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Towards an Anthropology of contraception: on the pill, control and embodiment

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Introduction

Access to modern contraceptives has increased rapidly in the past 50 years and contraceptive prevalence [(1)] has increased in all regions of the world. While demographic anthropologists relate increased contraceptive use to socio-economic changes, including an increased autonomy of women, it is clear that the global donor support to the implementation of family planning programs as a cornerstone of population (reduction) policies has increased the contraceptive options for women, if not actively pushed them towards using contraceptives by means of incentives or governmental sanctions for families with more the one or two children. Extensive fieldwork on the supply of contraceptives suggests that contraceptive pills, and often also IUDs, are present in remote areas in government health centres or that clinics of planned parenthood affiliates provide at least a limited range of contraceptives, usually for nominal fees or for free (Hardon *et al.* 1996). In addition, the commercial pharmacy generally sells a range of contraceptive pills. It caters especially for unmarried women and men who generally cannot obtain contraceptives from government clinics.

Anthropological ethnographies and studies have in the past described indigenous forms of fertility regulation and contraception, revealing how postpartum abstinence and lactational amenorrhoea serve as natural birth-spacing methods and how various herbs and other traditional methods are used by women to induce menstruation when their periods are delayed. (see for example Newman 1985). Such studies tend to mention the use of modern contraceptives as a means of fertility control only in passing.

In the 1990s a few ethnographies were published which focus on the use of modern contraceptive technologies and relate these to governmental popu-

lation policies and the quality of family planning programs as well as to societal changes, gender dynamics and culture. Gammeltopf (1999), for example, has described the way the provision of the IUD affects women's lives in Vietnam where families with more than two children are subject to economic sanctions. Saavala (1999) describes how women opt for sterilisation as the method of choice in India where for decades now sterilisation has been promoted as an effective population control technology. Morsy (1995) describes the way in which the Egyptian State uses newly developed hormonal implants to control the fertility of poor women. Russel and his colleagues published an edited volume (Russel *et al*. 2000) which resulted from a conference that aimed to examine contraception cross-culturally.

The contraceptive pill is the most widely used contraceptive method worldwide. It has been part of women's lives since the 1960s when the technology entered the market in Europe and the US, initially for 'menstrual regulation'. In the media, the introduction of the Pill is associated with the sexual revolution – it is represented as a 'liberating' technology – it allowed women to enjoy sex without worrying about the chances of becoming pregnant. In the 1980s, the Pill started generating controversies. Women's health activists voiced concern about possible adverse effects, and there was growing concern about the way in which these contraceptives were being provided to poor women in the developing world in population-control oriented family planning programs. Rather than being a 'liberating' technology the pill was represented as medicalising agent and a tool for population control. The women's health advocacy movement promoted the use of barrier methods, which have no 'medical' effects on women's bodies and are user-controlled. In particular, the movement opposed newer generations of longer-acting hormonal injections (like *Depo Provera*) and implants such as *Norplant* on the grounds that the safety of these technologies in terms of health risks had not been sufficiently studied. The reason of such opposition was because the technologies enhance the power of medical professionals who administer the injectables and insert and remove the hormonal implants, and because they were seen to be instruments of population planners who aim to reduce population growth and control women's wombs.

Despite these disempowering potentials of contraceptives, women in many settings experience the technologies as a means of control over their lives. It is the every-day experiences with hormonal contraceptives that we intend to focus on in this paper. We focus on the ambiguities involved in terms of women experiencing the technologies as more or less liberating, while at the same time submitting themselves to control by state-led family

planning programs, the marketing practices of pharmaceutical manufacturers, and medical professionals. Focusing on the lived experiences of women using contraceptives leads us to questions on the boundaries between artificial objects and natural bodies. We aim to describe how contraceptives affect women's material – biological – bodies and how they are embodied [(2)]. A focus on embodiment allows us to question constructs of 'natural' bodies and alien technologies. Comparative analysis, which we undertake in this article also, allows us to question the 'givenness' of culture-specific fertility regulation practices. What appears to be 'natural' reflects an inscription in women's bodies by means of technologies of a hegemonic social order. As Quaranta argues in this volume (2001), it is through the processes of embodiment that the political processes that sustain it become obscured.

We explore the above issues of control and embodiment by contrasting findings from anthropological fieldwork on the use of the pill among coloured women living in a coastal town in the Western Cape Province, South Africa, and young Dutch girls living in the province of Utrecht [(3)]. Let us now turn to the two diverse settings in which we conducted fieldwork on women's experiences with contraceptive technologies.

Case Study I. Young Dutch girls, the pill, embodiment and control

In the last 20 years, young people in the Netherlands have started having sexual relations at an early age. In particular, the sexual experiences of young girls have increased (Marneth in Ravensloot, 1991). The average age of girls who have had sexual intercourse is 16 years old. Contraceptive pill use by young sexually active women in the Netherlands is the highest in the world. 95% of the women within the age range of 20-24 years and almost half of the girls aged 15 to 19, sexually and non-sexually active, are on the pill (Brandt, 1991). The use of the contraceptive pill has significantly decreased the number of teenage pregnancies, and the number of abortions within the teenage group is the lowest of the world. (Brandt *et al*., 1996).

For our study, twenty girls of 13 to 21 years old were interviewed. They all used the contraceptive pill. Most of them had started to use the pill at the age of 15 or 16, though five started earlier. The youngest started at the age of 12. Eleven of the twenty girls lived in the city of Utrecht and surroundings, and nine of them lived in a small village near Utrecht. All of them still live at home. We found no difference in views between the girls living

in the predominantly protestant village of Almeida and those living in the less religious oriented city of Utrecht.

The pill, sex and health

I: *«Can you tell me why you are on the pill?»*

M: *«Because I had an acne problem. That is why I asked for the pill. And because I uh.. just did not want to get pregnant.»*

...

I: *«Did you have a boy friend?»*

M: *«No, I did not have a boy friend, but I knew I was going to having one soon, when he is there you cannot start anymore.... I find it during the summer time. I swallowed the pill for three months continuously, two no, three strips, one after the other, without stopping, because I did not want to menstruate – and it protects against pregnancy too.»*

The above text shows that the contraceptive pill has many functions for the girls. They take it not only to avoid becoming pregnant, but also for various 'medical' reasons and to have menstruation-free holidays.

We were surprised that more than half of the girls interviewed say that they started using the pill for reasons other than what we expected to be the main reason, that is being able to enjoy sex without worrying about becoming pregnant. The advantage of using the pill for reasons other than prevention of pregnancy is that they do not need to ask their parents for 'it'. Asking for the contraceptive pill when you have a boy friend is seen to be embarrassing – as if you are asking if you can make love to him. A girl explains:

«My father wanted me to start using the pill because I was sick each time I had my menstruation, and he was fed up of having to collect me from school. I think that if I had gone to my father to say that I wanted to start using the pill and he asked me: "Why?"... Then I would probably have said, I do not feel well... Look, you will never say to your father, I have a boy friend, in particulary not when you are 15...»

And another says:

R: *«Yes, I started at the time I had my menstruation, and not for 'safety', for a boy friend or so... it was somewhat different. I started taking the pill because I eh, was menstruating heavily... They considered it normal to take the pill for that reason..., that was o.k.»*

I: *«And if you had not had heavy menstruations?»*

R: *«Yes I think that it would have been different. I would have said, eh yes, I have a boy friend, or eh, I want to start the pill because I want to make love safely or something like that. They would have reacted differently. Then eh, oh, they'd probably ask "do you have to (have sex)"?»*

Dutch society is known for its tolerance. Young people are nowadays expected to talk openly about sexuality with their parents (the generation that was young in the sixties). Studies have shown that it is young people who would rather avoid talking about it. Parents intend to talk about sexuality with their children but when they try, their children often do not respond. Their adolescents prefer to get information through other, anonymous channels: girls magazines or TV programs, for example through (Ravesloot, 1997).

The contraceptive pill makes it possible for adults and their children to accommodate sex without talking about sexuality. With the exception of one respondent, all the girls had discussed with their mother whether they would start using the contraceptive pill, and often the mother accompanied them to the physician. In this way the mother tacitly agrees to the start of a safe sexual life and many girls find their mother's approval important.

The confidence in the contraceptive pill is enormous. The girls mention that the pill is the best way to control their fertility. They rely on it 100% Aware of the need to take it regularly, the girls have their strategies for not forgetting to take it. For example:

> *«I have my pills next to my bed on my table and then I see them and then I know it again. ... I am totally used to it, it's a habit. When I go to bed I take a glass of water, then I first take the pill and then I undress myself and then I go to bed...»*

A recurrent theme in all the interviews is the convenience of being able to 'plan' their menstruation. A number of girls told us that they started using the strip of pills on Monday, so their menstruation would start on Monday (4 weeks later) and be over by Friday – ensuring a menstruation free weekend. They also planned menstruation free holidays:

> *«You know when your menstruation comes, you can plan your holidays, and you are just not bothered by it.»*

> *«I am on the pill because I was lying on the beach three to four times this year and because I got my period at that time. With the pill you can swim and so on but really if you menstruate heavily, it is not convenient... The end of July I started, then I swallowed two strips one after the other... And yesterday was my birthday and I had to work the days following my birthday and I did not want to have my menstruation. So I swallowed the pill for seven more days... I find it very easy because I know exactly when I get my period, because I am usually very irregular.»*

The potential to control your menstruation as well pain are important functions of the contraceptive pill for women – they are at least as important as the pill's capacity to protect against pregnancy. Indeed most girls said they would continue to use the pill even if they were not having a sexual relationship.

Side effects of the pill

Most of the respondents are aware of a number of negative side effects of the pill. The most mentioned side effect is an increase in weight. About half of the girls say that they did gain weight while using the pill, but they did not consider this a problem. You can always stop if it bothers you too much. A number of girls mention that the side effects disappear after a while. Two girls were advised to switch to another pill because of their complaints. When complaints are mentioned to a doctor, the advice is usually to continue using the pill for at least three months as the body has to adapt to the change. The side effect is not blamed on the pill but on the body that has to adjust. If the adverse effects continue then they doctor usually advises the girls to switch brands. The underlying idea is that there is a contraceptive pill for everyone; it is just a matter of finding the right "match".

Most of the girls have heard about the risks of the pill and long term effects, but only a few have asked their doctor for information on possible adverse effects. The majority do not pay attention to the negative messages. A number even got angry about the negative stories about the pill. The reasons they put forward for not bothering about the side effects of the pill are their trust in the doctor and technology. In their view the advantages of the pill outweigh the disadvantages, and they focus on the short-term benefits rather than worrying about possible future risks. The following quotes illustrate these trends:

> *«Yes, I heard a lot about the side effects, but when I started it was not discussed. You now hear that the pill is good and that the pill is not good... But yes, I have taken the pill for a long time and I don't have any problems. When I go to the doctor for a repeated prescription, then I ask him if the pills I am using are bad, but he says they are safe. I trust him, I believe what he says.»*
>
> *«I do not think about it. Maybe after a few years it is dangerous or who knows what, but not now, not yet. Because I think when it is really dangerous they would have banned... If you do not take the pill, what can you do?»*
>
> *«Yes, there are stories that you can get cancer, or eh, other things, you are more at risk but nothing more... If I had not taken the pill then I would have probably got pregnant. And now I have taken it and I may have some other problems... I prefer not being pregnant now. I will see later.»*

The trust in the physician is considerable and carries more weight than the negative messages in the newspapers. *«If he says it is good, it is good. Who else can you rely on?»* Physicians prescribe the contraceptive pill routinely to young girls and pill-consultations are short. Little is said about the use and possible adverse effects of the pill. The physicians often refer

to the pill-package insert for additional information. They assume a high level of knowledge about the pill among their clients (van Delft en Ketting 1992).

The findings from the way young women in the Netherlands experience the pill suggest that for them the pill is a liberating technology. It provides them with an instrument to control their menstruation and plan their lives. The women have no problem in remembering to take the pills every day – they incorporate the pills in their day-to-day lives. They value the fact that the pill protects against pregnancy – but the technology is more than that. If they discontinue a sexual relationship they intend to continue using the pill.

Let's now move to the coloured women in Hout Bay, Western Cape Province, where the pill is experienced differently.

Case Study II. Coloured women in Hout bay, the Pill and loss of control

For this study, Harries interviewed women attending the family planning clinic at the Hout Bay Day Hospital. Hout Bay is off the Atlantic coast on the Southern Cape Peninsula approximately 20 kilometres from the centre of Cape Town. The Day Hospital is a government run out-patient clinic in the "coloured" section of the Hout Bay Harbour area. The harbour community, locally referred to as the 'fishing village', is a residential coloured area, an enclave situated within the greater Hout Bay area.

Interviews took place in the waiting area outside the family planning clinic and in some of the women's homes. Thirty women were interviewed, all coloured, and all interviews and discussions took place in English with some dialogue in Afrikaans. The age range of the women interviewed was 18-25 years. All were unmarried and the average number of children was two. Most lived with their parents, boyfriend's family or with an extended family member. The women in Hout Bay tend to start using contraception once they have proven their fertility, after their first child. Most of the women were not currently working though some had been previously employed on a part-time basis in local shops, as domestic workers and in the fishing factory. All were Christian with the exception of one woman who was a "Muslim through marriage".

The contraceptive methods currently available in government clinics in South Africa are: hormonal injectables;[4] IUDs, which are rarely inserted due to the high incidence of sexually transmitted diseases in South Africa;

condoms and spermicides, and finally sterilisation. Emergency contraception and abortion are also now currently available. Female condoms are available at certain government clinics. Despite the range of contraceptive methods, *Depo-Provera* remains the most pervasive form of contraception administered in the family planning clinic.

All the women interviewed were receiving the contraceptive injection, *Depo-Provera*. The responses to why women had not chosen the contraceptive pill were fairly consistent in linking forgetfulness to conception and hence pregnancy. The following comments illustrate their views:

> *«We hate the pill. We forget and then we are pregnant.»*
>
> *«I am too forgetful. I can't remember to take the pill everyday.»*
>
> *«I always forget the pills. No thank you, I do not want any more children.»*
>
> *«I just have to look at the pill and then the next day I am pregnant.»*
>
> *«If I take the pill today then tomorrow I am pregnant.»*

Another woman stated:

> *«I am on the three monthly, Depo. I like the injection. I don't like pills. I am not scared of the injection because I don't want any more children, 'maar ek wil ook nie dat hulle my laat toe maak nie'.»* (But I also do not want them to close me up, a reference to sterilisation).

For these coloured women, there is a causal relationship between pregnancy and the contraceptive pill, the polar opposite of its medical function. The women claimed that they were forgetful, which is the reason why they preferred the injection to the pill. The precision with which they observe their medical appointments for the injection contrasts with the forgetfulness, which they associate with the Pill.

The notions of safety and surety associated with the injection in contrast to the pill's unreliability is symbolised by the utterances of a young woman of twenty:

> *«I only have to look at the pill and then I am pregnant. Once I see that injection coming then I ask no questions. It is only every three months so I don't mind. That injection doesn't really hurt, it goes in fast. It's over quick. I'm used to injections I've been having it already so many times. My friend who was on the needle started growing all kinds of hair – but for me the needle is fine because ek will nie my laat doen nie – (i.e. to be done is the colloquial for sterilisation.) So, no thank you, I do not like the pill. You see this baby here that is what the story of the pill is about. I just can't remember to take the pill every day. How must I remember? There are so many other jobs in the house that one must do, like taking the children to school, cleaning, shopping and cooking.»*

The injection is a surety in an uncertain world. Furthermore, unlike the injection, the pill is constructed and symbolised by stereotypical gendered

polarities of male and female. The pill embodies female attributes, it is unreliable, disordered and capricious whereas the injection is male, powerful and controlling. The contraceptive injection is seen as symbolising modernity, a new technological development. Its efficacy and reliability is viewed as an advancement on the pill and the condom which are both perceived as being unreliable and, hence, unsafe.

The notion of forgetfulness voiced by many of these women takes on multiple meanings and can be connected to the loss of female agency within the home environment [(5)]. Forgetfulness in the home may be linked to the exhaustion and time demands of domestic labour typified as household duties (cooking, cleaning and shopping) and child-care. Thus forgetfulness, as in forgetting to take the pill everyday, leads to pregnancy which in turn produces further body labour in the form of pregnancy, giving birth and child-care. The experience of loss of control in the domestic space forges the assessment of both domestic and reproductive labour as the loss of personal agency.

The hidden practice of the injection

An informant voices the final proof of the pills' unreliability: *«you see this baby here, that is what the story of the pill is about»*. This reference to the baby is tangible proof of the pill's inefficiency. A young mother conveys the pill's stigmatising visibility in the following narrative.

> *«Often our husbands want us to have more children. I say no thank you, not me. You see, I had this friend she was on the pill, she had to hide it from her husband so she hid it in the kitchen and then her husband found it and he was angry and threw them away. Then I told her just tell him these pills are to make you, you know, your periods regular and such. Another friend she hid her pills but then she would forget where they were hidden, you see this system is no good. The injection it is better all round. You know these men they want us to have more children but it is very costly to bring up children, but these men don't think about that. The injection is safe. My time is too busy to remember to take a pill everyday.»*

The pill is kept in the home, visible and thus potentially subject to the male gaze. The injection is hidden from their husbands, it occurs in a clinic beyond local male control and beyond their gaze. In hiding the pill and hence concealing the action, resistance and defiance is directed towards male domination in the home [(6)].

In this context of hiding, the clinic embodies feminised space; it is beyond the male gaze, which is associated with the domestic sphere. The injection detaches them from male control in the domestic and community sphere.

The history of contraceptive choice

The history of *Depo-Provera* contains a specifically racial component. Since the 1970's it has been used extensively in South Africa, who has an effective family planning programme and services directed towards the black population.

It is now widely accepted by most observers both within and outside government circles that the primary motivation for both the *Family Planning Programme* in SA and the *Population Development Programme* was the fear within the white community in the 1960's and 1970's of being swamped by the larger numbers of the black population. *Depo-Provera* thus became associated with population control and coercion and by the government's attempts to control and limit African women's fertility. In 1974 the government introduced a national vertical *Family Planning programme*. A nationwide network of Family Planning clinics was established with free services provided to all racial groups but on a segregated basis. At the same time, positive incentives were offered to the white population to increase the number of children per family. Stories of coercion abound. *Depo-Provera* was reportedly given to women in labour wards immediately after giving birth, a practice that was allegedly so widespread that nurses in SA government hospitals for Africans had a saying that "*Depo* was the fourth stage of labour". This practice continues today and has been reported by many informants living in the Hout Bay area.

A young unmarried woman describes it.

> *«At the hospital they make you take the contraceptive injection so you won't forget. Mine was a normal birth. They gave me the injection straight after the birth of my baby. I didn't even have time to think and the birth was so painful that I didn't even realise that they gave me the injection. So now I am on the three monthly injection, Depo Provera.»*

The nurse in charge of the family planning clinic informed Harries that it is unethical to give *Depo-Provera* post-partum, it's not right but the nurses are concerned that the women won't return for their six week check up and will forget about contraception. Nurses in these maternity hospitals have thus assumed the role of moral custodians and guardians of the state and further reinforce notions of forgetfulness, as discussed above.

The following exchange which forms part of a wider discussion around the experience of giving birth further illustrates the coercive administration of post-partum *Depo-Provera* and the manner in which it becomes entrenched in women's early reproductive cycles. Cindy a recently married woman of 22 recounts the following:

> *«The nurses were quite nice at the hospital. But just the only thing I hated was the injection – the contraceptive, and they made you take the contraceptive when you*

leave. They say it is best for you and they don't have any tablets. Because you are going to be busy. You are taking care of your child, and you are just going to forget to take the pill and then they tell you, you can always change again but just for these first 2 to 3 months – its just in case you forget, just so that you don't fall pregnant. The nurses asked me whether I wanted the 2 months or the 3 months so I said the 2 months. It's not like... it's just that they don't want you to forget or whatever, it's just a safety procedure. They didn't actually give me another choice but OK everyone has to take it. They asked me what contraceptive I would like. When I said the pill then they decided for me. They said it's better to take the injection.

Afterwards when I came to the day hospital I carried on the injection for six months. It's as if when you ask for pills they say: "Are you ready for another child, do you have money, do you have a job' and stuff like that. But when I went to the day hospital to go and change onto something else, they said: " you must stop swapping like this, you must stay on one thing". So I said "well the first one wasn't actually of my choice and I am deciding what I want to go on" and then I went onto Triphasil. I think that people feel more comfortable on the injection because maybe they are worried that they are forgetful. They (the nurses) always stress that if you miss it out you can fall pregnant immediately and stuff like that. But I decided to take the pill. I am actually going to change my mind again and go for the loop (the IUD). I think it is safer to be off from all contraception and if I decide to have a baby again then I can have it taken out again.»

On a certain level this woman is ambivalent about the fact that she was given Depo Provera in the maternity hospital claiming that «everyone has to take it» and «its a safety procedure». However, at a later stage she decides to change to the pill and is assertive about this decision.

Conclusion

The case-studies explore the embodied experiences of Dutch adolescents and South African coloured women with hormonal contraceptives, focusing on the extent to which they experience the technologies as medicalising agents of control or rather as liberating technologies. The narratives of the young Dutch girls show how the contraceptive pill enables them to regulate their fertility without talking about sex. The main reason for using the pill is, contrary to what we expected, not the prevention of pregnancy, but the treatment of menstrual pain, other menstrual 'irregularities' and acne. The medical discourse surrounding the indications for pill use facilitates communication between the girls, their mothers and doctors on the use of the contraceptive pill. They do not need to talk about sex, which they find embarrassing (Ravesloot, 1997).

The pill not only helps in the treatment of menstrual disturbances, it also enables the girls to plan their menstruation in accordance with events in

their lives such as weekend parties and holidays. It thus serves as an important means of controlling their bodies (Hardon and van Zorge 1998). When a relationship ends and they do not actively engage in sex, most young girls continue to take the pill. It is like brushing one's teeth, they say, a self-evident daily practice. As a result, their menstruation becomes so regular that they know exactly on which day, and usually also what time of day their menstruation will start. The advantages of taking the pill in terms of control over their bodies outweigh the risks that pills have in terms of long-term health effects. The girls consider these risks to be minimal, an assessment that is reinforced by doctors. Better to prevent pregnancy now.

The South African women, paradoxically, associate the pill with forgetfulness, becoming pregnant and loss of control over their bodies. They turn to the contraceptive injection for protection and empowerment. Women's appropriation of *Depo- Provera* in contrast to the pill is linked to socially situated human agency (Gammeltoft, 1999: 6). For the Hout-Bay women, it is the injection that affords a certain amount of freedom and self-autonomy, because it can be taken without their partners knowing. The women complain that the men want more children than they do. By choosing the injection as a form of birth control, these women have both introjected the medical/population-control gaze and re-framed it in terms of their own everyday-life worlds. They relinquish their bodies to medical technology, yet through these actions they are able to free themselves from forced reproduction. Absent in their narratives is the need to control their menstruation, which for the Dutch adolescent girls is such an important characteristic of the contraceptive pill. This is intriguing, as *Depo-Provera* is known to cause menstrual disturbances, which women are unlikely to be pleased with. Apparently, for the Hout-Bay women the benefits in terms of protection against unwanted pregnancy outweigh the disadvantage of menstrual disturbances caused by the injection.

The notion of individual agency is rendered problematic when the wider political and historical context of Depo-Provera as a form of birth control is considered. Despite the cultural patterns discussed the controversy and negative inferences surrounding Depo-Provera and its place in feminist discourse cannot be disregarded. As we have discussed, *Depo-Provera* is a contraceptive method that has been advocated, distributed and popularised in developing countries. It is associated with curtailing the rights of women over their own reproductive processes because it has been used within the framework of coercive family planning programmes (Sciortino and Hardon, 1994; Morsy, 1995; Olu Pearce, 1995; Kaler, 1997). The prior objectives of state family planning policies in South Africa emphasised

demographic imperatives in curtailing the birth rate. The conceptual framework of state health policy has undergone major changes in the post apartheid years with current policy encompassing a broader vision of reproductive health care. Yet injectable contraceptives account for between 66% to 80 % of contraceptive use by African women (Beksinska, *et al.*, 1998). One important reason for this preference is its preventative efficacy, especially in the context of many women's social and economic realities. However, the South African data suggests that the contraceptive injection may be preferred in many communities because it is a "hidden practice" which takes place away from the male gaze in the domestic sphere as against "the pill" a regimen that is visible on a daily basis.

In this paper we have explored issues of embodiment and control in relation to the use of contraceptives. This has implications for the literature on fertility regulation, which frequently does not look at the contraception in its wider socio-cultural and political context. By looking at contraception in two diverse contexts we are able to access issues of female agency and how it can reveal local re-appropriations of contraceptives. Contraceptives not only act upon women's bodies but are also utilised by women themselves to alter and impact on their everyday social worlds.

Medicalization and population control are forces which cannot be denied, and they co-shape women's contraceptive practices, but we have also seen that power is not a possession of particular social groups, i.e. doctors, but that it is relational and more dispersed (Foucault 1980). Power, in fact shifts from one actor to another in the trajectory of contraceptive use. Doctors or nurses in clinics make initial provision, but women decide to visit the doctor and/or attend the clinic to start using. The options for women are limited by what the gatekeepers have to offer and advise. In the Netherlands doctors believe that the pill is the method of choice, and they construct adolescents as responsible users. In South Africa health workers in family planning clinics consider the women to be forgetful, and overburdened, and they prefer to give hormonal injections. Women's embodied experiences in both settings are influenced by these medical actions: Dutch girls rely always on the pill; Hout Bay women consider the injection to be the best option. Once they have initiated use, it is up to women to continue using the methods, or not. We have seen that they choose to come back for repeat prescriptions, because the methods give them control over their lives – in different ways. The contraceptives themselves also exert power, not only because they prove to be effective in preventing pregnancy but also because, in the case of the pill, it's administration allows women to plan their menstruations. Here the biological action of technology con-

tributes to the embodied experience of control that the Dutch girls exert. Without the menstrual regulating potential the technologies would probably be valued much less by the girls. The pill for the Hout Bay women has negative powers, which have nothing to do with its biological action; rather it acts as a screen on which they project the lack of control over their lives.

Our case studies encourage us to rethink issues of control and medicalization. Women clearly are not docile bodies acted on by medical doctors, subjected to governmental population control initiatives or the pharmaceutical forces of industry. They exert agency, which in paraphrasing Giddens (1984: 9) means that at any phase in the contraceptive encounter they could have acted differently. Whatever happened would not have happened if that individual had not intervened. But the choices they have are not unlimited. The actions of our respondents are conditioned by a culture in which the use of the contraceptive pill in the Netherlands and the use of *Depo-Provera* in South Africa is considered self-evident. Medical structures and local cultural configurations constrain our choices and the range of thinkable ideas and conceivable behaviours (Singer and Baer 1995).

The women's health movement has been an important de-medicalising power in the area of contraception. It has shown how family planning programs and medical practices have reinforced state ideologies on the need to reduce population growth and gender ideologies that give women the responsibility for contraception. The movement has developed alternative ideas and contraceptive options, including the use of diaphragms and condoms as dual means of protection against pregnancy and sexually transmitted diseases (*Boston Women's Health Collective* 1998). The movement has contributed both to an increase in options for women, and to a change in medical practice in some countries, where medical students are given courses in how to enhance reproductive choices, fit diaphragms and use condoms. However, these alternative contraceptive options do not appear to have had much effect on the way women in Utrecht/Almeide and Hout Bay use and experience contraceptive technologies.

Notes

(1) Defined as the number of married women or of reproductive age using contraceptives

(2) Csordas (1994) defines embodiment as an indeterminate methodological field defined by perceptual experience and mode of presence and engagement in the world.

(3) We haven't used a common conceptual framework for comparative purposes in the ethnographic case studies. The case-studies were done independently

(4) Depo-Provera (DMPA) given three monthly, *Nur-isterate* (NET-EN) administered two monthly, oral contraceptives *Nordette* and *Triphasil*

(5) The nursing staff alludes to these utterances of forgetfulness as well. Lifestyle issues and poor compliance are cited as the main reasons for the high usage of injectable contraceptives.

(6) Many of the households are female headed, yet social practices around child – rearing and domestic labour within the home are connected to gendered expectations and norms.

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