which informs and guides the direction of change.

Learning to assess, cope with and reassess their experiences of sexuality and contraception was for women in the study largely dependent upon their relationships with other women. Whether they looked to their parents, other relatives, teachers, doctors, students, work-mates or friends, it was predominantly the discussions between women which were informative and critical. The shared experiences and concerns about the adequacy of contraceptive methods - their reliability, ease of use, side effects and health hazards - often managed to break through the patriarchal stereotypes and taken-for-granted norms and practices which were problematic for women. From other women they gained the confidence to seek out and use birth control methods, the awareness of common problems about sexual relations and contraceptive relations, validation of the symptoms associated with the methods of contraception used, a sense of their right to sexuality and protection from pregnancy, a critical perception of medical expertise and an exploration of sexual, contraceptive and health care alternatives.

Sexuality

Patriarchal ideology and practices clearly define women's sexuality as secondary and subservient to men's. Sexual activity is a political relation. It is a highly structured ritual governed by rules and sanctions which allow few real choices. The emphasis upon masturbation as failure, and lesbianism as dereliction or disease, serves to inform women of their proper sexual duties and warn them of the consequences of choosing otherwise. With whom sex takes place, what

type of activity occurs and the purposes for which it is done are constrained by the parameters of women's subordination to men.

Women's experience of sexuality and having sex with men tends for the most part to be denied, except where it affirms and applauds normal male sexual ideas and practices. Unappreciative accounts are deemed to reveal more about a woman's own sexual hang-ups, or those of her mother, than they are about the actual experience of having sex with men. Having sex with women is unspeakable. Talking about the experience of sex is demeaned as unfeminine and regarded as an act of disloyalty to the man involved. The knowledge shared by women talking about sex as they find it is indeed a threat to the patriarchal sexual order, for in such validation comes the possibility of change.

Talking to young women about sex, or encouraging them to talk amongst themselves, is considered to be promoting promiscuity. Mothers and women teachers are potentially in a position to break the patriarchal taboo about women sharing their experiences of sexuality with women. Yet, both are invested with the task of ensuring femininity, including sexual innocence, is a predominant characteristic of the girls in their care. Both may lose their jobs if they can be seen to be encouraging promiscuity rather than feminine deference and family-centredness in young females. Sisters and aunts have less responsibility and less direct influence upon girls and may perhaps be in a favourable position from which to speak.

The tensions surrounding talking about sex were evident in the descriptions women gave of their conversations with their parents and teachers. Whether in informal discussions or in sex education lessons, the predominant themes were feminine sexual morality and the biology of

reproduction. What was seen as properly feminine was not the potential for female sexual enjoyment nor the politics of sexual relations. The possibility of women talking together about sex, their views and experience, was hampered by the need to maintain an appearance of innocence and ignorance as proof of girls' sexuality being preserved for marriage and motherhood.

Although mothers and female teachers were in the position where evidence of 'their' girls sexual experience reflected their own failure, there emerged several ways round this problem. One way for mothers was to inform their daughters about their own experience without the discussion focusing upon the daughter. Another, was to talk in general about sex without speaking about personal experience, or to focus upon the experience of a third woman. Once the evidence of the daughter's sexual activities was confirmed, through pregnancy or living with a partner or discussion, talking about contraception became easier. In some cases the support exchanged in times of crises placed mothers and daughters in alliance in confronting the sexual attitudes and behaviour of boyfriends/husbands/doctors. Sharing the consequences of patriarchal double standards and practices of sex, mothers and daughters were often able to turn to each other for protection in times of difficulty.

Female teachers shared a more distant personal relationship with girls than did mothers, but they were in a legitimate position to educate girls to protect themselves from pregnancy. Teenage pregnancy being recognized to be largely a result of sexual naivety, sex education was part of the school curriculum for many women in the study. Unfortunately most of these lessons were not about sexuality or contraception, and they did not encourage girls to discuss sex amongst themselves. Warnings against sexual promiscuity, the reproductive life of an impressive range of animals and the glories of marriage and

motherhood occupied the space made available for sex education in almost all cases.

A few female teachers seemed able to provide girls with some information at least about sexual relations, contraception and abortion. As with mothers, one approach appeared to be to present a general topic for discussion which would raise questions in this area. Another was to invite a speaker from a family planning service which might include a film, diagrams, samples of contraceptives and discussions. Discussions about menstruation sometimes managed to break down barriers of language and talking about sex. The women found on the whole that schools provided little information which would have been immediately useful to them, and they were largely critical of the attitudes conveyed. Still, the lost opportunity for some practical assistance or information at this stage when it was most needed was very much regretted.

Friends were most important in the sharing of experiences about sexuality. From the age of 16-17 girls increasingly gained experience of sex and began, somewhat hesitantly, to talk to other girls about it. It was largely their own experience of sexual relations which made them aware of their need to know more about contraception, and to reassess what they had been told about sexual morality. In this other girls were crucial - first in admitting that they might be having sexual relations, and then in exploring attitudes about sex and gaining the confidence to seek out and use contraception. The barriers of silence which had protected their feminine ignorance (apparent or actual) were slowly challenged as sex began to preoccupy much of their conversation.

The exclusion of girls from information about their own bodies and from the language and ease with which to discuss sexuality left women in the study largely unprepared to assess their own needs until after

they had become involved in sexual relations with men. Once they had begun to have sex the fear of pregnancy and being seen as promiscuous shocked them into seeking further information. In asking for contraception they had to be prepared to risk moral disapproval and punitive attitudes about their sexual behaviour. It therefore took confidence and/or great determination to attend family planning services.

Once women began to get involved in ongoing relationships with men, talking about sex with other women became more difficult as the barrier of loyalty appeared. Discussing this 'personal' issue, especially anything critical, could be seen as, or taken by the man involved as an act of disloyalty. At this stage women began to be more open with their partners about sexual relations and contraception, but talked less to their female friends about sex. It was when things began to go wrong or when problems appeared, either with sex or with contraception, that women once again looked to their female friends to share their experiences.

A critical stance about the double standard of sexual morality for men and women was gained through reading and discussing with other women their 'rights' in sexual relationships. The labelling of females as promiscuous, but men as virile, as a consequence of having sex was shunned by the women though recognized as a problem in how they were treated by other people. The freedom of women to engage in sexual relations on the same terms as men, and similarly to engage in other relationships on the same grounds as their partners, was regarded as desirable but problematic because of the men's reactions, sexual stereotypes and the fragility of their egos.

Equally a more informed and critical view of sexual expectations and activities was acquired through women sharing and comparing their experiences of sex. Many taken-for-granted assumptions about male sexual urges, male needs and capacities were found to reveal little more than male selfishness in their sexual practices. The normal definitions about what sex is and how it progresses were discovered to bear little consideration for women's pleasure. It came as a revelation to many women that their experience of sex was not a matter of their own inadequacies but of the male-oriented processes of sexuality. Change in sexual practices came about largely on the basis of women's shared understanding of men's attitudes, the confidence they gained from each other to challenge the sexual status quo, and the awareness women shared that change was both desirable and possible.

Contraception

In the context of enforced sexual ignorance women learned only the ideology and fantasy of sexual romance, marriage and motherhood. The processes involved in negotiating sex and contraception were diametrically opposed to this version of reality. Protection from pregnancy and moral degradation impelled women to take decisions and actions which contradicted patriarchal conceptions of feminine sexual attractiveness and passivity. Attempting to deal with this antithetical situation was highly problematic. The support, information and critical understanding shared by women was unequivocally the major variable in negotiating solutions to the problems which emerged.

In their early experience of sex and contraception women often relied upon their male partners' information and actions. Within a relatively short period of time, however, they were confronted by the inadequacies of this dependency upon assumptions of men's knowledge and

protectiveness. Sexual tension and worries about (or actual) pregnancy were frequent at this stage, and women began to seek out other sources of information and support. Reading material, mostly women's magazines, and discussions between female friends enabled women to rely less upon their partners and more upon their own knowledge and resources.

Finding a suitable method of contraception was not a static decision but a process of negotiation which required periodic reassessment and change. Differing situations of living arrangements, relationships, childbearing, the experience of symptoms and concerns about long-term health hazards provided for varying needs and assessments. The balance between the need for reliability, separateness from the sex act, and possible side effects and health hazards had to be reviewed in the light of changing problems and circumstances. Women's ability to assess their changing contraceptive needs depended upon their awareness of the alternatives, how to use them, possible side effects, their reliability and availability.

The easiest or most obvious method of contraception to use was usually the one first used by women. The particular method which was viewed in this way changed at different periods of time - notably from the sheath to the pill. The pill was the most likely to be used by those who attended family planning services. Changing methods became more of a problem for women once they were using the pill as most came up against the attitude of service providers that once a suitable method had been found, there was no reason to change. This assumption was complicated by the denial or dismissal of symptoms experienced as either not related to the contraceptive method used or as nothing to be concerned about. Suitability for service providers appeared to depend predominant y upon statistical reliability while for women using contraception s quality, health and potential fertility, and the length of time (up to 35 y ars) they envisaged needing contraception, were also central issues.

Decisions about whether to use, continue to use or change their method of contraception took place in the context of what other women were doing and thinking about contraception. Mothers, sisters, friends, other students and women at work were influential of and themselves influenced by the women's actions. Sharing experiences, information, reading material and media reports was central to the processes of decision-making. Most discussions between women focused upon the symptoms which they experienced, the risks of health versus pregnancy which they were taking and the attitudes and practices of their doctors. To a lesser extent, the relationship between their sexual activities and contraception was explored.

Regardless of the particular angle of the discussion on contraception between women, it was the validation which they received from each other which seemed most important to reassessment and change. Whether it was the symptoms they experienced, the problems they encountered or the solutions they found, recognition and visibility enabled women to initiate change. What had seemed an isolated personal dilemma or inadequacy was revealed as a social relation of sexuality, contraception or health care. Awareness of the similarities and differences in other women's experiences allowed for alternative possibilities to be envisaged. This understanding indicated to women first, that change was both desirable and possible in their personal circumstance and second, that the way in which sex, contraception and/or health care was organized should and could be improved for all women.

The patriarchal stereotypes of women encountered in medical care played an important part in the denigration of women themselves and in the invalidation of their experiences. Male doctors appeared more likely to impose these attitudes upon women and more able to affirm the political relations of sexuality through medical procedures such as the gynecological

examination. Women doctors were found to be more supportive, to listen more carefully, to have a greater concern for and understanding of the experiences of women. This greater validation allowed for problems to be explored in greater depth with female doctors, and solutions more likely. The preservation of the medical privilege of having the final assessment, and the power to offer or withhold alternative forms of treatment and/or methods of contraception, kept women patients in a relation of dependency to their female as well as their male doctors. Thus, while women doctors could provide women with a more validating form of contraceptive health care, their own position within the medical profession was in some ways in contradiction to the confirmation of women's experiences and interests.

Capitalizing on the shared experiences of women, feminist health groups have made visible the need, desirability and possibility of changing relations of sexuality, contraception and health care for women. A few women involved in the study had been part of such groups and explained the experience as challenging, revealing and affirming of women's abilities to care for themselves and each other. Whilst becoming aware of the need to gather further information and understanding, the range of information which women were found to have, their ability and determination. ...to confront health care issues, and the commonality of problems which they experienced endorsed the potential for change. The visibility of women's strengths as well as the validation of their common position in relation to patriarchal forms of sexuality, contraception and health care emerged as a major means and direction in which that change could take place.

Conclusions

It has been argued in this study that the taken-for-granted assumption of the adequacy of existing contraceptive technology and service provision has severely limited our understanding of contraceptive behaviour. Assuming the adequacy of methods and services, contraceptive research has been directed towards the identification and explanation of the individuals/groups whose 'failure' to use them efficiently appears to be irrational. Adequacy of the methods and services implies inadequacy of the people who do not use them.

The research project undertaken was based upon the view that such assumptions of adequate contraception and inadequate people are premature. The study set out to explore women's experiences with a range of contraceptive methods and services in order to assess if, how, when and why they were found to be adequate/inadequate to the women who used them.

The sample was deliberately highly selective for motivation, access to information, alternative career possibilities and experience with contraception. The data revealed that the women interviewed did have relatively good access to facilities. Their geographical mobility, as students on courses, provided for experience with a range of doctors and clinics; further, it placed them in a position from which they were generally able to change services when dissatisfied and to select to attend those services they preferred. Their educational training promoted a critical view of the information about contraception they received; this of course varied with the field of study in which they were engaged. Many had contact with doctors or medical students through family or friendship connections, and this lessened for them the authority imbued in the medical consultation. In some cases this connection

provided them with additional information about how to negotiate with doctors. As expected the motivation to prevent pregnancy at least until their course of study was complete, was high. Alternative career possibilities varied with the course undertaken and with the worsening opportunities for employment that were becoming evident at the time of interviewing the women. Yet, the desire to use their new skills, to find employment, and to develop their occupational capacities gave women a view of their future lives which would provide them with an alternative or addition to the experience and work of motherhood. The majority of women intended to have children at some time, or at least they wished the possibility of doing so to remain an open option.

This sample selection proved to be a very valuable one in the context of the research project undertaken. The relatively good social position of the women involved, based on the level of their educational attainment, highlighted their experiences with contraception, information, and services as likely to be better than exists for the majority of women in the population. Thus the difficulties they encountered could be taken to indicate a minimum level of what the adequacies and inadequacies of current contraception and service provision are for women generally. The sample used has thus been a very useful first step in the assessment of women's experience, needs and problems with contraceptive methods and services.

The limitations of the sample are a consequence of the necessity for such research to progress in stages. Comparative samples of women in different social situations - by educational attainment; by occupational class; by number of children; by cultural background; by geographical location; by age and so forth would reveal in detail the variations in the patterns which have emerged from this initial study. It is only once these patterns and their variations have been established that we will have gained a significant understanding of the adequacy of contraceptive

technology and service provision.

As an explanatory framework, setting women's contraceptive concerns in the context of sexuality revealed the importance of the ideology and practices surrounding sex to decisions and actions about contraception. In personal sexual interactions, in sex education, in medical consultations and examinations feminine naivety, sexual attractiveness and non-threatening behaviour (to men) was stressed. Effective contraception, on the other hand, required awareness, determination and perseverance in finding, using and periodically reassessing what was most suitable. This contradiction was a pervading influence upon women's perceptions and experiences with birth control methods and services.

Recognition of the inequality of sexual divisions between men and women led to an analysis of the inequality of sexuality. Patterns of sexual behaviour were not based upon an equal and flexible series of negotiations between individuals; rather they appeared as a rigidly defined and highly structured set of norms and practices. Women's subordination to men's sexual pleasure, needs and interests were affirmed through social sanctions with regard to with whom sex took place, what activities occurred and the purposes for which it was done. This power differential between women and their male partners was revealed to be highly significant to the acceptability and use of the various contraceptive methods available.

The position of women in a patriarchal society has thus been indicated in this study to have important consequences for patterns of contraception. Behaviour which may previously have appeared to be irrational or unintelligible has begun to emerge as being socially and politically derived. The rationality of the decisions and actions

women took to control their fertility could only be understood in context of the male dominant/female subordinate structure of the social institutions of heterosexuality and the family. Examples of these relations were evident in the women's ranking of considerations of reliability, health risks and separability from the sex act; the weighing of men's concerns with their sexual enjoyment against the health risks women were then obliged to take and the side effects they often endured; the enforced ignorance of sex and contraception of young women for fear of their 'promiscuity'; the invalidation of the symptoms women experienced of grounds of the 'natural' mental and genital state of ill health; the management of the gynecological examination as an affirmation of women's sexual subordination to men; the potential of women to validate each other's experience and to direct change.

Patriarchal relations were central to women's decisions and actions with contraception and therefore must be taken into account in future research in this field.

The question of women's liberation or coercion is not one which is assessable solely on the basis of existing contraceptive technology. The potential for women to control their fertility is made opportune and limited as much by social relations as by technological possibilities. What we know about contraceptive technology, its side effects and health risks, the purposes for which it is designed and distributed, moral and racial bias in the range of birth control measures provided, and judgments which distinguish between deserving and undeserving women - all of these are factors pivoted upon relations of sexual inequality. Nevertheless, as is clear from the findings of this study, what exists may be used by women to assert their desire for birth control, to negotiate sexual relationships and to seek change.

BIBLIOGRAPHY

- ACKERMAN-ROSS, F.S. and SOCHAT, N. (1980), 'Close encounters of the medical kind: attitudes toward male and female physicians', Social Science and Medicine, vol. 14, no. 1, pp. 61-4.
- ADLAM, D. (1979), 'The case against capitalist patriarchy', m/f, no. 3, pp. 83-102.
- AITKEN-SWAN, J. (1977), Fertility Control and the Medical Profession, Groom Helm, London.
- ASKHAM, J. (1975), Fertility and Deprivation, Cambridge University Press, Cambridge.
- BARKER, D. and ALLEN, S. (eds) (1976), Sexual Divisions and Society: Process and Change, Tavistock, London.
- BAKER-BENFIELD, G.J. (1977), The Horrors of the Half-Known Life, Harper Colophon, London.
- BARRETT, M. and ROBERTS, H. (1978), 'Doctors and their patients: the social control of women in general practice', in C. Smart and B. Smart (eds), Women, Sexuality and Social Control, Routledge and Kegan Paul, London.
- BART, P. (1981), 'Seizing the means of reproduction: an illegal feminist abortion collective - how and why it worked', in H. Roberts (ed) Women, Health and Reproduction, Routledge and Kegan Paul, London.
- BEECHER, V. (1979), 'On patriarchy', Feminist Review, no. 3, pp. 66-82.
- BERAL, V. (1976), 'Cardiovascular disease, mortality trends and oral-contraceptive use in young women', Lancet, 13 November, pp. 1047-51.
- BLAKE, J. (1974), 'Coercive pronatalism and American population policy', in E. Peck and J. Senderowitz (eds), Pronatalism: The Myth of Mom and Apple Pie, Thomas Y. Crowell, New York.
- BONE, M. (1973), Family Planning Services in England and Wales, HMSO, London.
- BONE, M. (1978), The Family Planning Services: Changes and Effects, HMSO, London.
- BOSTON WOMEN'S HEALTH BOOK COLLECTIVE (British edition by PHILLIPS, A. and RAKUSEN, J.) (1978), Our Bodies, Ourselves, Penguin, Harmondsworth.

- BROWN, C.A. (1975), 'Women workers in the health service industry',
International Journal of Health Services, vol. 5, no. 2, pp. 173-84.
- BUSFIELD, J. (1974), 'Ideologies and reproduction', in M.P.M. Richards (ed),
Integration of a Child into a Social World, Cambridge University
Press, Cambridge.
- BUSFIELD, J. and PADDEN, M. (1977), Thinking About Children, Cambridge
University Press, Cambridge.
- CADE, T. (1970), 'The pill: genocide or liberation?', in T. Cade (ed),
The Black Woman, Signet, New York.
- CARPENTER, E.S. (1977), 'Women in male-dominated health professions',
International Journal of Health Services, vol.7, no.2, pp. 191-207.
- CARTWRIGHT, A. (1970), Parents and Family Planning Services, Routledge
and Kegan Paul, London.
- CARTWRIGHT, A. (1976), How Many Children?, Routledge and Kegan Paul,
London.
- CARTWRIGHT, A. (1978), Recent Trends in Family Building and Contraception,
HMSO, London.
- CEULEMANS, M. and FAUCONNIER, G. (1979), Mass Media: The Image, Role and
Social Conditions of Women, UNESCO, Paris.
- CHESLER, P. (1972), 'Patient and patriarch: women in the psychotherapeutic
relationship', in V. Gornick and B.K. Moran (eds), Women in Sexist
Society: Studies in Power and Powerlessness, New American Library,
New York.
- CICOURAL, A.V. (1964), Method and Measurement in Sociology, Free Press,
Glencoe.
- CICOURAL, A.V. (1974), Theory and Method in a Study of Argentine Fertility,
John Wiley, New York.
- CLARRICOATES, K. (1981), 'The experience of patriarchal schooling',
Interchange, vol. 12, nos. 1/2.
- CLAVAN, S. (1972), 'Changing female sexual behaviour and future family
structures', Pacific Sociological Review, vol. 15, no. 3, pp. 295-308.
- COHEN, S., GREEN, S., MERRYFINCH, L., JONES, G., SLADE, J., and WALKER, M.
(1978), The Law and Sexuality, Grass Roots Books, Manchester.
- COREA, G. (1977), The Hidden Malpractice: How American Medicine Treats
Women as Patients and Professionals, William Morrow, New York.

- CROSS, M. and ARBER, S. (1977), 'Policy and practice in paramedical organisations', in R. Dingwall et al. (eds), Health Care and Health Knowledge, Croom Helm, London.
- DALY, M. (1979), Gyn/Ecology: The Metaethics of Radical Feminism, The Women's Press, London.
- DAVIES, C. and ROCHE, S. (1980), 'The place of methodology: a critique of Brown and Harris', Sociological Review, vol. 28, no. 3, pp. 641-56.
- DAVIS, A. and HOROBIN, G. (eds) (1977), Medical Encounters: The Experience of Illness and Treatment, Croom Helm, London.
- DAWKINS, R. (1976), The Selfish Gene, Oxford University Press, Oxford.
- DELPHY, C. (1980), 'A materialist feminism is possible', Feminist Review, no. 4, pp. 79-105.
- DINGWALL, R., HEATH, C., REID, M., and STACEY, M. (eds) (1977), Health Care and Health Knowledge, Croom Helm, London.
- DONNISON, J. (1977), Midwives and Medical Men, Schocken Books, New York.
- DOYAL, L. with PENNELL, I. (1979), The Political Economy of Health, Pluto Press, London.
- DRAPER, E. (1972), Birth Control in the Modern World, Penguin, Harmondsworth.
- DUFFIN, L. (1978), 'The conspicuous consumptive: woman as an invalid', in S. Delamont and L. Duffin (eds), The Nineteenth-Century Woman, Croom Helm, London.
- DUNNELL, K. (1979), Family Formation 1976, HMSO, London.
- EHRENREICH, B. and ENGLISH, D. (1973a), Witches, Midwives and Nurses: A History of Women Healers, Glass Mountain Pamphlet No. 1, The Feminist Press, New York.
- EHRENREICH, B. and ENGLISH, D. (1973b), Complaints and Disorders: The Sexual Politics of Sickness, Glass Mountain Pamphlets No. 2, The Feminist Press, New York.
- EHRENREICH, B. and ENGLISH, D. (1979), For Her Own Good: 150 Years of the Experts' Advice to Women, Pluto Press, London.
- ELSTON, M.A. (1977a), 'Women in the medical profession: whose problem?', in M. Stacey et al. (eds), Health Care and the Division of Labour, Croom Helm, London.
- ELSTON, M.A. (1977b), 'Medical autonomy: challenge and response', in K. Barnard and K. Lee (eds), Conflicts in the National Health Service, Croom Helm, London.

- ELSTON, M.A. (1981), 'Medicine as "old husbands' tales": the impact of feminism', in D. Spender (ed) Men's Studies Modified, Pergamon, Oxford.
- EMERSON, J.P. (1970), 'Behaviour in private places: sustaining definitions of reality in gynecological examinations', in H.P. Dreitzel (ed), Recent Sociology No. 2, Collier-Macmillan, London.
- ENGELS, F. (1968), 'The origin of the family, private property and the state', in K. Marx and F. Engels Selected Works, International New York.
- EVANS, L.J. (1978), 'Sexual harassment: women's hidden occupational hazard', in J.R. Chapman and M. Gates (eds), The Victimization of Women, Sage Publications, London.
- FARADAY, A. (1981), 'Liberating lesbian research', in K. Plummer (ed), The Making of the Modern Homosexual, Hutchinson, London.
- FARRELL, C. in collaboration with KELLAHER, L. (1978), My Mother Said... The Way Young People Learned About Sex and Birth Control, Routledge and Kegan Paul, London.
- FAUNCE, P.S. and PHIPPS-YONAS, S. (1978), 'Women's liberation and human sexual relations', International Journal of Women's Studies, vol. 1, no. 1, pp. 83-95.
- FEE, E. (1975), 'Women and health care: a comparison of theories', International Journal of Health Services, vol. 5, no. 3, pp. 397-415.
- FIRESTONE, S. (1971), The Dialectic of Sex, Jonathan Cape, London.
- FLETCHER, R. (1966), The Family and Marriage in Britain, Penguin, Harmondsworth.
- FOX, G.L. and INAZU, J.K. (1980), 'Patterns and outcomes of mother-daughter communication about sexuality', Journal of Social Issues, vol. 36, no. 1, pp. 7-29.
- FRANKL, G. (1975), The Failure of the Sexual Revolution, New English Library, London.
- FRANKFORT, E. (1973), Vaginal Politics, Bantam, New York.
- GILL, D. (1977), Illegitimacy, Sexuality and the Status of Women, Basil Blackwell, Oxford.
- GOLDBERG, S. (1973), The Inevitability of Patriarchy, Morrow, New York.
- GORDON, L. (1977), Woman's Body, Woman's Right, Penguin, Harmondsworth.

- GORDON, M. and SHANKWEILLER, P. (1971), 'Different equals less: female sexuality in recent marriage manuals', Journal of Marriage and the Family vol. 33, pp. 459-66.
- GRAHAM, H. (1977), 'Images of pregnancy in antenatal literature', in R. Dingwall et al. (eds), Health Care and Health Knowledge, Groom Helm, London.
- GRAHAM, H. (1982), 'Building a feminist methodology: the case of the survey method', Paper presented to the British Sociological Association Annual Conference, Manchester, April.
- GREENWOOD, K. and KING, L. (1981), 'Contraception and abortion', in The Cambridge Women's Studies Group (ed), Women in Society: Interdisciplinary Essays, Virago, London.
- GREENWOOD, V. and YOUNG, J. (1976), Abortion in Demand, Pluto Press, London.
- HARRIS, A. (1974), 'Sex education in schools', in R. Rogers (ed), Sex Education: Rationale and Reaction, Cambridge University Press, Cambridge.
- HARRIS, C.C. (1969), The Family, Allen and Unwin, London.
- HARTMANN, H. (1979), 'The unhappy marriage of marxism and feminism: towards a more progressive union', Capital and Class, no. 8, pp. 1-33.
- HAWTHORNE, G. (1968), 'Explaining human fertility', Sociology, vol. 2, pp. 65-78.
- HAWTHORNE, G. (1970), The Sociology of Fertility, Collier-Macmillan, London.
- HERSCHBERGER, R. (1948), Adam's Rib, Harper and Row, New York.
- HINDELL, K. and SIMMS, M. (1971), Abortion Law Reformed, Peter Owen, London.
- HOLMES, H.B., HOSKINS, B.B., and GROSS, M. (eds) (1980), Birth Control and Controlling Birth: Women-Centred Perspectives, Humana Press, Clifton, New Jersey.
- HOWELL, M. (1979), 'Can we be feminists and professionals?', Women's Studies International Quarterly, vol. 2, no. 1, pp. 1-7.
- HUBBARD, R., HENLFIN, M.S., and FRIED, B. (eds) (1979), Women Look at Biology Looking at Women, Schenkman, Cambridge, Mass.

- JACKSON, S. (1978a), On the Social Construction of Female Sexuality, Explorations in Feminism No. 4, Women's Research and Resources Centre, London.
- JACKSON, S. (1978b), 'The social context of rape: sexual scripts and motivation', Women's Studies International Quarterly, vol. 1, no. 1, pp. 27-38.
- JACKSON, S. (1980), 'Girls and sexual knowledge', in D. Spender and E. Sarah (eds), Learning to Lose: Sexism and Education, The Women's Press, London.
- JACKSON, S. (1982), 'Femininity, masculinity and sexuality' in S. Friedman and E. Sarah (eds), On the Problem of Men, The Women's Press, London.
- JANSON-SMITH, D. (1980), 'Sociobiology: so what?', in Brighton Women and Science Group (ed), Alice Through the Microscope: The Power of Science Over Women's Lives, Virago, London.
- KITSUSE, J. and CICOURAL, A. (1963), 'A note on the use of official statistics', Social Problems, vol. 11, no. 2, pp. 131-39.
- KLEIBER, N. and LIGHT, L. (1978), Caring for Ourselves: Report on the Vancouver Women's Health Collective, University of British Columbia, Vancouver.
- KOEDT, A. (1970), 'The myth of the vaginal orgasm', in L. Tanner (ed), Voices from Women's Liberation, Signet, New York.
- KORDA, M. (1978), Power! Coronet, Sevenoaks, Kent.
- LANE REPORT (1974), Report of the Committee on the Working of the Abortion Act, HMSO, London.
- LEAR, J.G. (1978), 'Women's health: the side effects of health bias', in J.R. Chapman and M. Gates (eds), The Victimization of Women, Sage Publications, London.
- LEATHARD, A. (1980), The Fight for Family Planning, Macmillan, London.
- LEESON, J. and GRAY, J. (1978), Women and Medicine, Tavistock, London.
- LENNANE, K.J. and LENNANE, R.J. (1973), 'Alleged psychogenic disorders in women - a possible manifestation of sexual prejudice', New England Journal of Medicine, 8 February, pp. 288-92.
- LEWIS, J. (1979), 'The ideology and politics of birth control in inter-war England', Women's Studies International Quarterly, vol. 2, no. 1, pp. 33-48.

- LORBER, J. (1975), 'Women and medical sociology: invisible professionals and ubiquitous patients', in M. Millman and R.M. Kanter (eds), Another Voice: Feminist Perspectives on Social Life and Social Science Anchor, Garden City, New York.
- LOWN, J. (1981), 'Mill life and "peculiar duties": the lives of women and girls in a nineteenth century Essex silk town', unpublished paper, University of Essex.
- LUKER, K. (1975), Taking Chances : Abortion and the Decision Not to Contracept, University of California Press, London.
- MACINTYRE, S. (1973), 'The medical profession and the 1967 Abortion Act in Britain', Social Science and Medicine, vol. 7, no. 2, pp. 121-34.
- MACINTYRE, S. (1975), 'Decision making processes following premarital conception', PhD thesis, University of Aberdeen.
- MACINTYRE, S. (1976), 'Who wants babies? The social construction of instincts', in D. Barker and S. Allen (eds), Sexual Divisions in Society: Process and Change, Tavistock, London.
- MACINTYRE, S. (1977), Single and Pregnant, Croom Helm, London.
- MARX, K. and ENGELS, F. (1970), The German Ideology, Lawrence and Wishart, London.
- McKEITH, N. (ed) (1978), The New Women's Health Handbook, Virago, London.
- MIDDLETON, A. (1981), 'Who pulls the strings? Male control of the ethnographer in a Yorkshire village', Paper presented to the British Sociological Association Sexual Divisions Study Group, University of Bradford, February.
- MILLETT, K. (1971), Sexual Politics, Rupert Hart-Davis, London.
- MILLMAN, M. and KANTER, R.M. (eds), (1975), Another Voice: Feminist Perspectives on Social Life and Social Science, Anchor, New York.
- MORGAN, D.H.J. (1975), Social Theory and the Family, Routledge and Kegan Paul, London.
- MORTON-WILLIAMS, J. (1976), The Role of Male Attitudes in Contraception, Social and Community Planning Research, London.
- MORTON-WILLIAMS, J. and HINDELL, K. (1972), Abortion and Contraception: A Study of Patient Attitudes, PEP Broadsheet 536, London.
- MURDOCK, G.P. (1949), Social Structure, Macmillan, London.
- NATHANSON, C.A. (1975), 'Illness and the feminine role: a theoretical review', Social Science and Medicine, vol. 9, pp. 57-62.

- NOTTMAN, M.T. and NADELSON, C.C. (eds) (1978), The Woman Patient: Medical and Psychological Interfaces, Plenum Press, New York.
- OAKLEY, A. (1974), The Sociology of Housework, Martin Robertson, Oxford.
- OAKLEY, A. (1976), 'Wisewoman and medicine man: changes in the management of childbirth', in J. Mitchell and A. Oakley (eds), The Rights and Wrongs of Women, Penguin, Harmondsworth.
- OAKLEY, A. (1980), Women Confined: Towards a Sociology of Childbirth, Martin Robertson, Oxford.
- OLIVEN, J.F. (1974), Clinical Sexuality: A Manual for the Physician and the Professions, J.B. Lippincott, New York.
- OVERFIELD, K. (1982), 'The packaging of women: science and our sexuality', in S. Friedman and E. Sarah (eds), On the Problem of Men, The Women's Press, London.
- PARSONS, T. and BALES, R.F. (1956), Family, Socialization and Interaction Process, Routledge and Kegan Paul, London.
- PEEL, J. and CARR, G. (1975), Contraception and Family Design, Churchill Livingstone, London.
- PLATT, J. (1981), 'On interviewing one's peers', The British Journal of Sociology, vol. xxxii, no. 1, pp. 75-91.
- PLUMMER, K. (1975), Sexual Stigma, Routledge and Kegan Paul, London.
- POHLMAN, E. (1969), The Psychology of Birth Planning, Schenkman, Cambridge, Mass.
- POLATNICK, M. (1975), 'Why men don't rear children: a power analysis', in J.W. Petras (ed), Sex: Male, Gender: Masculine, Alfred, New York.
- RAINWATER, L. (1965), Family Design: Marital Sexuality, Family Size and Contraception, Aldine, Chicago.
- RAKUSEN, J. (1974), 'The pill report: information or propaganda?', Spare Rib, issue 32, pp. 6-8.
- RAKUSEN, J. (1978), 'The pill...as bad as we thought', Spare Rib, issue 67, pp. 44-45.
- RAKUSEN, J. (1981), 'Depo-Provera: the extent of the problem. A case study in the politics of birth control', in H. Roberts (ed), Women, Health and Reproduction, Routledge and Kegan Paul, London.
- RAKUSEN, J. (1982), 'Feminism and the politics of health', Medicine in Society, vol. 8, no. 1, pp. 17-25.

- RICH, A. (1980), 'Compulsory heterosexuality and lesbian existence', Signs: Journal of Women in Culture and Society, vol. 5, no. 4, pp. 631-60.
- RIGHTS OF WOMEN ILLEGITIMACY CAMPAIGN GROUP (1979), Illegitimacy: A Feminist View, Rights of Women, London.
- ROBERTS, H. (1979), 'Women, social class and IUD use', Women's Studies International Quarterly, vol. 2, no. 1, pp. 49-56.
- ROBERTS, H. (1981a), 'Male hegemony in family planning', in H. Roberts (ed), Women, Health and Reproduction, Routledge and Kegan Paul, London.
- ROBERTS, H. (ed) (1981b), Doing Feminist Research, Routledge and Kegan Paul, London.
- ROCHE, S. (1979), 'Sociobiology', Unpublished paper, University of Warwick.
- ROYAL COLLEGE OF GENERAL PRACTITIONERS (1974), Oral Contraceptives and Health, Pitman Medical, London.
- ROYAL COLLEGE OF GENERAL PRACTITIONERS' ORAL CONTRACEPTION STUDY (1977), 'Mortality among oral-contraceptive users', The Lancet, 8 October, pp. 727-31.
- RUZEK, S.B. (1978), The Women's Health Movement, Praeger, London.
- SCHOFIELD, M. (1973), The Sexual Behaviour of Young Adults, Allen Lane, London.
- SCHOFIELD, M. (1976), Promiscuity, Victor Gollanz, London.
- SCULLY, D. (1980), Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists, Houghton-Mifflin, Boston.
- SCULLY, D. and BART, P. (1973), 'A funny thing happened on the way to the orifice: women in gynecology textbooks', American Journal of Sociology, vol. 78, no. 4, pp. 1045-50.
- SEAMAN, B. (1969), The Doctor's Case Against the Pill, Peter Wyden, New York.
- SEAMAN, B. (1972), Free and Female, Coward, McCann and Geoghegan, New York.
- SEAMAN, B. and SEAMAN, G. (1978), Women and the Crisis in Sex Hormones, Bantam, New York.
- SIMMS, M. (1974), 'Abortion law and medical freedom', British Journal of Criminology, April, pp. 118-31.

- SIMMS, M. (1976), 'Women's needs', in The Pill...On or Off Prescription, Report of the Family Planning Association Conference 23 March, The Family Planning Association, London.
- SMITH, D. (1978), 'A peculiar eclipsing: women's exclusion from man's culture', Women's Studies International Quarterly, vol. 1, no. 4, pp. 281-95.
- SNOWDEN, R. (1975), 'Recent studies in intrauterine devices: a reappraisal', Journal of Biosocial Science, vol. 7, no. 4, pp. 367-75.
- SPENDER, D. (1980a), Man Made Language, Routledge and Kegan Paul, London.
- SPENDER, D. (1980b), 'Education or indoctrination?', in D. Spender and E. Sarah (eds), Learning to Lose: Sexism in Education, The Women's Press, London.
- SPENDER, D. (ed) (1981), Men's Studies Modified, Pergamon, Oxford.
- STACEY, M., REID, M., HEATH, C., and DINGWALL, R. (eds) (1977), Health and the Division of Labour, Croom Helm, London.
- STACEY, M. with HOMANS, H. (1978), 'The sociology of health and illness: its present state, future prospects, and potential for health research', Sociology, vol. 12, no. 2, pp. 281-307.
- STACEY, M. and PRICE, M. (1981), Women, Power and Politics, Tavistock, London.
- STIMSON, G.V. (1974), 'Obeying doctors' orders: a view from the other side', Social Science and Medicine, vol. 8, pp. 97-104.
- STIMSON, G. and WEBB, B. (1975), Going to See the Doctor: The Consultation Process in General Practice, Routledge and Kegan Paul, London.
- SUTTON, J. and FRIEDMAN, S. (1982), 'Fatherhood: bringing it all back home', in S. Friedman and E. Sarah (eds), On the Problem of Men, The Women's Press, London.
- TIETZE, C. et al. (1976), 'Mortality associated with the control of fertility', Family Planning Perspectives, vol. 8, no. 1.
- TIGER, L. and FOX, R. (1972), The Imperial Animal, Dell, New York.
- VAUGHAN, P. (1972), The Pill on Trial, Penguin, Harmondsworth.
- VERSLUYSEN, M.C. (1981), 'Midwives, medical men and "poor women labouring of child": lying-in hospitals in eighteenth-century London', in H. Roberts (ed), Women, Health and Reproduction, Routledge and Kegan Paul, London.

- WADSWORTH, M. and ROBINSON, D. (eds) (1976), Studies in Everyday Medical Life, Martin Robertson, Oxford.
- WALSH, M.R. (1977), Doctors Wanted: No Women Need Apply, Yale University Press, London.
- WALSH, V. (1980), 'Contraception: the growth of a technology', in Brighton Women and Science Group (eds), Alice Through the Microscope: The Power of Science Over Women's Lives, Virago, London.
- WEAVER, J.L. and GARRETT, S.D. (1978), 'Sexism and racism in the American health care industry: a comparative analysis', International Journal of Health Services, vol. 8, no. 4, pp. 677-703.
- WEIDEGGER, P. (1978), Female Cycles, The Women's Press, London.
- WEISS, K. (1975), 'Vaginal cancer: an iatrogenic disease?', International Journal of Health Services, vol. 5, no. 2, pp. 235-51.
- WEISS, K. (1978), 'What medical students learn about women', in C. Dreifus (ed), Seizing Our Bodies: The Politics of Women's Health, Vintage, New York.
- WESTOFF, C.F. and RYDER, N.B. (1977), The Contraceptive Revolution, Princeton University Press, New Jersey.
- WHITEHEAD, A. (1976), 'Sexual antagonism in Herefordshire', in D. Barker and S. Allen (eds), Dependence and Exploitation in Work and Marriage, Longman, London.
- WILSON, E.O. (1978), On Human Nature, Harvard University Press, Cambridge, Mass.
- WOOLF, M. (1971), Family Intentions, HMSO, London.
- WOOLF, M. and PEGDEN, S. (1976), Families Five Years On, HMSO, London.
- WORLD HEALTH ORGANIZATION (1977), Special Programme of Research, Development and Research Training in Human Reproduction: Sixth Annual Report, WHO, Geneva.
- YOUNG, G. (1981), 'A woman in medicine: reflections from the inside', in H. Roberts (ed), Women, Health and Reproduction, Routledge and Kegan Paul, London.
- ZOLA, I.K. (1975a), 'medicine as an institution of social control', in C. Cox and A. Mead (eds) A Sociology of Medical Practice, Collier-Macmillan, London.
- ZOLA, I.K. (1975b), 'In the name of health and illness: on some socio-political consequences of medical influence', Social Science and Medicine, vol. 9, pp. 83-7.

University of Warwick

Coventry CV4 7AL

Telephone Coventry (0203) 24011

May 12, 1977

Department of Sociology

"Letter A"

Dear

I am a research student in the Sociology Department enquiring into women's attitudes towards and experiences with contraception.

As part of my research I will be interviewing graduate women students at this university. I would be very grateful if you would agree to be interviewed. I will be asking about your experiences with contraceptive methods and the factors which have influenced your own decisions.

The interviews will occur over 6 - 7 weeks beginning Monday, May 16, 1977. Would you please ring me in the Sociology Department, room 240, extension 2065 as soon as possible in order to a) let me know whether or not you will participate in the survey, b) arrange a convenient time for the interview, and c) ask any further questions you may have about my research.

The interviews will last 1½-2 hours and will occur at 10am or 2pm, Monday to Friday, or at a time more convenient to you. Once we have arranged a time, please come to the Sociology Department, room 240 at the agreed time for the interview.

All interviews will, of course, be strictly confidential and the information used solely for the purposes of my own research.

Thank you for your help.

Yours sincerely,

Scarlet Friedman

University of Warwick

Coventry CV4 7AL
Telephone Coventry (0203) 24011

Department of Sociology

Letter

Dear

As I have not heard from you regarding my survey, I am concerned that my first letter may not have reached you. Therefore, I am sending another copy of the letter to you.

I would be very grateful if you would ring me (ext. 2065) to let me know you have received it, and to tell me whether or not you would be willing to participate in the survey.

Yours sincerely,

Scarlet Friedman

University of Warwick

Coventry CV4 7AL
Telephone Coventry (0203) 24011

Department of Sociology

tt r G

Dear

Thank you very much for participating in this survey. I would like to assure you once again that the information you have given me will remain confidential and be used solely for the purposes of my own research. The tapes will be erased in a few weeks - as soon as I have obtained the information I require from them.

If you have any further questions regarding my research, please feel free to contact me or my supervisor, Prof. Margaret Stacey, via the Sociology Department.

Yours sincerely,

Scarlet Friedman

CARD A

Methods of Contraception

1. Partner withdraws / takes care
2. Sheath / condom / Durex / french letter / safe
3. Safe period / rhythm method
4. Going without sexual intercourse (in order to avoid pregnancy)
5. Cap / diaphragm / dutch cap
6. The pill
7. Coil / loop / I.U.D. / intra-uterine device
8. Foam tablets / jellies / creams / suppositories / pessaries / aerosol foam
9. Douching / washing within one hour
10. Female sterilisation
11. Male sterilisation / vasectomy
12. Any other method (specify)

CONTROLLING FERTILITY

Questionnaire

Introduction: I am a research student in the Sociology Department, University of Warwick. I'm doing a study of women's attitudes towards and experiences with contraceptive methods, and the factors which influence women's decisions in choosing how to prevent having children. I would like to ask you some questions. You may find some of them difficult to answer - so if you do not want to answer any particular question just say so. It will probably take 1½-2 hours. Anything you tell me will be treated as confidential - no names will be on the questionnaire or included in the study.

1. What is your date of birth? _____
2. So how old are you now? _____
20-24.....1
25-29.....2
30-34.....3
35-39.....4
40-44.....5
45+6
3. How long have you lived in the UK in the last 10 years? _____
4. Are you living with a partner? Yes/No
If yes, for how long? _____
If no, have you a regular partner with whom you have sexual intercourse? Yes/No
5. Do you have any/ any other partner(s) with whom you have had sexual intercourse in the last 6 months? Yes/No
6. Have you any children? Yes/No
If yes, how many? _____
What are their ages and dates of birth?

	<u>Age</u>	<u>Date of birth</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

7. Are you pregnant now? Yes/No

As far as you know, could you have (more) children if you wanted to ...1
or would it be difficult or impossible ...2
don't know, not sure ...3

a) If d/k, not sure

Have you any reason for thinking it might be difficult
or impossible? Yes/No

If yes, what is that?

b) If difficult or impossible, why do you think it would be?

i) If operation/sterilization, was this

to prevent pregnancy - wanted no more children ...1

- dangerous to health ...2

- other reason (specify) ...3

for some other reason(specify) ...4

ii) How long ago was it done? _____

Have you any strong opinions against the use of regular contraception?

Yes/No

If Yes, what is your opinion about it?

10. Here is a list of various possible ways of preventing pregnancy.

(Hand Card A)

- a) Can you tell me the ones you have ever heard of?
- b) Which ones have you ever used?
- c) Which of them, if any, do you usually use at present?
- d) Which of them did you last use (before that)?

If cannot have more children or is pregnant now:

- e) Which of them did you last use?
- f) Which of them did you use before that?

	a) Heard of	b) Ever used	c) Used now	d) Used before	e) Last used	f) Used before
Partner withdraws/takes care.....	1	1	1	1	1	1
Sheath/condom/Durex/french letter.....	2	2	2	2	2	2
Safe period/rhythm method	3	3	3	3	3	3
Going without sexual intercourse.....	4	4	4	4	4	4
Cap/ diaphragm/dutch cap.....	5	5	5	5	5	5
The pill.....	6	6	6	6	6	6
Coil/loop/I.U.D./ intra-uterine device.....	7	7	7	7	7	7
Foam tablets/jellies/creams/ suppositories/pessaries/aerosol.....	8	8	8	8	8	8
Douching/washing within 1 hour.....	9	9	9	9	9	9
Female sterilization.....	10	10	10	10	10	10
Male sterilization/vasectomy.....	11	11	11	11	11	11
Any other method (specify).....	12	12	12	12	12	12
None of these.....	13	13	13	13	13	13

g) If using sheath, do you use it with/without foam or pessaries?

If using cap, do you use it with/without cream or pessaries?

Do you use any other methods together? Yes/No

If yes, which? _____

11. Can you tell me, since you began using contraception, which methods you have used and the dates for which you used them?

For the time periods that you have not used any contraception, would you indicate why not (eg, pregnancy, no need, etc.).

NOTES: For pill, or IUD, list different types as subgroups.

For cap, or sheath, indicate used with or without spermicides.

Method	Dates	Time Period	Why chose method	Why stopped method	Whose idea to stop

For each method listed:

- a) Why did you choose this method?
- b) Why did you stop this method?
- c) Whose idea was it to stop?

12. If not using any method at present,

What are the main reasons why you and your partner(s) are not taking any precautions to prevent pregnancy?

want baby/don't mind if have baby _____
other (specify)

13. When you first began to use contraception, was this before or after you first began to have sexual intercourse?

before/after

If after, how long after? _____

why was that? _____

14. For each method (refer to Card A) would you say it is reliable or unreliable?

How reliable ~~in~~ terms of safety or effectiveness rates would you say it is?

15. For each method, which of the following disadvantages would you say applied:

- a) may be dangerous to health
- b) interferes with love making
- c) difficulties in obtaining it
- d) a nuisance to use
- e) messy to use
- f) other (specify)

Method	Rel.	Unrel.	a) dang. health	b) inter-feres	c) diff. obtain	d) a nuisance	e) messy	f) other	Rate %
With-drawal...	..1..	..1..	.....1.....	.....1.....	.....1.....	.....1.....	.....1.....	.....1.....	.....
heath...	..2..	..2..	.....2.....	.....2.....	.....2.....	.....2.....	.....2.....	.....2.....	.....
hythm...	..3..	..3..	.....3.....	.....3.....	.....3.....	.....3.....	.....3.....	.....3.....	.....
ap.....	..5..	..5..	.....5.....	.....5.....	.....5.....	.....5.....	.....5.....	.....5.....	.....
ill.....	..6..	..6..	.....6.....	.....6.....	.....6.....	.....6.....	.....6.....	.....6.....	.....
UD.....	..7..	..7..	.....7.....	.....7.....	.....7.....	.....7.....	.....7.....	.....7.....	.....
oam.....	..8..	..8..	.....8.....	.....8.....	.....8.....	.....8.....	.....8.....	.....8.....	.....
ouching.	..9..	..9..	.....9.....	.....9.....	.....9.....	.....9.....	.....9.....	.....9.....	.....

For other, specify: -

For methods considered may be dangerous to health, specify in what ways: -
(include emotional and physical dangers)

16. Have you ever thought of changing to another method at all, or not?

Yes/No

other (specify)

If yes, are you at present thinking about trying another method?

Yes/No

other (specify)

If yes, which methods are you considering?

7. For each method you have ever used, might you ever use it again or would you definitely not want to use it again?

Method & No.	might use	would not use	don't know	other (specify)
.				
.				
.				
.				
.				
.				
.				

13. Are there any methods you would definitely not want to use, apart from those already mentioned? (refer to Card A)

Yes/No

If yes, which methods?

why would you not want to use them?

Method & No.

Reason

19. Do you feel you know enough about different methods of preventing pregnancy, or do you feel you would like to know more?

knows enough.....1

would like to know more.....2

other (specify).....3

If would like to know more,

what would you like to know more about?

20.a) Do/did you prefer to take precautions yourself or do/did you prefer your partner to take precautions?

informant.....1

partner.....2

both.....3

doesn't mind.....4

other (specify)...5

b) Why do/did you prefer.....to take precautions?

c) Does your partner prefer to take precautions himself or does/did he prefer you to take precautions?

- prefers informant to take precautions...1
- prefers to take precautions himself.....2
- prefers both to take precautions.....3
- doesn't mind.....4
- don't know.....5
- other (specify).....6

21. Can I just check, (have you ever/how many times have you) been pregnant?

If ever pregnant, was/were all your pregnancy/ies intended?

Yes/No

If no, what method were you using at the time, if any?

Last pregnancy _____

Previous pregnancies _____

22.a) Do you tend to make love/have sexual intercourse regularly or occasionally?

Regularly/Occasionally

other (specify)

b) How often is that?

per week _____

or per month _____

c) Do you tend to know in advance usually, when you are likely to make love? Yes/No

d) What difference, if any, do you think that has made to the type of contraceptive method you decide to use?

23. If uses method other than rhythm/withdrawal/douching/abstinence only

a) If fitting or prescription required,

Who do/did you see to get your fitting or prescription for
.....(present method)?

- NHS gp.....1
- Private gp.....2
- F.P. clinic.....3
- other (specify)....4

b) Where do/did you (or your partner) actually get your(present method) supplies from?

- chemist.....1
- barber/hairdresser.....2
- shop/surgical stores.....3
- own doctor supplies method
(not prescription only)....4
- F.P. clinic.....5
- D/K.....6
- other (specify).....7

c) Who usually (gets/got) (it/them) - you or your partner?

- informant.....1
- partner.....2
- both/either of us....3
- other (specify).....4

d) How much, if anything, does/did it (do they) cost (each month on average)?

- £p _____
- cost nothing.....1
 - D/K, no idea.....2

e) Do/did you (does/did your partner) ever have to put off getting (another/more) because of the cost?

- Yes.....1
- No.....2
- D/K.....3
- Other (specify).4

f) Do/did you find the cost:

- fairly easy to afford.....1
- rather difficult to afford.....2
- or what? (specify).....3

g) Do/did you (does/did your partner) ever put off getting another/more because it is/was embarrassing going for it (them)?

- Yes.....1
- No.....2
- D/K.....3
- Other (specify).....4

h) Or do/did you (does/did he) ever have to put off getting another/more for any other reason?

- Yes (specify)....1
- No.....2
- D/K.....3

Can I ask some more about(your present method/method you used last)
(code.....1)

If PILL

24. Do/did you always remember to take your pill, or do you sometimes forget?

- always takes (including forgot once or twice only)...1
- sometimes forgets.....2

If sometimes forgets,

a) Do/did you sometimes forget to take it for several nights/ or mornings running, or just odd ones?

- several nights/mornings running.....3
- just odd nights/mornings.....4

b) Do/did you usually remember to take it within the next 12 hours or not?

- Yes.....5
- No.....6

25. a) When did you first start taking the pill? _____

b) When you first began to use the pill, where did you go for your prescriptions?

- NHS gp.....1
- Private doctor.....2
- F.P. clinic.....3
- Other (specify).....4

c) When you went to the doctor did you

- know you wanted the pill.....1
- think you would like to try the pill but
wanted the doctor's advice.....2
- want information or advice about various
methods.....3
- go for another reason and the doctor brought
the subject up.....4
- other (specify).....5

26. Did you discuss any other methods with your doctor?

Yes/No

If yes, which methods did you discuss? _____

27. What did you discuss with your ^{doctor} about the pill?

- safety/effectiveness.....1
- possible side effects.....2
- long-term health hazards.....3
- taking breaks.....4
- other (specify).....5

What were his/her ideas about each of the aspects you talked about?

28.a) Did the doctor:

- ask about your medical history....1
- already know it.....2
- neither.....3
- D/K, can't remember.....4

b) What tests were done, if any?

- blood pressure.....1
- breast examination.....2
- internal examination.....3
- cervical smear.....4
- other (specify).....5
- none.....6
- D/K, can't remember.....7

c) Did you go for regular check-ups?

Yes/No

If yes, how often? _____

what tests were done? _____

29. Where do you go for your prescriptions for the pill at present?

same doctor/other

If other,

a) Where do you go now?

- NHS gp.....1
- Private doctor.....2
- F.P. clinic.....3
- other (specify).....4

b) Why did you change?

- moved.....1
- dissatisfied with doctor.....2
- preferred F.P. clinic.....3
- other (specify).....4

If 2, 3, or 4, why was that?

- c) When you went to your present doctor did you
 - know you wanted the pill.....1
 - feel unsure about continuing/think you
 - might try the pill again and wanted
 - the doctor's advice.....2
 - want information or advice about
 - various methods.....3
 - go for some other reason and the doctor
 - brought the subject up/suggested it.....4
 - other (specify).....5

d) Did you discuss any other methods with your doctor?

Yes/No

If yes, which methods did you discuss? _____

e) What did you discuss with your doctor about the pill?

- safety/effectiveness.....1
- possible side effects.....2
- long-term health hazards.....3
- taking breaks.....4
- other (specify).....5

What were his/her ideas about each of the aspects you talked about?

f) Did the doctor:

- ask about your medical history....1
- already know it.....2
- neither.....3
- D/K, can't remember.....4

g) What tests were done, if any?

- blood pressure.....1
- breast examination.....2
- internal examination.....3
- cervical smear.....4
- other(specify).....5
- none.....6
- D/K, can't remember.....7

h) Do you go for regular check-ups?

Yes/No

If yes, how often? _____

what tests are done? _____

30. Can I just check, did you say you had changed the type of pill you use because of problems you experienced, which you felt were a result of taking the pill?

Yes/No

If yes,

a) What were the problems you were having?

b) Have you experienced any of these problems with the pill you are presently taking?

Yes/No

30.b) If yes, which problems are you still having?

31. Are you having any other problems with the pill you are presently taking?

Yes/No

If yes, what problems are you having?

32. When you were^{/are} having the.....(problems)

a) Did^{/do} you talk to your partner about it? Yes/No

If yes, what did he suggest you do?

In what ways, if any, was^{/is} your partner's attitude important to what you decided to do?

b) Did/do you talk to your friends or relatives about it?

Yes/No

If yes, what did they suggest you do?

32.b) In what ways, if any, were/are your friends' or relatives' attitudes important to what you decided to do?

c) Did you talk to your doctor about it? Yes/No

If yes, is that your present doctor or a previous doctor?

Present/Previous

what did he/she suggest you do?

In what ways, if any, was/is your doctor's attitude important to what you decided to do?

d) Whose attitude do you think was/is most important to what you decided to do?

- partner.....1
- friends or relatives....2
- doctor.....3
- self.....4
- other (specify).....5

33. Do you feel it is easy to discuss with your present doctor any problems or concerns you may have about ~~the pill~~ the pill?

Yes/No

If no, why do you think that is?

34. How long do you intend to use the pill? _____

a) What other method do you think you might use, if/when you decide to stop using it? _____

If IUD

35. Do/did you check for the thread in your vagina

- regularly (every month).....1
- occasionally.....2
- never.....3

If never, did your doctor ever suggest that you should?

Yes/No

If yes, why do you think that you don't?

36. a) When did you first start using the coil/IUD? _____

b) When you first went to it fitted, where did you go?

- NHS gp.....1
- Private doctor.....2
- F.P. clinic.....3
- Other (specify).....4

c) When you went to the doctor did you

- know you wanted the coil.....1
- think you would like to try the coil
but wanted the doctor's advice.....2
- want information or advice about
various methods.....3
- go for another reason and the doctor
suggested it.....4
- other (specify).....5

37. Did you discuss any other methods with your doctor?

Yes/No

If yes, which methods did you discuss? _____

38. What did you discuss with your doctor about the coil?

- safety/effectiveness.....1
- possible side effects.....2
- checking the thread.....3
- other (specify).....4

What were his/her ideas about each of the aspects you talked about?

9.a) Did the doctor:

- ask about your medical history.....1
- already know it.....2
- neither.....3
- D/K, can't remember.....4

b) What tests were done if any?

- blood pressure.....1
- breast examination.....2
- internal examination...3
- cervical smear.....4
- other (specify).....5
- none.....6
- D/K, can't remember....7

c) Did you go for regular check-ups? Yes/No

If yes, how often? _____

what tests were done? _____

40. Where do you go to have your coil fitted now?

same doctor/other

If other,

a) Where do you go now?

- NHS gp.....1
- Private doctor.....2
- F.P. clinic.....3
- Other (specify)...4

b) Why did you change?

- moved.....1
- dissatisfied with doctor...2
- preferred F.P. clinic.....3
- other(specify).....4

If 2, 3, or 4, why was that?

c) When you went to your present doctor did you

- know you wanted the coil.....1
- feel unsure about continuing/ think you
might try the coil again and wanted
the doctor's advice.....2
- want information or advice about various
methods.....3
- go for some other reason and the
doctor suggested it.....4
- other (specify).....5

d) Did you discuss any other methods with your doctor?

Yes/No

If yes, which methods did you discuss? _____

e) What did you discuss with your doctor about the coil?

- safety/effectiveness.....1
- possible side effects.....2
- checking the thread.....3
- other (specify).....4

What were his/her ideas about each of the aspects you talked about?

f) Did the doctor:

- ask about your medical history....1
- already know it.....2
- neither.....3
- D/K, can't remember.....4

g) What tests were done, if any?

- blood pressure.....1
- breast examination.....2
- internal examination....3
- cervical smear.....4
- other (specify).....5
- none.....6
- D/K, can't remember.....7

h) Do you go for regular check-ups?

Yes/No

If yes, how often? _____

what tests are done? _____

1.a) Which type of coil do you have, do you know?

_____/don't know

b) How often do you have it changed? _____

2. Have you experienced any problems which you feel are a result of using the coil?

Yes/No

If yes,

a) What problems have you had?

b) Are you still experiencing any of these problems?

Yes/No

42.b) If yes, which problems are you having?

43. When you were/are having the(problems)

a) Did/do you talk to your partner about it? Yes/No

If yes, what did he suggest you do?

In what ways, if any, was/is your partner's attitude important to what you decided to do?

b) Did/do you talk to your friends or relatives about it?

Yes/No

If yes, what did they suggest you do?

In what ways, if any, were/are your friends' or relatives' attitudes important to what you decided to do?

c) Did you talk to your doctor about it? Yes/No

If yes, what did he/she suggest you do?

In what ways, if any, was/is your doctor's attitude important to what you decided to do?

Is that your present doctor or a previous doctor?

Present/Previous

d) Whose attitude do you think was/is most important to what you decided to do?

- partner.....1
- friends or relatives.....2
- doctor.....3
- self.....4
- other (specify).....5

44. Do you feel it is easy to discuss with your present doctor any problems or concerns you may have about the coil?

Yes/No

If no, why do you think that is?

45. How long do you intend to use the coil? _____

a) What other method do you think you might use, if/when you decide to stop using it? _____

If CAP (uses with/without spermicides)

46. Do/did you always (put the cap in _____) before it was/is
(use the foam/jelly/suppositories)
needed, or do/did you sometimes take chances?

- always uses.....1
- takes chances.....2
- other.(specify).....3

a) Were you ever advised to use a pessary for each occasion of repeated intercourse while the cap is still in your vagina?

Yes/No

Do you usually do this? Yes/No

If no, why do you think you don't?

b) How long do you leave the cap in after intercourse?

- _____ less than 6 hours....1
- 6-8 hours.....2
- more than 8 hours....3

47.a) When did you first start using the cap? _____

b) When you first had a cap, did someone fit you with it - or was it just bought without being fitted?

Fitted/Bought without fitting

If fitted, where did you go to have it fitted?

- NHS gp.....1
- Private doctor.....2
- F.P. clinic.....3
- Other (specify)....4

c) When you went to the doctor did you

- know you wanted the cap.....1
- think you would like to try the cap but wanted the doctor's advice.....2
- want information or advice about various methods.....3
- go for another reason and the doctor suggested it.....4
- other (specify).....5

48. Did you discuss any other methods with your doctor?

Yes/No

If yes, which methods did you discuss? _____

49. What did you discuss with your doctor about the cap?

- safety/effectiveness.....1
- how to use it.....2
- other (specify).....3

What were his/her ideas about each of the aspects you talked about?

50.a What tests were done, if any?

- weight.....1
- internal examination...2
- cervical smear.....3
- other (specify).....4
- none.....5
- D/K, can't remember....6

b) Did you go for regular check-ups Yes/No

If yes, how often? _____
what tests were done? _____

How often did he/she suggest your cap should be replaced?

51. Where do you go to have your cap fitted/checked at present?

same doctor/other/none

If other,

- a) Where do you go now?
 - NHS gp.....1
 - Private doctor....2
 - F.P. clinic.....3
 - Other (specify)...4

b) Why did you change?

- moved.....1
- dissatisfied with doctor..2
- preferred F.P. clinic....3
- other (specify).....4

If 2, 3, or 4, why was that?

c) When you went to your present doctor did you

- know you wanted the cap.....1
- feel unsure about continuing/think you
might try the cap again and wanted
the doctor's advice.....2
- want information or advice about various methods...3
- go for some other reason and the doctor
suggested it.....4
- other (specify).....5

d) Did you discuss any other methods with your doctor?

Yes/No

If yes, which methods did you discuss? _____

e) What did you discuss with your doctor about the cap?

- safety/effectiveness.....1
- how to use it.....2
- other (specify).....3

What were his/her ideas about each of the aspects you talked about?

f) What tests were done, if any?

- weight.....1
- internal examination....2
- cervical smear.....3
- other (specify).....4
- none.....5
- D/K, can't remember.....6

g) Do you go for regular check-ups? Yes/No

If yes, how often? _____

what tests are done? _____

How often does your doctor suggest your cap should be replaced? _____

52. Have you experienced any problems with the cap? Yes/No

If yes,^{a)} what problems have you had?

b) Are you still experiencing any of these problems?

Yes/No

If yes, which problems are you having?

53. When you were/are having the.....(problems)

a) Did/do you talk to your partner about it? Yes/No

If yes, what did he suggest you do?

In what ways, if any, was/is your partner's attitude important to what you decided to do?

b) Did/do you talk to your friends or relatives about it?

Yes/No

If yes, what did they suggest you do?

In what ways, if any, were/are your friends' or relatives' attitudes important to what you decide to do?

c) Did you talk to your doctor about it? Yes/No

If yes, is that your present doctor or a previous doctor?

Present/Previous

What did he/she suggest you do?

In what ways, if any, was/is your doctor's attitude important to what you decided to do?

d) Whose attitude do you think was/is most important to what you decided to do?

- partner.....1
- friends or relatives.....2
- doctor.....3
- self.....4
- other (specify).....5

54. Do you feel it is easy to discuss with your present doctor any problems or concerns you may have about the cap?

Yes/No

If no, why do you think that is?

55. How long do you intend to use the cap? _____

a) What other method do you think you might use, if/when you decide to stop using it? _____

If Rhythm/Safe Period

56. a) What days do you feel are safe?

b) How do/did you work out which are/were the safe days - safe period each month?

If Other Method

57. Do/did you (and your partner) always use a method, or do/did you sometimes take chances?

- always uses a method.....1
- take chances.....2
- other (specify).....3

.....

Can I ask some more about the method you used before the (present/last used method).
(go back to method and code.....2)

If ever used pill (other than present and method used before)

Can I ask some more about your experiences with the pill?
(go back to pill and code.....3)

58. So far we have been talking about contraception, but another way of preventing children being born is for a woman in early pregnancy to have an abortion.

You may know that in 1967 an Act of Parliament was passed, so that now abortions are legal in certain circumstances.

Can I ask how you feel in general about women having abortions?

59. In what circumstances, if any, might you think of having an abortion?

60. Have you ever (you said you havè) had an abortion yourself?

Yes/No

If yes, what made you decide to have an abortion?

61. If you did decide you wanted to have an abortion (if a woman wanted to have an abortion)

a) how do you think you (~~she~~) would get one? (where would you go, etc.)

b) If other than NHS, how much do think it would cost?

Would this cost prevent you from having the abortion?

Yes/No

Do you think the cost is too high/reasonable/too low?

62. Do you know what methods are used/how abortions are done?

Yes/No

If yes, what methods do you know about?

63. Do you consider legal abortions to be safe?

very safe.....1

fairly safe.....2

not very safe....3

If 2, or 3, what do think are the health risks with abortions?

64. What about sterilization, in what circumstances, if any, would you be prepared to consider this?

Any/ None

If any,
65. a) Would you think it best if you or your partner were sterilised?

informant/woman.....1

partner/man.....2

D/K, never thought.....3

other (specify).....4

b) Why would you think it best for you/your partner to be sterilised?

c) Is it something you've ever thought about having done or not?

Yes/No/Other (specify)

If yes,

is it something either of you are considering at the
moment? Yes/No/Other (specify)

.....

66. Can you tell me what services are available in this area for

a) contraception

b) sterilisation

67. How do you feel about going to your doctor/F.P. clinic for
contraception and/or sterilisation?

68.a) Is your doctor a man or a woman? Man/Woman

b) Do you have a preference for either or doesn't it matter which?

- man.....1
- woman.....2
- doesn't matter.....3

If 1 or 2, why is that?

69. What do you think would be a useful way of providing contraceptive advice and services?

.....

I am interested in learning what influences have been, or are, important to you in choosing how to prevent having children/more children.

Can I ask you some questions about where you learned about contraceptive methods.

70 . a) Did you have any formal sex education at school?

Yes/No/Can't remember

If yes, did you discuss:

- conception.....1
- birth.....2
- contraception.....3
- abortion.....4
- sexual relations.....5

b) Do you think the sex education you received at school was sufficient? Yes/No

If no, How do you think it could have been better?

71. Where have you learned most of what you know about methods of preventing pregnancy?

77. Have you ever discussed with your parents

- conception.....1
- birth.....2
- contraception.....3
- abortion.....4
- sexual relations..5

If any, in what ways, do you think your discussions with your parents have influenced your own attitudes and knowledge?

78. Can you give me a brief explanation of
a) the menstrual cycle

b) how conception occurs

79. Going back to the various methods you said you had ever heard of ,
can you tell me how each one works to prevent pregnancy?
(refer to CardA)

80.a) Do you discuss the contraceptive methods you use, with your partner

often.....	1
sometimes.....	2
very occasionally....	3
never.....	4

b) Which methods do you think your partner

	<u>Method</u>	<u>Reason</u>
i) prefers
ii) dislikes
iii) refuses to use

Why do you think he does?

c) In what ways, if any, do you think that your partner has influenced your choice of contraceptive methods?

d) How important an influence do you think your partner(s) have been to your decisions about contraception?

- Very important.....1
- Fairly.....2
- Not very.....3
- Not at all.4

81. a) Do you discuss contraception with your friends
- often.....1
 - sometimes.....2
 - very occasionally.....3
 - never.....4

b) Which methods do most of your friends use?

- most 1. _____
- next most 2. _____
- next most 3. _____

- c) Do you find that your friends tend to
- make assumptions about whether you will or ought to have children without asking your intentions.....1
 - make moral judgments (or are disapproving) about your sexual relationships.....2

If either, specify:-

d) In what ways, if any, do you think your friends (or the methods your friends use) has influenced your choice of contraceptive methods?

- e) How important an influence do you think your friends are to your decisions about contraception?
- Very.....1
 - Fairly.....2
 - Not very.....3
 - Not at all....4

32. a) Do you discuss contraception with your parents or relatives

- often.....1
- sometimes.....2
- very occasionally...3
- never.....4

b) Do you find that your parents tend to

- make assumptions about whether you will or ought to have children without asking your intentions.....1
- make moral judgments (or are disapproving) about your sexual relationships.....2

If either, specify:-

c) In what ways, if any, do you think your parents have influenced your choice of contraceptive methods?

d) How important an influence do you think your parents have been to your decisions about contraception?

- very.....1
- fairly.....2
- not very....3
- not at all..4

83. a) Do you discuss contraception with your doctor
 often.....1
 sometimes.....2
 very occasionally...3
 never.....4

b) Do you think your doctor has a preference for any particular method? Yes/No

If yes, which? _____
 why do you think he does?

c) What is your doctor's attitude to abortion?

d) What is your doctor's attitude to sterilisation?

e) Do you find that your doctor tends to
 make assumptions about whether you will or ought to
 have children without asking your intentions.....1
 make moral judgments (or is disapproving)
 about your sexual relations.....2

If either, specify:-

f) In what ways, if any, do you think your doctor has influenced your choice of contraceptive methods?

g) How important an influence do you think your doctor has been to your decisions about contraception?

very.....1

fairly.....2

not very.....3

not at all.....4

84. Do you think anyone else has been an important influence to your decisions? Yes/No

If yes, specify:-

85.a) Have you read or heard about different methods in

magazines.....1

newspapers.....2

radio.....3

television.....4

b) Do you find them helpful in any way? Yes/No

If yes, in what ways?

c) Do you have any doubts about them? Yes/No

If yes, why is that?

d) How important an influence do you think they have been to your decisions about contraception?

very.....1

fairly.....2

not very.....3

not at all.....4

86a) Have you read about different methods in

- leaflets.....1
- books.....2

b) Have you found them helpful in any way? Yes/No

If yes, which? _____
in what ways?

c) Do you have any doubts about them? Yes/No

If yes, which? _____
in what ways?

d) How important an influence do you think they have been to your
decisions about contraception?

- very.....1
- fairly.....2
- not very.....3
- not at all.....4

87. How knowledgeable do you think you are about contraceptive
methods?

- Very.....1
- Fairly.....2
- Not very.....3
- Not at all....4

If 2,3, or 4, why do you think you do not know more?

- prefer not to think about it.....1
- embarrassment in talking about it.....2
- fear disapproval.....3
- information is not widely available....4
- other (specify).....5

88. How important is it to you not to have a child now (i.e. to have 100% contraception)?

very.....1

fairly.....2

not very.....3

not at all....4

89. Would having a child now make an great difference to your

education.,.....1

job prospects.....2

finances.....3

time.....4

relationship with partner.....5

relationships with friends....6

relationship with parents.....7

other (specify).....8

For each specify:-

90. Do you feel you would at some time like to have a/another child?

Yes/No/Don't know

Can you tell me what you feel about it?

91. Do you find taking¹ about your body and sexuality

	with partner	with friends	with doctor	in this interview
Open and easy.....	.....1.....	.....1.....	.....1.....	.....1...
Fairly easy .....	.....2.....	.....2.....	.....2.....	.....2...
Fairly difficult...	.....3.....	.....3.....	.....3.....	.....3...
Difficult.....	.....4.....	.....4.....	.....4.....	.....4...

92. a) How do you feel about a doctor examining your breasts?

b) Have you heard about examining your own breasts each month for changes, especially lumps? Yes/No

If yes, have you ever done it? Yes/No

do you do it regularly? Yes/No

If no, would you be interested in knowing more about it?

Yes/No

93. a) How do you feel about a doctor examining you internally?

(examining your vagina and cervix)

b) Have you heard about examining your own vagina and cervix regularly for changes? (using speculum, torch, and mirror)

Yes/No

If yes, have you ever done it? Yes/no

do you do it regularly? Yes/No

If no, would you be interested in knowing more about it?

Yes/No

94. a) Do you feel that your breasts and vagina are parts of your body that you should explore or not? Should/Should not

If yes, do you feel comfortable and able to do this?

Yes/No

95. a) Is masturbation a part of your sexuality that you enjoy?

Yes/No

b) Do you feel comfortable and easy about masturbating?

Yes/No

c) Do you find talking about masturbation

	with partner	with friends	in this interview
Open and easy.....	1.....	1.....	1.....
Fairly easy.....	2.....	2.....	2.....
Fairly difficult.....	3.....	3.....	3.....
Difficult.....	4.....	4.....	4.....

96. Do you find talking about your sexual likes and dislikes with your partner

- easy.....1
- fairly easy.....2
- fairly difficult..3
- difficult.....4

- b) Do you feel comfortable initiating love-making with your partner or do you feel it is more appropriate for him to initiate it?

Yes/No/Other (specify)

- c) Do you feel comfortable about making love during your menstrual period, if you feel like it? Yes/No/Other (specify)

- d) Do you feel that men's and women's sexual needs are similar or different in some ways?

same/different (specify)

Is this true for you and your partner? Yes/No (specify)

- e) How important is having orgasms to your sexual enjoyment?

- f) Do you find in practise, that your expectations and desires in love-making are generally satisfied?

Yes/No/Other (specify)

97.a) Do you feel that if you get (as you are) married that you ought to have children? Yes/No/Other (specify)

b) If you decided to have a/another child, would it be important to you to be married? Yes/No

Why is that?

98. Which of the following alternatives for rearing children would you

a) prefer:

	would prefer	would ever consider	would not consider
living with a partner, married ...	.....1.....	.....1.....	.....1.....
living with a partner, not married	.....2.....	.....2.....	.....2.....
living on your own.....	.....3.....	.....3.....	.....3.....
living with another woman.....	.....4.....	.....4.....	.....4.....
living with a group, men and women	.....5.....	.....5.....	.....5.....
living with a group, all women.....	.....6.....	.....6.....	.....6.....
other (specify).....	.....7.....	.....7.....	.....7.....

b) Which of them might you ever consider?

c) Which of them would you definitely not consider?

d) If has children, which are you doing?

99. Do you feel a woman's fulfilment is dependent upon having children? Yes/No (specify)

00. a) Who do you think should be primarily responsible for child-care?

- mother.....1
- father or partner....2
- both.....3
- those living in home.4
- other...(specify)....5

b) Why do you think this is important?

c) If has children, is this how it works out for you in practise?
Yes/No/Other (specify)

