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Sexual and reproductive health 'choice': women living with contraception

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The Chief Executive Officer of The Victorian Health Promotion Foundation recently acknowledged that in the debate about access to abortion in Australia, pregnancy prevention has dropped off the agenda. He asks "where is the focus on contraception, including emergency contraception?" (Moodie 2007).

For many years in Australia, and much of the rest of the Western world, contraceptive use has been normalised, considered effective and therefore somewhat of a 'closed case' for medical research and society. It is also relatively unquestioned that women bear the major responsibility for societies' expectations about the management of population (re)production. Women in this role are forced to depend upon medical practitioners to access the most effective and commonly used contraception (e. g. the pill, other hormonal contraceptives and tubal ligation).

As women's interaction with contraception largely remains within this medical sphere it is hardly surprising that mainstream contraceptive research is largely directed at patient-compliance. Women's (and sometimes men in the case of condoms and vasectomy) use of contraception tend to be discussed in medicalised language. Contraceptive failure, discontinuation and non-use use are labelled as problems of non-compliance. Marginalised women, teenagers, those who inject drugs, and/or who belong to an ethnic minority are branded the least compliant and most risky in their use of contraception (Armstrong et al. 1991; Catania et al. 1992; Harvey et al. 2006; Lindberg 1998; Tafelski & Boehm 1995; Vidal-Trecan et al. 2003; Weber et al. 2003).

Yet it would appear that most women, not only the 'risk groups', in Western countries such as Australia, the USA and the UK could be placed in the noncompliant basket at some stage of their life as unplanned pregnancy, termination and sexually transmissible infection rates remain common. For example, one U.S. study suggests that about half of all annual pregnancies in the United States are unintended and of these, half occur among women who are using contraceptives (Strauss & Kafrissen 2004). A recent Marie Stopes Foundation study in Australia also shows that 50 % of pregnancies in Australia are unintended (Marie Stopes International 2006). Is this the fault of the user or the technology?

While it is clear that the onus on women to consume contraception brings with it potential freedom from pregnancy and therefore the ability to be able to control their reproductive bodies, it also carries with it contradictory consequences. Only in research that focuses on women's perspectives of their own sexual and reproductive health is the medicalisation of contraception considered a deterrent to access for women (Bissell & Anderson 2005) and the possibility that women are not comfortable with contraceptive technology considered (Keogh 2005a; Keogh 2005b). Social research has found, for example, that women across the globe commonly experience or fear disruption to their perceived 'normal' bodily system with the use of hormonal contraception (Hardon 1997; Woodsong et al. 2004). This is generally played out as disruption to the menstrual cycle which are culturally understood as 'unnatural' and dangerous, particularly when prolonged. Yet

when women discontinue contraceptive use because of these concerns they are again considered non-compliant or their experiences are dismissed as minor side effects (Hardon 1992).
Industry has made advances in reducing the levels of hormones in certain contraceptive methods however it remains the fact that hormonal contraception for women continues to be the primary 'choice' if they wish to avoid pregnancy. This limited development in contraceptive technology maintains women's dependence on medical practitioners to perform and dispense the technology narrowing again the real 'choice' women (and their partners) can express over their sexual and reproductive lives. This is despite research evidence that shows for example, giving women easier access to emergency contraception in advance does not lead to repeated use or to increased risky sex (Ziebland et al. 2005).
This high rate of unplanned pregnancy and termination, and apparent cultural conflict with contraceptive technology suggests that we have reached a plateau in our contraceptive successes. Carl Djerassi, creator of the contraceptive pill, predicted over a decade ago that political and social climates in the Western world combined with minimal interest of the pharmaceutical industry in contraceptive development would limit development to minor modifications of existing methods (Djerassi 1989). This is exactly what we have seen.
Perhaps the most significant shortcoming in the development of innovative contraceptive devices is the failure to understand people's own ideas of reproductive physiology, their own perceptions of how the technology works, and their own cost-benefit analysis of choosing a method (Hardon 1992). If future research (including that which examines microbes to protect against HIV transmission) were to take into account the complex ways in which a new product might fit into a cultural understanding of the reproductive body (whether it is male or female), women's struggle to find a suitable contraceptive strategy may be lessened and perhaps more of the burden of contraception can be redistributed to men.
For all its liberating and advantageous uses, contraception continues to sit uncomfortably in many women's beliefs and attitudes about their reproductive and sexual body. It should not be forgotten that this burden of limited 'choice' lies with women and their bodies and in reviving an interest in sexual and reproductive health we should also question what that means for women and their rights.

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