Women's contraceptive decision-making: juggling the needs of the sexual body and the fertile body.

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Abstract

The contradictions faced by women in the area of fertility management justify an in-depth qualitative study of contraceptive use. The experience of needing emergency contraception (EC) is an opportunity to study decision-making about fertility management. Thirty two in-depth interviews were conducted with users of EC recruited in Melbourne, Australia. Women were juggling the needs of the sexual body and the fertile body. The sexual body was expected to be available in women’s relationships, and the fertile body required protection from pregnancy in the present and preservation for the future. The needs of these two bodies were very often in conflict and women chose to resolve this conflict in subtly different ways; three strategies were identified. Some women chose to make sexual availability and security from pregnancy a priority; others felt forced to sacrifice sexual availability and security from pregnancy; and a final group chose to make the protection of the fertile body for the future a priority. This study provides a starting point for developing a context-based, woman-centered understanding of the experience of fertility management for women in developed countries.

Keywords: Emergency contraception, qualitative research, contraceptive decision-making, fertility, sexuality.

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Introduction

That contraception is so widespread and fertility rates are falling in so many countries could be taken to imply that the problems associated with contraception have been solved. When we look more closely at the experiences of the young women this is clearly not the case. Much unfinished business remains, many problems are still to be faced (Bryson, Strazzari, & Brown, 1999, p37).

The contradictions faced by women in fertility management require an in-depth qualitative study of contraceptive use. While the trajectories of women’s lives in developed countries have changed, the contraceptive options available to women have remained much the same. Women now spend a longer period of time contracepting, during which sexual relationships are taken for granted, but child bearing is performed only when a number of social criteria have been met. Consequently, abortion rates remain consistently high, and many women struggle to find a suitable contraceptive strategy.

One factor that has a significant impact on the experience of fertility management is the later age at which women have their first child in developed countries. The median age of mothers of newborn children in Australia is now 30 years and has been steadily increasing from the age of 26.5 years in 1979 (Australian Bureau of Statistics, 2001, 2002). Also the average length of the interval between births and the number of women having no children has increased (McDonald, 1998). Other developed countries report similar trends towards later child-bearing and lower fertility rates (Morgan, 2003). Therefore, a significant minority of women spend all of their fertile years contracepting and many women spend a large proportion of their fertile years contracepting.
Persistently high rates of abortion indicate that effective contracepting is still difficult, despite the availability of new technology. In Australia an estimated one in three women resort to abortion (Cannold, 1998), and one in five pregnancies are aborted (Hugo, 2001). UK figures are similar to those for Australia, an estimated one-third of British women will have an abortion by age 45. In the US, the proportion is higher at 43 per cent (Oakley, 2002). Beck-Gernsheim (1989) argued that unwanted pregnancy has become less and less acceptable as contraception and abortion have become more so.

Women have become more reliant on technology to fit childbirth into their lives. Women’s bodies are held in an artificial state of infertility from the age of first sexual intercourse (about 17 years) (Wellings, Wadsworth, Johnson, Field, Whitaker, & Field, 1995) to about the age of 30 years when the first child is born. An increasing number of women also rely on \textit{in vitro} fertilization technology (IVF) to increase fertility (Hurst & Lancaster, 2001). Thus a significant proportion of Australian women are not managing their fertility effectively: one-third experience an unwanted pregnancy that ends in termination; at the other extreme, a group of women turn to IVF after not becoming pregnant naturally. While the technology available to women significantly increases choice, Beck-Gernsheim (1989) pointed out that with increased choice, new problems and challenges have emerged. ‘The less willing we are to accept the limits of nature, the more fully we are placed under the domination of medicine and technology’ (Beck-Gernsheim, 1989, p31). Roberts highlighted the role of race in mediating assisted reproduction technologies in the United States, arguing that these technologies are disproportionately used by white middle class Americans and that Black women are most vulnerable to ‘state interference in reproductive decision-making’ (Roberts, 1997, p293)
Since the introduction of the pill, women tend to have a range of sexual experiences before having children (Whicker & Kronenfeld, 1986). Gidden’s refers to this as ‘plastic sexuality’, which he describes as ‘decentered sexuality, freed from the needs of reproduction’ (Giddens, 1992, p2). Contraception has changed sexuality; the possibility of sex without pregnancy is now taken for granted. Women’s bodies are the site on which this change has been enacted.

Women’s bodies can be conceptualized as consisting of a fertile body and a sexual body. The fertile body signifies the reproductive elements of a woman’s body, the capacity to conceive and carry a baby. The sexual body signifies the body that experiences sexual activity. Both bodies have not only physical aspects, but social meanings and associated conditions. Feminist writers have identified the body both as a material body, and a socially constructed body. Grosz (1994) referred to the body as a ‘cultural product’, and suggested that this aspect of the body must be better understood. Martin (1987) said that women embody oppositions, ‘home versus work, sex versus money, love versus contract, nature versus culture, women versus men’. Contraception is a way to resolve the conflicting needs of the sexual and the fertile bodies, allowing women to experience the sexual body but not the fertile body.

The increased time spent contracepting and the increased expectations that sexuality is freed from the needs of reproduction, and together with the persistently high rates of abortion and increasing use of IVF indicate that the issues around contraception are far from ‘solved’. Even in countries where access to contraception and abortion are accepted and endorsed, practice is far from ideal.

Beck (1992, p137) suggested that ‘how one lives becomes the biographical solution of systemic contradictions’, implying that women interact with and
solve in their lives the contradictions presented by the social system. Therefore, by studying how women make decisions about contraception, it may be possible to gain insight into the systemic contradictions they face and how they are managed.

This paper reports on the way women who presented for emergency contraception (EC) described their decisions about contraception. Both the value and the difficulty associated with emergency contraception arise because they operate during a very small window of time between intercourse and implantation. Morrow (1994) suggested that ‘only in crucial conjunctures do the ruptures of social reproduction become studiable in the mediations between systemic structure and social action’ (Morrow, 1994, p270). The failure of contraception is a point in women’s lives at which they are forced to reassess and reflect on their practice, and therefore provides an opportunity to study the social processes around fertility management.

This study included analysis of how women made decisions, the factors that they weighed in these decisions and the discourses they used in describing their experiences. An instance of the use of EC was a valuable time to ask women to reflect upon their fertility management and to gain a better understanding of how women constructed the fertile body and the sexual body.

**Methods**

Until July 2002 the most commonly prescribed method of emergency contraception in Australia was the Yuzpe method, a combination of estrogen and progestogen taken in two doses, twelve hours apart, within 72 hours of unprotected intercourse. Since July 2002, a progestogen-only preparation, taken in a similar way to the Yuzpe method, has been licensed in Australia and is becoming the preferred method. When this research was conducted in 1999-2000,
however, no product had been licensed as an emergency contraceptive in Australia. Hence EC was only available by prescription, and the Yuzpe method was used in most settings as it could be constructed from pre-existing pill packets.

Participants
Users of EC were recruited through three sites in metropolitan Melbourne: a Family Planning Clinic, a Sexual Health Centre and a hospital Emergency Department. At each site, the clinician treating women presenting for EC (doctor or nurse) offered them a flyer inviting them to join the study, and interested participants left their contact details in a secure box in the clinic. Women under 18 years-of-age were excluded. Participants were contacted two weeks after their consultation and were invited to be interviewed about their experience of using EC. Recruitment occurred between August 1999 and October 2000; a total of 32 interviews were conducted in a variety of settings chosen by participants (homes, cafes, parks). Before the interview was conducted, informed consent was obtained by the interviewer. Of those who were handed a flyer at the sexual health centre, one in four participated; of those handed a flyer at the family planning clinic and the emergency department, one in eight participated.

Data Collection
Interviews were conducted by the author and were unstructured, covering topics about sexual and reproductive health. The key themes were: background, experience of using EC, contraceptive history, STDs and perceptions of fertility. The qualitative method was chosen over quantitative method because predetermining the types of responses participants can give (through the use of highly structured modes of data collection), may exclude information and perspectives outside the paradigm adopted by the researcher (Maynard, 1994, p11; Patton, 1990, p44). Particularly in the case of contraception, for which the scientific and medical paradigms predominate in much of the research, it was
important to give women an opportunity to express their experiences in their own words. The qualitative method allows for the most flexibility in data collection (Denzin & Lincoln, 1998, p3).

**Analysis**

Standard qualitative methods were used to analyze the data. Preliminary analysis began during data collection. Through the development of some initial categories of types of users of EC it was possible to assess when saturation was reached (Glaser & Strauss, 1967). By interviewing 32 participants, no major new information arose from the study sample. Saturation had been reached for this group of women.

Interviews were transcribed by the author, and a pseudonym was substituted for women’s names to protect their privacy. Transcripts were read and re-read until the main themes became clear. From these themes a coding framework was constructed, comprising a coded list of concepts that were consistently raised throughout the interviews. Sections of the interviews were then grouped under the relevant codes (Huberman & Miles, 1998). Four different types of users of EC were identified from this analysis (Keogh, 2005a). The data reported in the present paper relate to the analysis of users’ contraceptive decision-making styles.

**Results**

The sample of women interviewed for this study was likely to have been drawn from a slightly higher socioeconomic pool than the general population and to be better educated, given what we know about EC users (Delbanco, Mauldon, & Smith, 1997; McDonald, 1999; Pyett, 1996; Siedlecky, 1986; Sorensen, Pedersen, &
Over half the sample had attended a religious or private school and nearly one third were full time university students (Table 1).

**The sexual body**

The sexual body was not mentioned explicitly by women very often, but these women saw sexual availability as a given in their relationships. For some this meant 24-hour-a-day availability, and for others the sexual body was available only at certain times, but no one questioned the assumption that sex was expected in relationships in which child-bearing was not a possibility.

The 32 women interviewed had sex in relationships that ranged in length from one night to six years, and one woman had sex in a casual relationship that had continued intermittently over 14 years (see Table 1). Women described the following situations: Cathy had one sexual experience with someone she had never met before; Melany had occasional sexual experiences with a good friend, but not ‘boyfriend’; Leanne and Nicole had sexual experiences that had the potential to be the start of new relationships, but were not. A large proportion of the sample had sex in stable relationships (short- and long-term) including marriages.

Isobel was 23, a student and had been in a relationship for three years. She used the pill because ‘it works 24 hours around the clock, everyday of the year’. She explained the need to have a contraceptive that allowed constant sexual availability in the following way;

*ISOBEL* … *Because stress and self esteem and depression and being happy don’t necessarily coincide with each other. So the moments you do coincide it needs to be really important that you can both act on it and I think it would be destructive if you couldn’t.*
One theme that was implied rather than stated explicitly was that the sexual body was expected to be available in a wide range of settings, although women were willing to place limits on their sexual availability. In contrast to Isobel, Melissa said of fertility management:

*MELISSA What it means to me is basically being aware of where my body’s at in my cycle, and making sure that I listen to it and not have unprotected sex in the times when I think I’m at my most fertile.*

In no relationship was the idea of not having sex a serious consideration. Skye experienced discomfort using condoms, but the only other option was not having sex, and she said, ‘*But neither of us liked the idea of that*’. They decided to continue the struggle with condoms in their relationship.

Women’s accounts of their discussions with their male sexual partners about contraception, revealed that in some cases, the sexual body was expected to be separate from the fertile body. For example, Selma, Sam, Leanne, Mandy and Nicole had all been in a situation in which sex occurred in the absence of any discussion about contraception. Sam, Nicole and Leanne all had a ‘one night stand’ during which contraception was not discussed, except in Leanne’s case her partner told her he hoped she was ‘*on the pill*’. Selma and Mandy were both in relationships with men who did not consider it their responsibility to think about contraception or to initiate the use of condoms.

Suzy was unusual in that she expressed the belief that the man should not need to be concerned about the fertile body. Suzy was a 22-year-old single student and part-time worker living in a shared house. Her relationship had recently ended. She explained her decision not to talk to her partner about having used EC:

*SUZY …Because I still see it as like, I’d feel like a burden, he’d feel guilty, and sex all of a sudden has this clinical, medical health overtone, where I go through pain. And it’s not this really sexy*
thing any more, you know what I mean? And I guess that ultimately connects to the fact that then he wouldn’t find me attractive or desirable, because all of a sudden I’d be this medical object, not a sexual object.

She was expressing the importance of the sexual body remaining free from any association with the fertile body. More commonly, however, women felt that contraception should ideally be a shared responsibility.

**The fertile body**

Unlike the sexual body, which was mainly experiential, the fertile body was described by many of these women as the potential to have children; for many women it was untried and therefore unknown, which had both positive and negative consequences. Cathy, a 27-year-old single student living in a shared house, explained it as follows:

**CATHY** I feel like it’s [fertility] my most precious and feared thing. Both my greatest ambition and my worst nightmare if you become pregnant, and has always been that. There’s a real duality about the way you see your fertility: it’s like a power, which is great, but it has the potential to really fuck up your whole life.

The two main themes that women raised in relation to their fertile bodies were protecting themselves from unwanted pregnancy and preservation of their fertility for the future. Three different experiences illustrated the importance and meaning of timing in relation to pregnancy. Selma had two children resulting from two unplanned pregnancies while on the pill and felt this had significantly affected her opportunities to start a career. Selma was 30-years-old, married and had recently arrived from Turkey. She was unable to find a contraceptive that suited her and yet described not wanting to have a tubal ligation because she was keen to preserve the potential to have more children in the future.

**SELMA** It’s not easy to have little kids like these. Very close to each other, no-one in the buildings, all of them need you, and you will

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not be able to cope, the other thing is, I'm very interested in finishing off my studies and start to do something for myself … I feel like I'm buried with this life.

LOUISE What does your husband think about this? ... Is he understanding about your need for contraception, and your need not to get pregnant? Or would he not mind if you got pregnant?

SELMA No he’s OK, he feels like we shouldn’t have any more, but he. Look this is the way Turkish think, he can’t cut his tubes, I can’t do that myself, because you never trust, you might some day loose one of them, or you go to marry another one (laughing). So, ahh, they like always to have a hope.

Selma showed a clear desire to preserve her fertility, but also a strong desire to protect herself from further unplanned pregnancies. Angela, on the other hand, described her management of her fertile body with pride. She saw herself as having had the ideal biography when it came to her fertility, and the main contrast with Selma’s experience was the planned nature of her child rearing. Both had two children in their twenties, but for Angela this experience was planned, and therefore positive, compared to Selma’s unplanned, difficult experience. Angela was 46-years-old, worked full time and had two children. She was married for 18 years. She described her two pregnancies;

ANGELA I knew Mark for three years before we married, I knew he would be a good father and he is, and so I was making a very conscious decision as a young woman to start a family … Mark probably would have waited another year, but I wanted to see, and you know and we got pregnant very easily and quickly, it was a breeze, it was one of those aspects of my life that was so simple. I stopped my method of contraception and waited a month and bingo, straight away. And very much a wanted pregnancy, and the same with the second one … Managing my fertility like that and having two children, and having a boy and a girl, it was a breeze, no miscarriages, no still births.

Sam had been unable to organize her biography to fit around her ideal and had therefore abandoned her desire to create a life with a partner and children. She
had a difficult childhood and several unsuccessful relationships. She was a 28-year-old single woman living with family. She worked and studied.

SAM ... I now prefer to plan a life on my own, and do things. Rather than plan to have everything and still be waiting, because he may never show up. I don’t want to spend my life waiting for something that may never happen, that’s not the way to be. It’s only recently that I’ve come to these conclusions ... The fairy tale that girls are schooled with, I’ve blown it out of the water basically, where is that prince charming? I’m 28!

Only Angela was happy with her experience of the fertile body. Selma had not managed to time her children to suit the other goals in her life, and Sam expressed a sense that her time was running out to arrange her life in a way that would make having children a possibility. These three experiences show the challenge of managing the fertile body, the range of women’s experience of the fertile body and the importance of timing and planning to women’s experience of fertility.

When asked when they would like to have children, women offered a range of further social inscriptions on the fertile body, suggesting that their fertility should meet criteria such as occurring at the appropriate age, in the appropriate relationship, fitting in with a career, when they have enough money, stability, maturity, and when they have achieved other life goals. Melissa was a 30-year-old professional, engaged to be married and had been with her partner for 6 years, and was planning to start trying to fall pregnant in 6 months time.

MELISSA Well, I’ve got a really stable relationship, I’ve got full-time work, I’ve got a house. I don’t own it, but I’ve got a nice place to live in, all those monetary issues are taken care of. I feel like I could, within myself, I feel like I’m really ready to give of my time to someone else, not be so selfish. I’ve got a lot of my boyfriend’s family have been having children and that’s spurred me to thinking ‘well if they can do it, I can do it’. So I’m losing that feeling that I’m too young to have a child. I’m
maturing a lot, I’ve matured a lot in the last year or so, I just sort of think, I’d love to have a child now simply because I’m getting a little old.

Suzy was a 22-year-old single student and part-time worker, living in a shared house. Her relationship had recently ended. Timing of children depended on:

SUZY I’d like to be married, I’d like to be in my late 20s, really happily married. I would like to have achieved a lot, I would like to have travelled the world around. Um, established some kind of career path, even if it’s not a permanent career. I’d like to have a home, I’d like to be pretty emotionally stable. I mean late twenties, early thirties, probably no younger than 28, no older than 33.

To experience their fertile bodies, women felt that they needed to meet a range of social conditions. A significant condition was a stable relationship, in some cases marriage, although some women acknowledged that they may never be able to meet this condition. Women also had financial conditions and surprisingly narrow age limits for child bearing. The ideal for these women was to have a planned and prepared-for pregnancy once all their social conditions for child bearing had been met. To achieve this, many were aware of the need to preserve their fertile body for this future event. Eliza was a 25-year-old unemployed single woman, recently returned from overseas and living with a friend.

ELIZA … I don’t smoke cigarettes and I don’t indulge in too many dangerous activities, because I think I have to look after my body, because one day it will be the vessel for another body. So not just for now but for later, and not just for me but for somebody else.

Negotiating the fertile body involved both protecting its potential, but also ensuring that the right timing was achieved in relation to having children.

**Strategies for negotiating the sexual and the fertile**

The three key goals for all women in this study were: 1) to be sexually available without interference, 2) to achieve security from unplanned pregnancy and 3) to preserve the fertile body for the future. However, no woman felt she was able to
achieve all of these goals at the same time. Instead, women had to assign priorities to their goals to find a workable contraceptive strategy. Women were categorized into one of three groups in terms of which strategy they adopted.

**Strategy 1: Give Priority to sexual availability and security from pregnancy**

This strategy was adopted by the largest group of 16 women. These women chose to give sexual availability and security from pregnancy highest priority and therefore the preservation of their fertile body lower priority. They chose a highly effective contraception strategy that suppressed their fertility in the short term, so that their sexual body could be experienced easily without concern for fertility (the pill or an IUD). Eight young women (under 25 years) did not see their fertile bodies as significant in their current experience and could therefore compromise their fertile body in the short term, assuming that it could be re-activated in the future when they wanted to have children. Three women had completed their child-bearing and no longer felt the need to give priority to the preservation of their fertility. The other five women were aged 26 to 32 years and were not as comfortable choosing to give priority to their sexual body. They acknowledged the cost to the fertile body and more so than the others in this group, felt ambivalent about their decision.

This strategy allowed the women who adopted it to ignore their fertile body, so as to enjoy their sexual body without the ever-present concern about becoming pregnant. Anna was an example of a young woman who was clearly not concerned about her fertile body. She was 20–years-old and preserving her fertile body was not a big part of her decision-making. Anna was more concerned about a contraceptive that would allow her to enjoy her sexuality without being concerned about becoming pregnant. She chose the pill because it was *the most effective* and says of her fertility:

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ANNA  I don’t really think about it. I don’t really think about it much at all … I just say, ‘No, I don’t want to have kids and that’s it’. Maybe when I get married I’ll change my mind, I’ll see my friends around me having babies and that might be something natural that comes along after you get married for a few years.

For Anna, assigning priorities was not difficult, but Emily (a 21-year-old student who lived with her boyfriend) had the added complication of bipolar disorder. She had been told she could not have children for ten years and was willing to compromise her fertile body to a greater extent than other women. She chose to avoid menstruating by not taking the inactive pills in her oral contraceptive pill packet, even though she suspected that her body was ‘storing them [periods] up against her’ and that it was not ‘natural’. She managed this by focusing on what was best for her in the ‘here and now’.

EMILY  …It’s not natural. And what’s happening to the eggs that I produce? And the lining? Is that just going stale or something? I always think it’s going to take me longer than most people to get pregnant after I come off the pill. But over ten years, does that mean it’s going to take me ten years to get pregnant? Who knows? But at the moment, I just sort of think more of the here and now. It’s too much if you weigh up everything, and think about the future. But yeah, I think it would do some damage, I don’t see how it wouldn’t. Changing the whole body’s hormones and chemistry

Isobel considered herself closer to child-bearing age. She was 23, and she acknowledged the risk she was taking with her fertile body but chose to give priority to the ability to have sex whenever she felt like it, to sustain her three year relationship. She was a part-time student who lived at home.

ISOBEL  … Ideally, I’d like to do the rhythm method, but that’s inconvenient, because you have to not do it sometimes and do it other times. And when a relationship is starting to get stale or having rocky periods, being able to do that [have sex] at the drop of a hat is a bonding moment that can enable you to repair things. But if you have to say, ‘Oh yes, but I can’t’ then that breaks a chance. So I don’t think that works either.

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LOUISE  So what would you say are the most important prerequisites in a contraceptive for you?

ISOBEL  It works 24 hours around the clock, every day of the year, I think is probably number one. I guess it needs to not effect your health, but I mean, I’m assuming the pill doesn’t, I don’t know. But I mean the more natural the better I guess, but it’s not very natural to stop your fertility I don’t think…

The women who adopted this strategy assigned priority to the sexual body, sex being relatively ‘easy’, and free of stress in their relationships. They expressed varying levels of concern for the fertile body and dealt with this concern in a number of ways. The pill allowed 24-hour sexual availability, which was important to many of the women adopting this strategy.

**Strategy 2: Forced to sacrifice sexual availability and security from pregnancy**

A smaller group of four women had similar goals to the first group. They would have preferred a reliable method of contraception that allowed them to put their fertility on hold while not interrupting the experience of the sexual body but were unable to find a suitable strategy. These women were forced into a negotiation between the sexual and the fertile body that they would have rather avoided. All of these women said they were unable to use the pill and had to rely on less effective methods. Consequently their experience of the sexual body suffered, and the risk of becoming pregnant increased. Teresa was a 23-year-old student; she lived with her boyfriend whom she had been seeing for two years. The pill caused her to become depressed and forced her to rely on condoms. She therefore had to engage with her fertile body more than she would if she were on the pill. Her account of how well condoms worked in her relationship provided evidence that the sexual body had to be curtailed to manage fertility, and that condoms also placed her at an increased risk of becoming pregnant.
TERESA I think it’s good, but you’ve got to be, you can’t be stupid. It’s an OK thing if you’re using lubricant every time, but for the man it’s actually less stimulating for him, so sometimes he might get a little bit frustrated. But what it does, is it tells you that it’s maybe not always about sex, too, it can be about other stuff as well … So the condom is a good idea … But it’s not always guaranteed, and that’s the good thing about the morning after pill … But it’s the last option, because I get sick with it. It’s the last option, it’s only if we definitely know that there’s a good chance that I am going to [fall pregnant], which is anytime it breaks that I haven’t got my period.

Cathy was a 27-year-old single student living in a share house. She would also have preferred the pill but was forced instead to use condoms because she had genital herpes. She described condoms as ‘not a great sensation’ and discussed why she would have preferred to use the pill:

CATHY Just because you don’t have to. Then you can have more spontaneous sex, you don’t have to put a condom on, and have it. And I also find that um, because I can get herpes right, if I have sex that’s abrasive, or that my body is not warmed up enough, that can often bring on a case of herpes, and I don’t want to do that, so, um. I also find condoms get quite dry and that rubbing, also increases the chance of me transmitting it.

Strategy 3: Give priority to the protection of the fertile body for the future

Twelve women made the opposite choice to those in the first two groups. These women chose to make the protection of their fertile body for the future their first priority, which meant they sacrificed either sexual availability or protection from pregnancy or both. While these women endorsed the need for sex in their relationships, they questioned the idea that the sexual body had to be available 24 hours-a-day, 7 days-a-week, without interruption for contraception. They gave priority to the ideology of protecting and preserving the fertile body for the future. Eight women chose condoms and two avoided sex during the fertile period, one used a diaphragm and another abstinence from casual sex.

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Jodie expressed a strong political stance against the pill. She was an advocate of the Billing’s method and women understanding their fertile bodies. She was willing to compromise on the experience of the sexual body to preserve the ‘natural’ state of her fertile body. She was 35-years-old, worked full time and lived in a shared house. She had had one abortion.

**JODIE** … I’m not going to go on the pill, and um, it’s really interesting, when I do go and see the doctors, they all say, look about the pill, la la la. And I just think, ‘How old am I? I’ve been pregnant once, I’m not going to go on the pill, I’m not going to sacrifice the rest of my health, and the moods and the other stuff, for that’. I’m not going to be a slave to drug companies. I’m very grateful it’s there. I’m sure it’s been a wonderful thing to control the population, but-

Melissa was a 30-year-old professional, engaged to be married and had been with her partner for 6 years. She had had three abortions, and she chose a contraceptive based on how it affected her body rather than on the effectiveness of the contraceptive. Her choice of strategy limited her to having sex only at certain times of the month (see quote on page 9), showing her decision to compromise sexual availability.

**LOUISE** What would you say would be the main issues that effect your decisions about contraception?

**MELISSA** How they affect my body, that’s number one. I’ve never really thought about whether it works or not, I suppose I should.

Eliza was a 25-year-old unemployed single woman, recently returned from overseas and living with a friend. She preferred to use condoms because she said: ‘I just think if it’s in a condom, I can see it, and it hasn’t gone inside me’. She was very aware of the relationship between her fertile body and her sexual body, as illustrated by the following quote. Like others she admitted that a drawback to
this strategy was that the sexual experience might suffer. When asked to describe fertility management, she said:

ELIZA  
_Fertility, as in pregnancy, as in being fertile, having offspring, and management being control, so I guess deciding each time. I don’t know, like when you get the condom out, ‘Do I want to be having sex with this person? ... Yes, Do I want their baby? Maybe, but not right now’._

LOUISE  How do you find condoms?

ELIZA  Um, yeah - I’d prefer skin on skin, and sometimes I feel like after a while it takes moisture away, yeah, but.

Melany was having casual sex, did not see the point of going on the pill, and instead relied on condoms. She described using condoms as a hassle, and would go on the pill once she was in a stable relationship. Nicole intended to continue using condoms for the same reason, and Jane also felt this way when she was in previous casual relationships.

Women adopted this strategy either to ‘listen to their bodies’ and limit the times when they can have sex, or because they felt their new or casual relationships did not justify the commitment of a more effective contraceptive. They saw themselves as suffering minimum disruption to the integrity of their reproductive systems, but often acknowledged some disruption to their sexual bodies.

**Conclusions**

The experience of using EC provided a ‘crucial conjuncture’ in which women articulated their decision-making processes about contraception. Women evaluated both the competing needs of their sexual and fertile bodies, and the tools available to assist them in juggling these competing needs. This paper has
outlined three competing goals of fertility management and three subtly different strategies for managing fertility. The sexual body needed to be available in women’s sexual relationships, and the fertile body needed to be protected from pregnancy at the wrong time and preserved for pregnancy at the right time in the future. Some women chose to give priority to sexual availability and security from pregnancy; others felt forced to sacrifice sexual availability and security from pregnancy; and a final group chose to give priority to the protection of the fertile body for the future.

The users of EC were recruited through clinics and though the participation rate was low, sample demographics indicated diversity. The class balance may reflect the class balance of users of EC in the population, but this self-selected sample may also be biased towards more middle class women. The findings are not necessarily generalizable to all contraceptive users, and the categories are unlikely to be exhaustive; however, the categories of contraceptive decision-making reported in this paper are a starting point for developing a context-based, woman-centered understanding of fertility management in developed countries.

Fertility management for the women in this study meant compromise. The needs of the fertile body and the needs of the sexual body were not considered compatible. The ideology of technology also places additional pressure on women to manage their contraception efficiently and effectively (Rothman, 1989). The data showed that the goals for which women strived could not all be achieved at the same time. Instead women believed that they were faced with a choice, either to compromise the long- or short-term health of their fertile bodies, or the availability of their sexual bodies and protection from pregnancy. This illustrates that women did not perceive it to be possible to avoid all risk, as each choice involved some risk.
Women drew on powerful discourses in their contraceptive decision-making. While the fear of unplanned pregnancy was enough to motivate some women to adopt a ‘highly effective’ contraceptive strategy, for others the fear of damaging the fertile body was enough to deter them from this path. The common perception among users of EC that the use of the pill or depo provera may damage fertility in the long term is a significant finding of this research and needs to be further explored. In a forthcoming paper, the different ways that risk is interpreted by users and providers of emergency contraception is explored (Keogh, 2005b).

Rather than becoming easier in late modern societies (Giddens, 1991), it may be that negotiating the sexual and the fertile body is becoming harder. Women have a very limited window in which they consider it socially acceptable to have children, and the technology available to women to assist them in negotiating their fertility and their sexuality has not improved dramatically since the 1960s (Dickens, 2000). Sex has long ago been freed from the restriction of marriage and therefore occurs in a broader range of settings than previously (Giddens, 1992). Women did not question this idea but instead found themselves in many situations in which sex was occurring, but child-bearing was not considered an option. Yet many women also had a perception that their fertile body was fragile, and must be protected and preserved for future child-bearing. Women should be able to control their fertility and sexuality but have pressure to plan a perfect biography (Beck-Gernsheim, 1989). Few new tools are available to assist women in juggling the needs of their sexual and fertile bodies in this complex social context.
References


Table 1 Demographic characteristics of the sample

<table>
<thead>
<tr>
<th>Demographic characteristic</th>
<th>Number of women</th>
</tr>
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<tbody>
<tr>
<td><strong>Age group</strong></td>
<td></td>
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<tr>
<td>18-20</td>
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</tr>
<tr>
<td>21-25</td>
<td>8</td>
</tr>
<tr>
<td>26-30</td>
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<td>31-35</td>
<td>3</td>
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<td>36-40</td>
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<tr>
<td>Over 40</td>
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</tr>
<tr>
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<td>Overseas</td>
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<tr>
<td><strong>Position</strong></td>
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</tr>
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<tr>
<td>Full time in service industry</td>
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<tr>
<td>Full time blue collar worker</td>
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</tr>
<tr>
<td>Full time professional</td>
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<tr>
<td>Full time management</td>
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</tr>
<tr>
<td>Unemployed</td>
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<tr>
<td><strong>Current relationship</strong></td>
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<td>Casual</td>
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<tr>
<td>New (up to 3 months)</td>
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</tr>
<tr>
<td>Established (4 months to 5 years)</td>
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<tr>
<td>Defacto or marriage</td>
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<tr>
<td><strong>TOTAL</strong></td>
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</tbody>
</table>
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