

“IT’S NOT ABOUT HEALTH; IT’S ABOUT SEX, PUMPKIN”: REPRODUCTIVE
AUTONOMY, MEDICALIZATION, AND CONTRACEPTIVE RHETORIC IN THE WAKE
OF THE WAR ON WOMEN

A Paper
Submitted to the Graduate Faculty
of the
North Dakota State University
of Agriculture and Applied Science

By

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In Partial Fulfillment
for the Degree of
MASTER OF ARTS

Major Department:
English

July 2013

Fargo, North Dakota

North Dakota State University
Graduate School

Title

“It’s Not About Health; It’s About Sex, Pumpkin”: Reproductive Autonomy,
Medicalization, and Contraceptive Rhetoric in the Wake of the War on
Women

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ABSTRACT

The purpose of this study is to better understand the ways in which contemporary women describe their contraceptive needs in the wake of the war on women, primarily in the context of the Sandra Fluke and Rush Limbaugh controversy. After surveying contemporary American women, this study aligns with previous research in finding that the majority of participants describe their contraceptive needs in a variety of ways, but primarily as a means for planning, preventing, or delaying pregnancy. However, women who were not in committed relationships were much more likely to cite medical reasons for their contraceptive use, and much less likely to cite preventing pregnancy than their peers in committed relationships.

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CHAPTER ONE. INTRODUCTION

In the United States, there is great debate and discussion regarding women's reproductive rights. While, historically, elements of women's reproductive rights, such as abortion, the pill, and various contraceptive devices, have been topics of heated discussion, in contemporary American culture and politics, this topic seems to be especially heated, as a new round of laws and proposals have been introduced that limit women's reproductive rights and access to birth control methods previous generations fought so hard to gain. These various measures that attempt to limit or void established women's rights have been identified by the political left as the war on women. It is within this context that my study emerges. In this study, I will analyze women's rhetoric, regarding contraceptives, in the context of the war on women.

The "war on women" is a highly politicized phrase that first appeared in the 1991 book *Backlash: the Undeclared War Against American Woman*, by Susan Faludi. In her book, Faludi argues that although women at the close of the 20th century were viewed as having "made it," as the fight for gender equality had supposedly been won, many political events of the late 1980s and early 1990s suggested otherwise, as a political and media backlash against feminism, along with the emergence of the New Right, seemed to attack the women's rights that previous generations fought to gain (18-32). Faludi specifically details this in her chapter entitled "The Politics of Resentment: The New Right's War on Women." In this chapter, Faludi discusses the emergence of the New Right in the late 1980s, when New Right leaders accused feminists of attacking the traditional American family. One such leader was political activist, commentator, and the father of the New Right, Paul Weyrich, who proclaimed that feminists "'believe that the future for their political power lies in the restructuring of the traditional family, and particularly in the downgrading of the male or father role in the traditional family'" (Faludi 255). According

to Faludi, to attack the so-called degradation of the traditional American family, the New Right initiated the Family Protection Act of 1981.

In the 1981 article “The Family Protection Act,” published in *The Boston Globe*, the author explores the bill initiated by Republican Senators Roger Jepsen and Paul Laxalt. The *Globe* writes that, according to Jepsen, the bill was intended to save and instill basic family values that were degraded and threatened by “government intrusion and growing secular humanism” (“The Family Protection Act”). However, closer inspection of the bill shows that the bulk of the initiatives are a blatant attack against women’s rights. In Rhonda Brown’s 1981 editorial, “Blueprint for a Moral America,” published in *Nation*, she writes that, “The Family Protection Act...seeks to strengthen the family by codifying the role of women” (630). Various examples of this include ending federal funding for what Brown defines “progressive education,” that attempts to diminish traditional gender roles, along with attempts to limit the intermingling of sexes in sports (630). In addition, politicians in favor of this bill sought to deny federal funding to any program that offers contraceptives, abortion, or venereal disease treatment to minors, while also encouraging women to stay at home through tax incentives (631). Proponents of this agenda sought legal means to “encourage” American women to stay in the home, as pregnant mothers and named that role “moral.”

While the phrase “the war on women” is roughly twenty-two years old, many of the arguments Faludi makes have emerged again in our contemporary culture. In Ruth Conniff’s 2012 article “The GOP War on Women,” she not only uses the term, but also highlights various initiatives introduced by the Right that attack women’s rights. According to Conniff, some of these measures include “bills to let employers decide which forms of medical care their employees should be able to access, a return to failed abstinence-only sex ed programs, and bills

requiring new hoops to jump through for women seeking abortions” (9). In more depth, Conniff also describes the 2012 initiative proposed by Texas Governor Rick Perry, one that would make illegal women’s health funds to going to Planned Parenthood, which Coniff describes, “provides health care to forty percent of the 130,000 women” enrolled in Medicaid Women’s Health Care program (9). Across the country, other bills and ballot initiatives have been ignited by the organization Personhood, in the attempt to pass personhood laws, in which human embryos are defined as persons, and given the same legal rights as human beings. In the *Newsweek* article “War of the Wombs,” Abigail Pesta writes that, although Personhood has been around since the 1970s, the group has increasingly gained support, as they have helped initiate twenty-two personhood bills and ballot initiatives across the country.

Yet one of the most talked about examples of the war on women occurred in the spring of 2012, as President Barack Obama introduced a section of the Affordable Care Act, which would require employers and institutions, including those with religiously affiliations, to offer contraceptive coverage through their insurance companies. On February 12th, 2012, a panel comprised of twelve religiously affiliated men testified during a congressional meeting, regarding this act. While this initiative created much controversy, the representation of an all-male panel arguably received far more attention, because women, including Georgetown Law student, Sandra Fluke, were denied the opportunity to testify about why women need contraceptive coverage. Proponents of this section of the Affordable Care Act argued that women should have a voice in the issue of contraception, since they are often the ones most affected by pregnancy, while the act’s opponents argued that the root of the conflict regarded the infringement of religious freedom. Regardless, the lack of women represented at the hearings did not go unnoticed and various members of congress walked out in protest (ABC News). Although

Fluke had been denied the right to testify, eleven days later she spoke before the Democratic Policy Committee in a testimony that would spark a number of personal, sexualized rhetorical attacks by members of the right wing media.

On February 23rd, 2012, Sandra Fluke testified before the Democratic Policy Committee advocating the reasons why women need contraceptive coverage. In Fluke's testimony, she argues that women, like herself, who are denied insured contraceptive coverage through religiously affiliated employers, face "financial, emotional, and medical burdens." To evoke these burdens, Fluke provided stories and examples of women who have experienced struggles in not receiving contraceptive coverage.

To begin her testimony, Fluke shared the story of a fellow married student who had to quit taking contraceptives because she could no longer afford them. She then expressed the powerlessness and shame this woman felt when she could not pay for contraceptives at the pharmacy, and had to walk away empty-handed. While this story focuses on the economic burden to women needing access to contraceptives, the bulk of Fluke's argument expresses the medical reasons why women need access to affordable contraceptives. Fluke argues that, "In the worst cases, women who need the medication," for situations other than preventing pregnancy, "suffer dire consequences" (Fluke). Fluke then goes on to tell the story of another Georgetown student who suffers from polycystic ovarian syndrome. Fluke states that, "After months of paying over \$100 out of pocket, she couldn't afford her medication anymore and had to stop taking it." Because of this, a massive cyst formed on her ovary, and she had to undergo surgery to remove the entire ovary.

Although Georgetown insurance policies covered contraceptive needs that were considered medical, and not for the intention of preventing pregnancy, Fluke argues that other

religious institutions do not have such a policy. Furthermore, Fluke argues that women who need contraceptives for medical reasons, such as polycystic ovarian syndrome or endometriosis, are interrogated by insurance companies, employers, or university administrators, because they must prove that their purpose in obtaining contraceptives is medical and not to prevent pregnancy. This is both an affront to privacy rights and a time consuming process. Fluke argues, “When they do exist, these exceptions don’t accomplish their well-intended goals because when you let university administrators or other employers, rather than women and their doctors, dictate whose medical needs are legitimate and whose aren’t, a woman’s health takes a back seat to a bureaucracy focused on policing her body.” In other words, contraceptives are not only a matter of health, but are also a matter that should, like other medical issues, be private—between women and medical professionals—not the purview of insurance companies or employers.

While the message and tone of Fluke’s testimony highlighted various medical reasons why women need access to contraceptives, what ensued was not merely resistance to Fluke’s argument, but sexualized, personal, rhetorical attacks against Fluke herself. On February 29th, 2012, conservative and controversial radio talk show host Rush Limbaugh used Fluke’s testimony as his topic of discussion. Limbaugh, who is known for approaching, as Conniff writes, “the absurd with absurdity,” was not new to controversy, or the type of bullying rhetoric towards women that emerged (1). Limbaugh, whose audience is seventy-two percent male, popularized the phrase “feminazi,” in his book *The Way Things Ought to Be* (Conniff 1). However, Limbaugh’s February 29th broadcast regarding Fluke’s testimony seemed to have crossed a new line. At the core of Limbaugh’s attack was an attempt to sexualize Fluke’s testimony and the use of contraceptives, by identifying Fluke as a “slut” and a “prostitute” (ABC News). Moreover, Limbaugh argued that if taxpayers were to pay for contraceptive coverage,

then they should be considered her “pimps,” and they should be getting something in return for their money, or video coverage of her sexual acts. Following Limbaugh’s broadcast, various news stations played clips of the broadcast. ABC News, for example, played the following:

What does it say about the college co-ed Susan [*sic*] Fluke, who goes before a congressional committee and essentially says that she must be paid to have sex, what does that make her? It makes her a slut, right? It makes her a prostitute. She wants you and me and the taxpayers to pay her to have sex. She’s having so much sex she can’t afford the contraception. She wants you and me and the taxpayers to pay her to have sex. What does that make us? We’re the pimps.

By associating Fluke as a “slut,” “prostitute,” and the taxpayers as her “pimps,” Limbaugh attempts to weaken Fluke’s argument by associating her as someone who is sexually deviant, and more specifically, sexually overactive. Furthermore, while Limbaugh’s coverage of Fluke’s testimony was a personal attack against Fluke, it was also inaccurate, as this aspect of the Affordable Care Act would not require taxpayers to cover the expense of contraception.

Although Limbaugh’s response to Fluke’s testimony received the most mainstream media attention, a variety of other political commentators, such as Glenn Beck, also focused on the issue. Although Beck’s argument against Fluke’s testimony received less attention or criticism, his message was the same. On the February 29th radio broadcast of the Glenn Beck program, Beck and his co-hosts echo Limbaugh’s argument that a woman’s need for contraception is due to an overly active sex drive. During this broadcast, Beck and his co-hosts play clips of Fluke’s testimony. When Fluke argues that one should not have to compromise education with the need for contraceptive coverage, Beck and his co-hosts argue that one needs to “make it” in America by obtaining an education, but that one does not need to attend a religiously affiliated university to do so. At this time, Beck proclaims, “She can make it. She can make it a lot. She’s making it aaaaall the time,” insinuating that she was “making it” sexually (Glenn Beck Radio Program).

Furthermore, Beck uses similar language to Limbaugh's by associating Fluke as a prostitute, taxpayers as her pimp, and claiming that she wants be paid to have sex "in every position" (Glenn Beck Radio Program). Beck even goes as far as to not only attack Fluke, but also the women she advocates for in her testimony. When describing her peer who realized her contraception was not covered at the pharmacy, and the embarrassment she endured, Beck shouts, "Attention shoppers in aisle 10. This skank standing here cannot afford contraception...Sandra Fluke wants to make it with her boyfriend tonight" (Glenn Beck Radio Program). The solution to this issue, according to Beck, is simple: to not have sex. Furthermore, although the core of Fluke's argument advocates for the medical reasons why women need contraceptive coverage, Beck dismisses her argument and states that, "It's not about health. It's about sex, pumpkin" (Glenn Beck Radio Program).

As I watched these events unfold through various media outlets, I began to ask myself many questions. If Fluke's argument advocates the importance of contraceptives as primarily a form of medicine for conditions such as the case of her peer suffering from endometriosis, why are attacks against her argument sexual? Furthermore, are medical disorders primarily the reason why women need access to contraceptives? Do contemporary women talk about their own contraceptive needs as medical? While a number of women use contraceptives for noncontraceptive purposes, i.e. not as a form of pregnancy prevention, studies indicate that the primary reason women use contraceptives is pregnancy prevention. In the 2011 study "Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills," author Rachel K. Jones reports that while more than half of women who use oral contraceptives report experiencing medical benefits, such as less painful periods, regulated periods, or acne treatment, the majority of women reported using birth control pills primarily for pregnancy prevention (4). In fact,

according to Jones' study, 86% of women who use the pill indicated birth control as the primary reason for taking it (3). In 2013, does this notion remain true? In this study, I will build off of Jones' findings to better understand the ways in which contemporary women describe their contraceptive needs, primarily in the wake of the war on women.

From Jones' research, it is evident that many American women, perhaps even the majority, describe their contraceptive needs as primarily to prevent pregnancy. However, in Fluke's testimony, the argument that women need access to contraceptives for pregnancy prevention was highly overshadowed by her emphasis of the medical reasons why women need access to contraceptives, such as endometriosis. She therefore did not articulate the overwhelming and evident social and economic benefits that access to contraceptives provides.

In the Guttmacher Institute's March 2013 article, "The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children," Adam Sonfield, et al. pull data from an extensive literature review of research regarding the impact of family planning, spacing, or delaying pregnancy (Sonfield et al 6). From this study, the authors conclude that when women have access to contraceptives, the benefits for women include a higher chance of educational attainment, professional establishment, advancement, and financial stability. Furthermore, the authors found that in addition to receiving a higher education, and professional advancements, women who delay pregnancy also have a higher chance of mental health and happiness, because they are less likely to suffer from depression and anxiety (21). Along with the wellbeing of mothers, the authors also argue that planned pregnancies improve the wellbeing of children. The authors write, "carefully timing and planning a family allows people to prepare themselves for parenthood" (23). This timing and planning includes prenatal health, healthy behaviors, maturity, and wisdom (23). While this study provides valid and crucial arguments

regarding the importance and benefits of women having access to contraceptives, Fluke did not mention these reasons in her testimony.

Because these aspects stand out as key components as to why women need access to contraceptives, their absence in Fluke's testimony seemed alarming to me. However, in analyzing the history of contraceptives, and their legality, it becomes clear that perhaps their omission was a rhetorical move. Historically speaking, contraceptives have been more easily accepted when supported and controlled by the medical community. In fact, contraceptives did not become legally, widely accessible until the medical community became involved in their distribution. It seems that in keeping the focus on medicine, Fluke perhaps anticipated resistance, and framed an argument that she believed would be more easily accepted. However, does framing advocacy for women's access to contraceptives in a medical context advocate effectively for women's reproductive autonomy?

As previously mentioned, the legality and accessibility of contraceptives was not effectively established in the United States until the medical community supported and controlled their distribution. This process, by which tools available for nonmedical purposes (such as contraceptive devices), along with natural processes, both come under the control of the medical community, is known as medicalization. Although the history and ramifications of the medicalization of birth control will be reviewed in the literature section, it is crucial to first understand what medicalization is. In Peter Conrad's "Medicalization and Social Control," he defines medicalization as "a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (209). These non-medical problems are then placed under medical supervision, and treated in a medical manner (210).

Conrad notes that this term is typically used in non-neutral terms, because “medicalization” is primarily used as a critique, or in terms of overmedicalization.

While there can be benefits to medicalization, as in the case of medicalization leading to the legality of contraceptives, there are also negative consequences for bodily autonomy. Foucault’s 1963 work, *The Birth of the Clinic: An Archaeology of Medical Perception*, for example, explores these ramifications. In his work, Foucault defines “the medical gaze.” This notion, which he argues emerged in the late 17th century, is a concept that dehumanizes the notion of “the patient,” so that the body of the patient is separate from the person’s identity. According to Foucault, “This patient gaze has even been attributed with the power of assuming—with the calculated addition of reasoning (neither too much nor too little)—the general form of all scientific observation” (11). In other words, although the patient is human, he or she is viewed in the same manner as all scientific observations, as objectively as possible. To further identify this medical gaze, Foucault quotes J. –Ch. Sournia’s *Logique et morale du diagnostic*, who writes that in order to effectively treat a patient, “We ‘observe’ him in the same way that we observe the stars or a laboratory experiment” (Foucault 11). As we will explore later in the literature review, this scientific stance poses a problem when it comes to contraceptives, as a woman’s identity, her gender, her economic status, her race, her age, highly influence her contraceptive options and access.

In addition to the separation of identity from the patient, Conrad echoes Foucault, primarily regarding what Foucault identifies as medical surveillance, of which Conrad writes, “physicians may legitimately lay claim to all activities concerning the condition” (216). Through this control, and the set of attitudes that encourage it, more problems begin to occur as the decisions, options, and overall power, fall into the hands of physicians. In regards to

contraceptives, this is a problem because, ultimately, a woman's contraceptive options lie in the hands of her physician, and not herself. Furthermore, the medical community is a deeply patriarchal system, in which men have historically held authority.

While the medicalization of contraceptives resulted in their legality, it has also put women in a difficult place, as many women do not have access to the medical resources needed for accessing contraceptives, for various reasons that will be explored in the literature review. Furthermore, in the political context of the war on women, advocates for contraceptives, such as Sandra Fluke, often focus advocacy on the medical benefits of contraceptive access, ignoring the more politically charged social and economic reasons women need access. Today, even when advocating primarily the medical benefits of contraceptives, the backlash is often personal and sexual.

This paper explores how young women using contraception today rhetorically frame their reasons and experiences. The paper that follows is divided into four chapters, beginning with chapter 2, a literature review outlining the historical context and rhetoric surrounding the development, legality, and medicalization of birth control in the United States. This chapter also explores medicalization and Sandra Fluke's testimony in more depth, a discussion from which my research questions emerge. The next chapter, three, is a review of the methods used to conduct the study, to better understand the ways in which contemporary women describe their birth control needs. Following that, chapter four describes and analyzes of the results of the survey used to conduct the study, and finally, chapter five discusses of the results of the survey, returning to the central research questions that framed it.

CHAPTER TWO. LITERATURE REVIEW

As a whole, this chapter offers an overview of the long history of contraceptives, primarily focusing on the development of their legality, and the implications of this development. This historical overview will describe why contraceptives are often sexualized today, and will describe how contraceptives became medicalized. This chapter is divided into four sections: (1) the historical context of contraceptives; (2) the Comstock Law and the legality of contraceptives in the United States; (3) the impact of the medicalization of women's bodies on autonomy; and (4) the research questions that guide this study.

Historical Context

The development of contraceptive methods has been considered one of the most revolutionary developments of the modern world. When the pill, for example, first emerged on the U.S. market in 1960, its popularity among women spread rapidly, despite controversy. After one year on the market, 1.2 million women relied on the pill to prevent pregnancy, and within five years, the number more than quadrupled to six and a half million married women. It is not reported how many unmarried women were taking the pill, as that information was not documented in official reports (Watkins 34). According to Elizabeth Siegel Watkins' *On the Pill: A Social History of Oral Contraceptives 1950-1970*, the pill has been categorized as having a cultural impact equal to "the discovery of fire and the developments of tool-making, hunting, agriculture, urbanism, scientific medicine, and nuclear energy" (1). Decades later, journalists continued making this observation. In the 1992 article, "The Age of the Thing," published in *The Economist*, the pill was ranked as "one of the seven wonders of the modern world" (1). Some scholars even argue that this contraceptive development was so remarkable, as to divide reproductive history into "before and after the pill" (Maogoto and Anolak 2).

While the development of various contraceptive methods, such as the pill, may seem relatively modern, the notion of controlling one's fertility is not. In the article "The Pill—A Rose Ringed by a Thorn Bush? Stirred but not Shaken; Past and Present Ramifications," scholars Jackson Nyamuya Maogoto and Helena Anne Anolak trace the development of contraceptives throughout history. According to the article, the development of contraceptives dates back to the ancient Egyptians, who referenced a bullet-shaped device made of crocodile droppings, honey, and fermented dough, which was inserted into the vagina, to dissolve and release into the body from one's own body heat. Scholars have also found evidence of the classical Romans using silphium, a north African plant commonly used in medicine and cooking, as a method of avoiding pregnancy (1). During the Aristotelian period, women applied olive oil to their cervixes before engaging in intercourse, a method that was proven to provide a zero percent pregnancy rate, out of 2,000 cases, in a 1931 study (Tone 14). By analyzing the various means and methods women have utilized as birth control, one can see that avoiding pregnancy and planning one's family have been of concern, historically, for a variety of reasons.

While these various methods of birth control existed to avoid pregnancy, they were often used as a way to hide love affairs, whether it was an extramarital affair, prostitution, or sex outside of marriage. According to Maogoto and Anolak, "The illegitimate birth rather than the affair was what attracted the heaviest shame and stigma" (1). This, therefore, historically set the tone for those in opposition of contraceptives, as contraception was not only associated with, but also allowed for, promiscuity to go unnoticed and unpunished. Although the intention behind birth control was often associated with promiscuity and illicit affairs, Maogoto and Anolak argue that advancements in science during the 19th century helped to advance and popularize contraceptives, although they were not legal, because modern medicine decreased infant

mortality rates, population increased, and birth control methods spread to the married upper classes (1). Along with these changes, reproductive science became an integral part of biology studies, thus acknowledging birth control as something scientific, and not just a means to cover up promiscuity (2). Although these factors may have helped shift the tone of birth control from promiscuity to family planning and medicine, the stigma that the usage of contraceptives equaled promiscuity remained. We can see this through the struggle in legalizing contraceptives, and yet today, as those in opposition to contraceptive access portrayed Sandra Fluke as promiscuous.

The Comstock Law and the Legality of Contraceptives

Although contraceptive use dates back to the early Egyptians, their acceptance and legality in the United States was a long, arduous fight, due to the Comstock Law. This was a law introduced in 1873 by Anthony Comstock, a politician, United States Postal Service inspector, and devout Congregationalist who dedicated his work to upholding morality and purity in America. This law ultimately made the distribution, and selling, of information about birth control and contraceptive devices illegal. While the law was not focused on birth control alone, its purpose was to tighten any loopholes from a previous law, which made the distribution of what were considered “obscenities” a crime (Tone 5). Typical “obscenities” were crude novels, pamphlets, and pornographic photographs that circulated through the mail (Tone 5). By 1873, any material about birth control, or contraceptive devices themselves, fell into this category. Much as it had been framed in previous cultures, the rhetoric against distributing information about birth control was related to controlling female promiscuity.

While the Comstock Law defined contraceptives as obscene devices, birth control proponents and activists fought for their legality. Leading this fight was Margaret Sanger, birth control activist, and founder of Planned Parenthood. Sanger’s passion and involvement grew out

of her experiences and observations of late nineteenth century life. Sanger, born in 1879, in Corning, New York, was the middle child of 11 siblings. She endured a childhood of poverty and struggles, including witnessing her mother's eighteen pregnancies, seven miscarriages, and ultimate death in her early forties (Wardell 737). In addition to her childhood experiences, author Emily Taft Douglas, author of *Margaret Sanger: Pioneer of the Future*, argues that Sanger's work as a nurse highly influenced her activism. Sanger became a nurse who primarily worked in poor neighborhoods, where she often encountered women who had many children, and who also experienced both miscarriages and abortions (Douglas 30). Many of these babies were born to parents who not only did not have the resources to care for another child, but who did not want another child (30).

It was these experiences that sparked Sanger's activism in not only the legality of, but also the access to, birth control for all women. However, in order to accomplish these social changes, Sanger had to fight both the stigma— notion of promiscuity, which had become associated with contraceptives—as well as the Comstock Law. In 1914, Sanger published *The Woman Rebel*, a journal that coined the term “birth control,” and as Tone writes in *Devices and Desires*, “demanded legal contraception and full woman's rights” (118). After the U.S. Post Office deemed *The Woman Rebel* obscene, Sanger began writing *Family Limitation*, a pamphlet that taught women how to use douches, condoms, and cervical caps, and encouraged them to teach other women how to do so as well. According to Tone, “Sanger envisioned a world of grassroots birth control where women from all walks of life could use contraceptives without reliance on doctors” (118). However, this approach ultimately failed, as *Family Limitation* resulted in the arrest of Sanger's husband for the distribution of the pamphlet (118).

Sanger made little progress in her fight until she traveled to London and the Netherlands to tour contraceptive clinics. In Holland, Sanger met Dr. Aletta Jacobs, a physician who, according to Tone, firmly believed in “the need for physician control over the distribution of contraceptive information and technology” (121). In Holland, Sanger learned the methods of the medical clinic’s distribution and prescription of birth control, primarily the diaphragm, in which patients received a pelvic exam, measurement of the diameter of the vagina, selection of a diaphragm, and instruction of insertion. The clinic also required that women show their doctors that they were able to insert the diaphragm themselves successfully before leaving the clinic (121). This was very different from the distribution that Sanger had envisioned, in which women were given pamphlets with instructions, and over-the-counter contraceptives.

Nevertheless, it was the medical method Sanger adopted in order to not only successfully distribute contraceptives, but also, to change the sexual stigma surrounding them. Because contraceptives were historically associated with promiscuity, medicine became the new rhetoric of contraception. What was once a movement about making birth control accessible, universal, and ultimately in the hands and control of women, became a movement to shift control into the hands of physicians, and to exempt them from obscenity laws that might challenge them. Rhetorically, contraceptives became an issue not of sexual reform, or autonomy, but rather, medicine. However, by adopting the medical method and rhetoric of contraceptives, Sanger did not change the promiscuous connotations that go along with them, primarily for women. Again, this is evident in our contemporary culture.

Although support from the historically patriarchal medical community ultimately resulted in the legalization of contraceptive devices, the medicalization of women’s birth control has put women in a difficult place, as it limits many women’s access to the types of contraception they

desire. The ways in which this medical control of the distribution of contraception and information affects women most directly can be seen in a direct comparison to the distribution of male contraception, through condom availability, which is nearly like the utopia Sanger envisioned, with grassroots knowledge shared among men, and availability regardless of age, over the counter and even in public men's rooms. We cannot envision men being required to demonstrate their mastery of a condom at a clinic before they would have prescription access.

Why Is Medicalization a Problem?

While the medicalization of contraceptives was the pivotal move in their legalization in Western Europe and the United States, it ultimately affects women's reproductive autonomy, and the ways in which we advocate for women's access to them. Today, we follow the same doctor-patient routine, in which many physicians require that a woman must receive a pelvic exam prior to being prescribed a type of birth control, such as the pill. While the medical community has arguably advanced the contraceptive options for women, the control over one's contraceptive options lies in the hands of one's physician. Furthermore, if advocates for contraceptives rely on the medical community for validity, as Sanger and Fluke did, the social and economic reasons why women need access to contraceptives are often overlooked. This rhetorical choice also requires us to frame contraception as a primarily individual choice, not a matter of public good.

The primary issue that emerges from the medicalization of contraceptives is that physicians have the capability to not only prescribe contraceptives, but also deny them. If, for example, a physician's religious belief prohibits the use of contraceptives, the physician may deny the patient the type of contraception she desires (Purdy 288). This is especially an issue when it comes to the topic of sterilization, as women can be denied certain procedures based on age and number of offspring. L. Purdy describes this issue in her article "Women's Reproductive

Autonomy: Medicalisation and Beyond.” She argues that cultures that limit women the rights to sterilization are as equally in violation of women’s human rights as those that enforce involuntary sterilization. Purdy writes that when women seek sterilization, they can be “subjected to various limits based on their age and number of children” (288). Therefore, if a young woman chooses not to have children, she can be denied the procedure, merely because of her age and childless state.

Another problem that emerges with the medicalization of contraceptives is that this structure keeps some women from having access to contraceptives as they may choose not to receive a pelvic exam, or they simply may not have the financial resources to do so. Purdy also writes that poverty is one of the main factors that affect women’s reproductive autonomy. Although some may argue that there are options for low-income women, such as women’s health clinics, or Planned Parenthood, these facilities are often threatened by political initiatives to defund, or close them down (Conniff 9). Additionally, they can be stigmatized by the presence of protestors, and are often geographically distant from women needing their services. As a whole, as long as the medical community controls the distribution of contraceptives, there will be women who simply do not have access to various methods, because they cannot afford exams, products, or travel.

While one cannot argue that all aspects of contraceptives fall into the medical sphere, and that advancements in medicine have improved the options for women regarding birth control, the problem that often occurs is that medicalization overlooks the social, economic, and political constraints that require action to enable the well-being of women. In Laura Purdy’s “Medicalization and Feminist Medicine,” she writes that while medical intervention and advancements have helped many women, it is often political action and organizations that

advocate the wellbeing of women. However, in the political spectrum, contraceptives have been more easily accepted when framed in a medical context. We can see this in both the work of Sanger, and the way that Fluke constructed her testimony. However, when sexualized attacks such as Limbaugh and Beck's occur, we must question, is this rhetorical move effective? Furthermore, is it really about health, or is it something more? As we can see from the literature provided, there are a number of reasons why women need and should have the right to birth control. However, do contemporary women talk about these reasons? It is this context, and these questions that lead me to this study.

Research Questions

Specifically, I explore the ways in which contemporary women describe contraceptive needs in the wake of what has been called the war on women, primarily in the context of the very publicized attacks against Sandra Fluke. I am further analyzing whether contemporary women tend to describe their contraceptive needs as medical, or as about planning, delaying, or preventing pregnancy. Furthermore, I am researching whether or not relationship status with one's PIV (penis in vagina) partner will affect this description. My hypothesis is that women who are not in committed or monogamous relationships will perhaps describe their contraceptive needs as medical, as a way to avoid personal and sexualized backlash. By rhetorically analyzing the ways in which women describe their contraceptive needs, we can hope to better understand the reasons women need access to contraceptives, along with the ways in which the context of the war on women might affect this description. Furthermore, we can possibly begin to encourage a new rhetoric, in which contraceptive proponents advocate the many reasons women need access to contraceptives, which are not merely medical.

CHAPTER THREE. METHODS

This chapter is a review of the methods used in conducting the study, and is split into three categories, including (1) a description of the survey; (2) the methods used in distributing the survey; and (3) a description of the ways in which the data has been analyzed.

Instrument

To better understand the ways in which contemporary women describe their contraceptive needs in the wake of the war on women, I have used a mixed methods approach, combining both qualitative and quantitative methods. The data utilized in this study is obtained from an online survey comprised of both multiple option and open-ended questions. The ten multiple option questions are designed to better understand demographic information about contemporary women, ages 18 and older, and their experiences in using various methods of contraceptives. The demographic information drawn from this portion of the survey includes, age, relationship status, types of birth control used, and the levels of agreement concerning the reasons for using various forms of contraceptives, including pregnancy prevention, family planning, and medical reasons, such as endometriosis, acne, and lighter periods, which are often considered common reasons that women might use certain forms of contraception. As a whole, these questions are designed to look at the big picture of women's descriptions of their contraceptive needs, and to better understand the ways in which a woman's relationship status to her PIV partner might affect that description. The two open-ended questions are designed to gather in-depth data that I coded for emergent categories to better understand the language women use to discuss their contraceptive needs (see appendix A).

Survey Distribution

Upon receiving IRB approval, I distributed the survey. To do this, I applied the snowball, or chain referral, sampling method. In this method, the researcher selects an initial set of participants, who may or may not take part in the study, but who also function as a link in referring the study forward, to another set of potential participants. Although this method is not without bias, as the researcher must select the initial wave of participants, various scholars have analyzed the benefits of using this method. Sociologist Douglas D. Heckathorn analyzes the effectiveness in his article, “Respondent-Driven Sampling II: Deriving Valid Population Estimates from Chain-Referral Samples of Hidden Populations.” Heckathorn notes that although there is bias due to the researcher’s selection of the first wave of participants, this method is proven to be effective in surveying groups that are considered hidden populations, such as “injection drug users, men who have sex with men, and the homeless” (1). These hidden populations are typically difficult to identify, due to stigma within their communities. In the case of this study, it is difficult to identify women who are using, or have used contraceptives, as that aspect of one’s life is often private, and may be associated with stigma, as we have seen in the case of Sandra Fluke.

To distribute the survey, I uploaded the link to my online survey to my personal Facebook page, and requested that women, ages eighteen and older, take the survey and share the link on their own pages. I also requested that those who could not, or were not, willing to participate, share the survey as well. From this method, twenty-seven participants shared the survey from the initial link. From there I was not able to track how many more shares occurred. In addition to utilizing social media, such as Facebook, I also e-mailed the survey using the

NDSU English Department ListServ, and requested the same process be followed. I was not able to track how many participants forwarded the survey in this case.

Data Analysis

Upon closing the survey, I analyzed both the quantitative and qualitative data to better understand the ways contemporary women describe contraceptive needs. To begin, I started with the quantitative data to take a big picture look at the data. Because the purpose of this study is to better understand the ways in which women describe their contraceptive needs, and the ways in which a woman's relationship status might affect this description, I filtered the data, so that I could analyze participants' responses based on relationship status to one's PIV (penis in vagina) partner. Therefore, the question, "If you engage in PIV, how would you describe your relationship to your current PIV partner(s)?" was filtered so that I could analyze and compare the ways in which women who identified their PIV partner as "one committed partner" describe their contraceptive needs to all other PIV relationships, which included "multiple casual partners," and "a single casual partner."

In addition, I coded the data from the survey's two open-ended questions for emergent categories. The first question was a supplemental question in which participants could share contraceptive methods they had used or are using that were not provided as an option in the survey. The other question was provided at the end of the survey, as a way to gather supplemental data, and was framed as, "Is there anything else you want to say about these topics?" This question was included to gather the rhetoric women use to describe their contraceptive needs and experiences.

To guide the analysis of the qualitative data, I utilized the methods identified in Juliet Corbin and Anselm Strauss' *Basics of Qualitative Research*. Specifically, I applied the "looking

at language” method, in which I analyzed the ways in which participants use language to discuss birth control. According to Corbin and Strauss, “Examining how respondents use language can tell us a lot about a situation” (82). For this study, the language can help us better understand the ways in which women discuss contraceptives, and also the types of experiences women have had obtaining and using contraceptives. In addition, I applied a feminist rhetorical interpretation, specifically influenced by the context of the war on women. In Faludi’s *Backlash*, she defines feminism’s agenda as asking, “that women be free to define them-selves—instead of having their identity defined for them, time and again, by their culture and their men” (32). While there are a number of feminist scholars whose work would be applicable, I found this definition particularly key, as the war on women and the response to Sandra Fluke’s testimony demonstrate how patriarchal culture attempts to wrestle the right to self-definition from women, just as surely as it works to limit self-determination.

In coding the data, I first read through the survey responses in their entirety to grasp an understanding of the data as a whole. Next, I focused on the open-ended responses, analyzing the data for words or phrases that were of interest, unique, or that emerged frequently. I then read through the data a second time, analyzing the language, while developing categories. Next, I read through the data a third time to merge like categories together. To ensure soundness in this process, I then met with my advisor for a debriefing session, in which I presented the list of codes I had developed. We then coded the data together, looking for similarities and differences. From this debriefing session, we developed additional categories that emerged, and grouped categories that were similar together. Following this session, I coded the data one additional time.

CHAPTER FOUR. RESULTS AND ANALYSIS

This chapter explores the results and provides analysis of the data; it is also split into two sections: (1) quantitative data; and (2) qualitative data. The first portion of the chapter analyzes the quantitative data from the survey, primarily in regards to whether participants provide medical, or planning, delaying, or spacing pregnancy as their reasons for using contraceptives. The second portion of this chapter focuses on the qualitative data, primarily discussing the codes and themes that emerged from the open-ended questions of the survey.

Quantitative Data

As a whole, 563 participants started the survey, although not every participant answered each question, and the 23 male and transgender participants who started the survey were not included in the data. Because the purpose of the survey was to better understand the ways women describe their contraceptive needs, only female participants were recruited, and participants who selected “male” or “transgender” were directed to the end of the survey. Because all male and transgender participants were not allowed to complete the survey, and women participants had the option of not answering every question, the sample size for each question was not 563. Around 70-80 participants opened the survey, but answered no questions. Regarding the closed-ended questions, aside from gender, the sample size ranged from 484 participants to 181 participants, although more than four hundred participants answered nearly every question.

From the data, 540 participants were female, 21 were male, and two were transgender. Nine participants did not answer. Of the participants, 484 women revealed their age, and were closely distributed in ranges from 18-26 (135); 27-30 (103); 31-35 (116) and over 36 (130). In addition, 484 women revealed their sexual orientation. The majority of participants, 410, or 72%

identified as heterosexual, while 55, or 10%, identified as bisexual. Six participants, or 1% identified as lesbian. Thirteen participants, or 2%, also selected the “Other, please describe” option, and sample responses included queer, asexual, bicurious, pansexual, and panamorous.

In addition to this demographical information, participants were asked if they engage in PIV (penis in vagina) sexual activity. Of the 480 participants who responded, the majority responded that they do engage in PIV sexual activity. Four hundred and twenty-seven, or 89%, of participants selected yes, while 53, or 9%, selected no. Ninety-two participants did not answer this question, and seem to have left the survey at this point.

In addition to these demographics, participants were also asked information regarding relationship status, and their relationship status to their PIV (penis in vagina) partner(s). More than half of the participants identified as being in some type of committed relationship. Regarding relationship status, 481 participants responded. Many participants (242 or 42%) were married, while 86, or 15%, were in a committed relationship. Sixty-eight, or 12%, were single, and 21, or 4%, were dating. In addition, seven participants, or 1 percent, were divorced, and two participants, or 0.35% were widowed. Participants also had the option to select “Other, please describe.” Five participants selected this option, which included “polyamorous,” two participants who responded “married, but polyamorous,” “In between ‘single’ and ‘committed relationship’ – beginning of possible committed relationship,” and “committed relationship until yesterday” (see Table 1, Appendix B). Regarding the relationship to one’s PIV partner, a large majority (370 participants or 65%) surveyed having one committed PIV partner, with 99 offering another relationship status. In addition, thirteen participants completed the “Other, please describe” option, in which participants described that they were not currently sexually active, but had been in the past, were in open relationships, were with one committed partner, but not engaging in

sexual activity, or that they currently had multiple committed partners (see tables B.2 and 3.B, appendix B).

Along with these demographics, participants were also asked to select the types of contraceptives they had used, or were currently using. Of these questions, participants were allowed to select more than one option, as many women change birth control methods in their lifetime, or use more than one method at a time. These various types of contraceptives were split into three categories, and participants were to select the types of contraceptives they have or had used. The first category was split into what are considered barrier methods, along with the options of “I don’t use birth control,” and “I don’t need to use birth control, as I do not engage in PIV.” Four hundred and thirty-seven participants responded to this question. Of the 437 women, 47, or 8% did not use birth control, and 21, or 3.5% did not need to use birth control, as they were not engaging in PIV. Regarding various barrier methods, the majority of women, 395, or 66%, have used a male condom, while other barrier methods were less used. Seventy-one, or 12%, have used spermicides, thirty-four women, or 6%, have used a diaphragm, 25, or 4% have used a contraceptive sponge, and 5, or 0.83% have used a female condom (see table B.4, appendix B).

The next question on the survey was in relation to various hormonal birth control options. Four hundred and sixty-eight participants responded to this question, 33, or 4%, of which responded that they do not use birth control, and 15, or 2%, responded that they do not need birth control, as they do not engage in PIV. More than half of these participants, 412, or 56% have used a form of birth control pills, while smaller percentages have used other various forms of hormonal or chemical birth control. Eighty-seven participants, or 12%, have used an Intrauterine Device (IUD), and 83, or 11%, have used the NuvaRing/Vaginal Ring. In addition, 55 women, or

%, have used the birth control shot, such as Depo-Provera, 48, or 7%, have used the birth control patch, such as Ortho Evra, and 9 participants, or 1%, have used a birth control implant, such as Implanon or Nexplanon (see table B.5, appendix B).

The final question regarding contraceptive methods was in relation to what are considered natural family planning birth control methods. Of the 141 participants who responded to this question, 42, or 19%, responded that they do not use birth control, and 19, or 9%, responded that they do not need to use birth control, as they do not engage in PIV. The most popular natural family planning method was the calendar method/charting, of which 84, or 38%, responded. Additionally, 29, or 13%, of participants responded to using the cervical mucus method, and 27, or 12%, responded to using the temperature method. From this data, it is evident that the majority of participants have used, or were currently using, chemical or hormonal contraceptives, aside from usage of the male condom, which also had a large percentage of participant usage (see table B.6, appendix B).

The women in this sample who engage, or have engaged, in PIV sex, describe their birth control needs, and access experiences, in a variety of ways. This sample suggests that while some participants describe their contraceptive needs in varied medical terms, the majority of participants describe family planning, and/or pregnancy delay or prevention, as the reasons for their contraceptive needs. To better understand the ways women describe their contraceptive needs, participants were asked to provide their level of agreement regarding common reasons women use certain forms of birth control. These options included the prevention of pregnancy, effective family planning, a physical or mental illness that makes pregnancy dangerous to a fetus, or mother, and various medical reasons women take contraceptives, along with the benefits of

controlled, or lighter menstruation. Participants had the option of selecting “strongly agree,” “agree,” “disagree,” or “strongly disagree.”

Among the women in the sample who engage in PIV sexual activity, 72% (416) of the 478 answering the question regarding pregnancy prevention responded as “strongly agreeing” that they use contraceptives for the prevention of pregnancy. Furthermore, 53% (305) of participants “strongly agreed” that they use contraceptives to plan their families effectively. The second most common reasons women “strongly agreed” to using contraceptives were to control, or lighten periods, and lessen the effects of PMS: 33% or 189 use contraceptives to control their menstrual cycles; 28% (or 162) use contraceptives for lighter/fewer periods; and 24% (or 138) use contraceptives to lessen the effects of PMS. Finally, a smaller percentage of women “strongly agreed” that other medical reasons, such as endometriosis, ovarian cysts, and polycystic ovarian syndrome were their reasons for using contraceptives: 6% (or 31) women strongly agreed that endometriosis was the reason they needed contraceptives; 8% (or 48 women) said that ovarian cysts required contraception; and 7% (or 39) used contraceptives for polycystic ovarian syndrome.

In addition to the ways women describe their contraceptive needs, I also wanted to better understand if relationship status with one’s PIV (penis in vagina) partner would affect this description. My hypothesis was that women who are not in committed relationships might be more likely to describe their birth control needs in medical terminology, perhaps as a way to avoid personal, sexualized, rhetorical backlash. Of the 369 women who responded as in a committed relationship with their current PIV partner, 90% (334 participants) “strongly agreed” to using contraceptives to prevent pregnancy, while 68% (251) “strongly agreed” in using contraceptives to effectively plan their families. In addition, 6% (24 women) “strongly agreed”

in using contraceptives for endometriosis, 8% (30 women) “strongly agreed” in using contraceptives for ovarian cysts, and 7% (25 women) “strongly agreed” to using contraceptives for Polycystic Ovarian Syndrome. Furthermore, 36% (135) of women in a committed relationship to their PIV (penis in vagina) partner “strongly agreed” to using contraceptives to control their menstrual cycles, 31% (116 women) “strongly agreed” in using contraceptives for fewer, lighter, periods, and 26% of women (97) “strongly agreed” in using contraceptives for PMS (see table B.7, appendix B). (Note that this n used to filter—=365 women in committed relationships—is smaller than the n overall; this results in percentages that look different than in the overall figures.)

Of the 100 women who responded as not in a committed relationship with their current PIV partner(s), 75% (75 women) “strongly agreed” to using contraceptives for pregnancy prevention and 48% (48 women) strongly agreed to using contraceptives to effectively plan their families. Regarding medical reasons, 6% (6 women) “strongly agreed” to using contraceptives for endometriosis; 15% (15) “strongly agreed” to using contraceptives for ovarian cysts, and 13% (13 women) “strongly agreed” to using contraceptives for Polycystic Ovarian Syndrome. In addition, 50% (50 women) not in committed relationships “strongly agreed” to using contraceptives to control their menstrual cycles, 42% (42) “strongly agreed” to using for lighter, fewer periods, and 37% (37 women) “strongly agreed” to using contraceptives to lighten the effects of PMS. Conversely, the numbers and percentages for strong disagreement reflect the same pattern. Women not in committed relationships disagreed strongly more often than those in committed relationships that they used contraception to prevent pregnancy, and strongly disagreed less often to a medical reason for their contraceptive use (see table B.8, appendix B). As the analysis in the next section suggests, these data, though I used only descriptive statistics,

would seem to confirm my hypothesis that women in committed relationships are more likely to describe their contraceptive needs as about preventing pregnancy or planning families than women not in committed relationships. Those women not in committed relations are more likely to provide a medical (or medicalized) reason for their contraception use.

Qualitative Data

As the second component of this study, I coded participant responses for emergent categories to better understand the ways in which women describe their contraceptive needs. While the purpose of this study is to understand how women frame their contraceptive needs, many of the open-ended responses reveal not only the ways women describe their contraceptive needs, but also the ways in which participants' personal experiences with contraceptives have shaped their views on contraception. The primary open-ended question was framed as, "Is there anything else you would like to say about this topic?" Seventy participants responded to this question. From the data in response to this question, five categories emerged. These categories include: Medical Needs, War Metaphor, Luck/Blessings, Misuse of Power, Choice, and Challenging the War on Women.

Medical Needs

Prior to conducting the study, I had hypothesized that participants, especially participants who are not in committed, or monogamous relationships, would describe their contraceptive needs as medical, in the context of the war on women. While the majority of women described their needs as a means of planning, delaying, or preventing pregnancy, ten participants wrote about contraceptives as a medical need. The medical reasons women described vary from relief from a variety of disorders, such as Polycystic Ovary Syndrome to alleviation of menstrual pain or acne.

In one response in particular, we can see the ways in which this participant relies on the birth control pill to alleviate pain and the effects of Polycystic Ovary Syndrome (PCOS). In this response, the participant wrote that “Being on the birth control pill made my life livable and bearable, if not pain free. Without that I may not have LIVED to 23 for all the pain I was in for so long.” From this response, we can see the impact and importance of contraceptive access to the participant’s health and wellbeing. In addition to PCOS, other medical conditions women discussed were hormone replacement therapy after cancer and migraines. In other responses, participants described medical reasons that are less severe, and while not actually conditions, are used for the alleviation of “symptoms” or pain related natural life processes such as menstruation. Specifically, these examples include lighter or regulated menstruation, acne, and early symptoms of menopause. In one response, for example, the participant wrote that she uses the Depo shot “to control” her periods. She wrote that “I have been very happy with the Deposhot which I now use to control my periods (my partner has had a vasectomy).” In another, the participant wrote, “My under-18 year old daughter takes it for acne and PMS.” In these examples, the participants make it clear that pregnancy prevention is not their purpose in using contraceptives, but rather, what might be considered a medical need, or benefit.

Along with using contraceptives primarily for a medical reason, some women wrote that they avoid using certain forms of birth control, because they do not have medical conditions. In one response the participant wrote, “I have never been diagnosed with endometriosis but my mother has suffered from it for years. I don’t particularly suffer from PMS effects other than cramps, which I would like to avoid.” This response indicates that this participant may view the primary reason for using a chemical or hormonal method, such as the pill, as a means of avoiding a medical condition her mother faced, and because of her contraceptive choice, she has remained

without symptoms. From these responses, it is evident that some women use contraceptives for medical reasons, and in some cases, the primary purpose is not pregnancy prevention.

War Metaphor

While ten women described their contraceptive needs as medical, some participants wrote about the struggles they have endured in obtaining access to various forms of contraception, and in regards to the ways in which certain forms of contraception make them feel physically and emotionally. In two responses, women wrote about these experiences using war metaphors to express the challenges they endured. In these cases, the term “battle” was used. In one response, for example, the participant described her experiences in trying to receive a tubal ligation after becoming pregnant at the age of 25, and experiencing health problems both mentally and physically. Knowing she did not want to get pregnant again, she used hormonal birth control, but could not afford the prescription. She wrote, “it was an expensive battle every time I had to go to the doctor for the prescription and to the pharmacy to have it filled. Although I was receiving federal assistance and unemployed, it was also a battle to have my tubal ligation scheduled, paid for and administered.” In this case, the participant identifies her experience in obtaining contraceptives as a battle between herself, insurance companies, and possibly (though unstated) her medical practitioner.

In another response, the participant described the negative experience she had in finding contraceptives that suited her physically and emotionally. She first described birth control as, “the worst medication I’ve ever taken.” Then, to evoke the ways in which it made her feel, she wrote, “I feel like a slave to it. It has reversed my physical fitness goals, damaged my self-confidence, and has completely taken my emotions on roller coasters.” By describing herself as a

“slave” to her birth control, she indicates the severe control and effects over her body and emotions that birth control had over her.

Although some participants, which will be analyzed later, express a sense of ease in obtaining contraception, while also questioning, or even denying, the war on women, these participants express the struggles they have endured financially, physically, and emotionally, in both obtaining and finding a suitable method. Additionally, these participants use war metaphors to describe such experiences. While they do not refer to the war on women directly, they do use warlike metaphor, while also describing experiences that are in conjunction to what has been defined as the war on women.

Lucky/Blessed

While some participants expressed the struggles they endured regarding contraceptives, two participants in particular stand out as describing the result of this struggle as “luck” or “a blessing.” In both of these responses, their PIV (penis in vagina) partners were willing to undergo vasectomies. In the first response of this nature, the participant wrote, “I feel lucky to be married to a man who volunteered for a vasectomy after my IUD failed.” Although this participant took measures to either prevent or delay pregnancy by using an IUD, and although her partner volunteered to undergo a vasectomy after her IUD failed, she expressed this experience in terms of luck. In a similar response, another participant wrote about her experience in finding a doctor that would perform a tubal ligation on her, as some considered her too young, and because she was without children. However, at the age of 28, her husband was able to undergo a vasectomy without an issue. She wrote, “This was a blessing given that at that time, and ever since then, I have worked for public state organizations whose insurance does not cover birth control for women.” In a similar fashion to the previous response, both participants

expressed a lack of control in her contraceptive experience, as she described it as a blessing, even though she and her partner took extensive measures to ensure an effective method of birth control.

Misuse of Power

While two participants expressed their contraceptive experiences in terms of “luck” or “blessings,” other participants expressed concern, anger, and at times the embarrassment and shame in either witnessing or experiencing a misuse of power in relation to contraceptives. This misuse of power includes members of political, religious, and medical communities. Three participants expressed their opinions regarding the political measures that threaten contraceptive and birth control access in the United States. In one response, the participant wrote, “Men do not understand the importance of birth control, and should not be making these decisions, particularly in the political arena.” In a similar response, another participant wrote, “I think it’s sad that contraceptives can come with a hefty price as well as stigmatization for those that seek it.” In another response, the participant wrote about personhood laws, and that she fears for the future of women, such as her daughter. She wrote that, “it baffles my mind that something that for SO LONG has been considered run-of-the-mill healthcare is now up for debate... I seriously fear for my daughter’s future access to the same sorts of things I have taken for granted.” As the open-ended question these responses comes from was framed as, “Is there anything else you would like to say about this topic?” it is evident that expressing anger, disappointment, or fear regarding the access of various methods of birth control was of importance for these three participants.

In addition to political abuse, two participants shared stories of religious abuse, primarily through being uninformed or misinformed about the effectiveness of contraceptives. In one

response of this nature, the participant wrote about her experiences in receiving sex education, both growing up in what she identifies as a “conservative family,” and receiving little sex education in school. Furthermore, she wrote that these experiences led to an unplanned pregnancy. She described this as “a completely terrifying experience. I would never want my daughter to have to experience an unwanted pregnancy because she is uninformed or it was unavailable. It is unrealistic to believe that women will not engage in pre or post marital sex.” In addition to being uninformed, other participants indicated that they were misinformed about birth control. In another example, the participant, who remained abstinent until marriage for religious reasons, wrote that, “I learned that the pill didn’t work, IUDs cause abortions, and that condoms don’t stop the AIDS virus. My wedding night, my husband wore a condom, I had been on NuvaRing for months, and I also used spermicide. I was still afraid.” In these cases, the lack of information, and the relay of misinformation about birth control, was used to instill fear about sex, pregnancy, and sexually transmitted diseases. Again, we see the notion that birth control equals promiscuity.

In addition to religious abuse of power, three participants shared stories regarding abuse of power in the medical field. In some situations, this came from religious physicians who refused to prescribe forms of contraception. In one response, the participant describes the embarrassment, and overall struggle, she endured in trying to go on the pill, as her Catholic physician refused to give her a prescription. She described this experience as “a true challenge.” She wrote that, “Having suffered from PMDD (Premenstrual Dysphoric Disorder) since puberty, I suggested Yaz – a medication known for lessening the painful side effects. He suggested using the ‘charting’ method to predict my least fertile days to engage in sexual activity. He told me that as a doctor, he had the right to not prescribe medications he did not believe necessary. Slightly

embarrassed, and upset that I would actually have to pay for a useless appointment, I scheduled in another appointment with a Gynecologist.” In this example, the participant understood her body and its needs, but because her physician did not believe Yaz was necessary, she was denied a prescription. It is also interesting that she distinguishes her doctor from a Gynecologist (with a capital G), a professional who understood women and their needs.

Yet another example of physician abuse of power that emerged more frequently is physician refusal to prescribe contraception that increases the risk of sterility, or refusal to perform sterilization procedures on women who are young, and without children. In one response, the participant writes about her physician’s refusal to place an IUD, because as the physician argued there was, “slight increase in complications and the lack of studies in nulliparous women.” Instead, she was prescribed a form of the pill, even though she informed her doctor that she was sensitive to estrogen. In describing the result of this, she wrote that, “It absolutely wrecked me.” This response echoes the last, as the participant understood her body’s needs, but again, was denied access, due to her physician’s beliefs.

In other responses, participants also wrote about their doctors’ refusal to perform tubal ligation procedures. However, in these responses, participants’ partners were able to receive vasectomies, without struggles. In one example, the participant wrote, “a vasectomy for my husband was the only option. My doctors refused to do a tubal ligation on me, saying I was ‘too young’ (I was 30) and that I would ‘change my mind’ about not wanting to be pregnant. He was told no such thing when he made his appointment (he was 28).” Furthermore, the participant’s partner’s procedure was covered 100% with co-pay, but the participant did not have insurance that would even cover contraceptives. In these examples in particular, we can see the ways in which, as L. Purdy argues, women lose control over their reproductive autonomy through the

medicalization of birth control. In these examples it is apparent that these participants understood their bodies, and had intended on making contraceptive choices. However, because of their physicians, they were not able to do so.

Choice

While a number of women expressed struggles, or negative experiences regarding birth control, it is crucial to note fifteen participants also expressed, or acknowledged, having a choice in determining if and when they have children, along with what type of birth control method they use. In each of these responses, the key component is that the participants expressed that having children is their choice. In one response, the participant expressed that she and her partner have both undergone sterilization. She then ended her response by writing that “We are childfree by choice.” In another response, the participant expressed, “I love sex but I would never want to have kids. If I had kids, we would all be miserable.” In both of these responses, express a sense of reproductive autonomy, and a sense of knowing who they are and what they want.

While some participants expressed empowerment in the choice not to have children, others expressed empowerment in their decision to have children, but choosing when to do so in their lifetimes. One participant wrote, “I have used hormonal birth control at many parts of my life, always for the primary purpose of preventing pregnancy, I’m OK with that, and I think planning my family (and having children after establishing a stable relationship and lifestyle) to be a responsible choice.” Again, this participant emphasizes that planning her family is her choice. Her claim that she is “OK” with that also suggests that she is aware that other would interpret her contraceptive use differently, perhaps not as part of a responsible choice.

In other responses, women expressed choice through the relationship with their PIV partners, in sharing the responsibility of contraception, or birth control. Examples of this include

sterilization, such as a vasectomy, or the use of a male condom. In many of these responses, the participants expressed not only the notion that their partner complied, but also a rather direct and explicit sense of empowerment in doing so. In one response, the participant wrote, “I made him have the snip before I’d move in with him.” In another response, the participant wrote in a similar manner stating that, “I make the man I am with wear a condom.” In these examples, we can see that these participants express choice in sharing the responsibility of birth control with their sexual partners.

In other responses, women directly expressed choice by acknowledging that the birth control methods they use are their choice. In one response, the participant wrote that, “I consider choosing to not engage in PIV a form of birth control.” In another similar example, the participant expresses that remaining abstinent prior to marriage “was a religious ‘choice’” she made as a child. In both of these examples, by expressing that this is a choice, the participants not only express empowerment, but again, reproductive autonomy.

Finally, while some participants expressed empowerment through choosing their contraceptive methods, and family planning, others expressed the empowerment birth control gave them while enduring sexual abuse. In one response, the participant wrote that, “Birth control helps me feel in control of my body and what happens to me. After a date rape, a sexually abusive childhood, and an abusive boyfriend...the confidence it gives is important to me.” While this participant could not control her abuse, she was able to gain empowerment and control over her body through the use of contraceptives and the knowledge that abuse would not lead to the further trauma of unplanned pregnancy. Again, while some participants expressed the feeling of a lack of control in their contraceptive methods, it is evident that a portion of

participants expressed control in both their choices of contraception, or birth control, and if and when they choose to have children.

Challenging the War on Women

Another category that emerged from the data was that two participants both expressed a sense of ease in obtaining contraceptives, and therefore, challenged the notion of a war on women. In the first example, the participant expressed that she used to take the pill, but quit because of hypertension and high blood pressure. However, when she described having access to the pill, she wrote that, “I have never had issues getting it: I got a prescription for a product, and I paid for it when I wanted it. I don’t feel like there is any war on women, despite the Democrats’ efforts to make me feel like I’ve been victimized.” Although it is unclear what the participant’s economic status is, she perhaps evokes the sense that money is not of an issue, or at least a problem when it comes to obtaining contraceptives.

In a similar response, the participant wrote about the ease in finding affordable birth control. She also indicated that she, too, does not understand what the war on women is. She wrote that, “My master’s degree is in Community Health Nursing, so I can point you to a place to get cheap birth control in about 10 seconds or less. Just curious on what you think the war is?” In this case, the participant is perhaps privileged in the sense of medical literacy, because she is a member of the medical field. She does not examine how her knowledge may not represent the universal experience of women.

CHAPTER FIVE. DISCUSSION

This chapter provides discussion of the results of this survey. I have concluded several things related to the research questions from which this study developed: 1) the majority of contemporary women in this sample tend to describe their contraceptive needs in relation to planning, preventing, or delaying pregnancy; and 2) women who are not in committed relationships with their PIV (penis in vagina) partners appear to be more likely than women who are in committed relationships to their PIV (penis in vagina) partners to describe their reasons for using contraceptives as medical. In addition, this chapter discusses the notion that while Sandra Fluke's testimony was courageous, it did not represent the reasons that majority of American women need contraception. Also, advocates for contraceptive access who frame their arguments in relation to medical reason for birth control, often overlook arguments about the social and economic benefits of contraceptive access, and reaffirm the control of contraceptives in the medical community. This has negative effects for many women, as women in this study have suggested, both through their comments and what appears to perhaps be an unwillingness to embrace those very real social and economic benefits of controlling fertility. This chapter will also discuss the limitations of the study, along with room for further research regarding the topic.

Discussion of Results

From the survey results, I was able to determine that while smaller percentages of women in my sample identify a variety of medical needs among their reasons for using contraceptives, a larger percentage of the women in my sample identify planning, delaying, or preventing pregnancy as the reason they use contraceptives. The results from my study indicate that 72% of the participants align with the 2011 study "Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills," in which Jones concludes that while many women report experiencing

medical benefits from using the pill, 86% of women indicated birth control as the primary reason for taking it (3). That 86% most closely aligns with the 90% of women in my study who were in committed relationships with their PIV partner. In addition, I hypothesized that women, especially women who are not in committed relationships with their PIV (penis in vagina) partners, might be more likely to provide medical reasons as to why they use contraceptives, primarily in the wake of the rhetoric surrounding Fluke's testimony and what the left has called the war on women. From the women in my sample, this appears to be the case. In fact, relationship status appeared to have a strong effect on the ways in which women describe their contraceptive needs. In all responses EXCEPT "endometriosis" I found women not in committed relationship more likely to provide a medical reason for their contraceptive use, and women in committed relationships to provide a family-planning or pregnancy prevention reason. Because relationship stability has been shown to be such an important factor for readiness for child-rearing (Sonfield et al. 21-22), it seems that those not in committed relationships would have more likelihood of using contraception. Therefore, I wonder if this disparity points to uncommitted women feeling that pregnancy prevention alone is not a strong enough argument for contraceptive use, as we saw in the testimony of Fluke.

From these results, it is possible that while the intention of Sandra Fluke's testimony was to advocate for women's access to contraceptives, her testimony seems to advocate and represent a small percentage of women I surveyed, as the bulk of her argument highlights the medical reasons why women need access to contraceptives. From the survey results, it is possible that women overall use contraceptives for many reasons, but most specifically for family planning, pregnancy prevention, and various medical reasons. However, Fluke did not mention many of these important reasons why women need access to contraceptives. While I find Fluke's

testimony to be courageous, and an event that helped spark conversations about contraceptives, and the need to advocate their access, from my interpretation, it does not seem to be a representation of the ways in which contemporary women, especially those in committed relationships, describe their contraceptive needs. However, her testimony and rhetorical strategy may be related to women not in committed relationships describing their needs for contraception as medical in far greater percentages than those in committed relationships. Furthermore, if as Laura Purdy argues in “Medicalization and Feminist Medicine,” political action often advocates for the wellbeing of women, rather than medicine alone, how are we to truly advocate for women’s reproductive autonomy, if we primarily discuss contraceptives as medicine, especially in the political sphere?

While historically, the medicalization of contraceptives led to their legality, we must be aware of what women ultimately lost: reproductive autonomy. We can see from some of the examples and stories women shared in the survey, that some participants were denied forms of contraceptives, sterilization procedures, and others could not afford the contraception they desired; the medicalization of contraceptives has put women in a difficult place, in which they do not have full control over their own bodies. In addition, if advocates for contraceptives, such as Sandra Fluke, must rely on the medical community, and medical reasons why women should have access to contraceptives, the benefits and importance of women’s reproductive autonomy will continue to be overlooked in the political spectrum. This is a problem, as having the independence, freedom, and overall choice to have children is both empowering and beneficial for society. Furthermore, advocates who support the medicalization of contraceptives also encourage a flawed, patriarchal system in which many women do not have access to contraceptives, because they cannot afford exams or the products. Finally, this medicalization

seems to have begun colonizing the minds of young women, like Fluke and many of those in my survey, especially those not in committed relationships, who did not feel able to say they chose contraception simply because they wished to delay or avoid pregnancy and child rearing. They have been forced to become part of a medicalization machine that assumes women's natural bodies and functions are always already symptomatic and need to be treated, fixed, and/or drugged.

Limitations

While I was able to provide possible conclusions from my study, there are limitations. The main limitation present in the study is that the only research tool utilized was a survey. Although the survey provided rich, useful data, I was not able to discuss the topic of contraceptives and participants' contraceptive needs in person. Because of this, I was not able to ask follow-up questions, nor was I able to ask participants' questions that would clarify any responses that were not clear. Therefore, the qualitative data comes from written responses, and the interpretation of my advisor and myself.

Suggestion for Further Research

Due to limitations, this study could serve as a launching point for another study in which the researcher could analyze the ways in which women's responses might differ in an interview setting. As I have argued that Sandra Fluke's testimony may not fully represent the ways in which many women describe their contraceptive needs, this description might be different in a face-to-face context. While some participants may have felt comfortable sharing their stories and views on contraception in a survey setting, in which extensive measures have been taken to remove identifiers, they may be less inclined to do so in a face-to-face context. Although measures would be taken to ensure that the interview is confidential, I would expect to see an

amplification of the same effect I found in this survey, in which women who do not identify as having one committed PIV partner are more likely to provide medical reasons regarding their contraceptive needs. Furthermore, in an interview setting, the researcher could ask follow-up questions, clarify responses, and gather more qualitative data.

Conclusion

When Beck proclaimed in his response to Fluke's testimony that, "It's not about health; it's about sex, pumpkin," perhaps he was on to something. While the reasons women need contraceptive access might in fact be about sex, it is also about so much more. Contraceptive access is about women's health, women's access to education, the eradication of poverty, and a culture that produces happy, healthy children and parents. It is about understanding one's body, and having the power and ability to tend to its needs. However, contemporary advocacy for contraceptive access often omits the social and economic benefits of women's reproductive autonomy. As we can see from Fluke's testimony, the medical needs of using contraceptives are often highlighted in an intentional rhetorical move, while arguments in favor of reproductive autonomy are often overlooked. However, as we have learned from the personal, sexualized, rhetorical attacks against Fluke, framing advocacy and access for contraceptives from a medical standpoint does not solidify advocates' arguments, nor does it protect advocates from personal attacks from opponents. Therefore, this research suggests advocates should use a range of rhetorical strategies and the goal should be women's bodily autonomy rather than further entrenching medicalized arguments.

WORKS CITED

- ABC News. "Rush Limbaugh Calls a Female Georgetown Student, Sandra Fluke, a 'Slut.'" *Youtube*. Youtube, 2 Mar. 2012. Web. 12 Oct. 2012.
- Brown, Rhonda. "Blueprint for a Moral America." *Nation* 232.20 (1981): 617-632. *Academic Search Premier*. Web. 2 July 2013.
- Conniff, Ruth. "The GOP War on Women." *Progressive* 76.5 (2012): 8-9. *Academic Search Premier*. Web. 16 Nov. 2012.
- Conrad, Peter. "Medicalization and Social Control." *Annual Review of Sociology* 18 (1992): 209-232. *JSTOR*. Web. 14 May 2013.
- Corbin, Juliet and Anselm Strauss. *Basics of Qualitative Research 3e*. Los Angeles: SAGE, 2008. Print.
- Douglas, Emily Taft. *Margaret Sanger: Pioneer of the Future*. New York: Holt, Rinehart and Winston, 1970. Print.
- Faludi, Susan. *Backlash: The Undeclared War Against American Women*. New York: Three Rivers Press, 1991. Print.
- "The Family Protection Act." *Boston Globe*: 1. June 25 1981. Web. 2 July 2013.
- Fluke, Sandra. "Testimony – ABC News." *ABC News*. ABC News, 23 Feb. 2012. PDF file.
- Foucault, Michael. *The Birth of the Clinic: An archaeology of medical perception*. London: Tavistock Publications Limited, 1973. Print.
- Glenn Beck Radio Program. "Glenn Beck Reacts to Sandra Fluke's Contraception Testimony." *Youtube*. Youtube, 29 Feb. 2012. Web. 23 Oct. 2012.
- Heckathorn, Douglas D. "Respondent-Driven Sampling: A New Approach to the Study of Hidden Populations." *Social Problems* 44.2 (1997): *JSTOR*. Web. 10 Oct. 2012.

- Jones, Rachel K. "Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills." *Guttmacher Institute*. Guttmacher Institute, November. 2011. PDF. file.
- Maogoto, Jackson Nyamuya and Helena Anne Anolak. "The Pill—A Rose Ringed by a Thorn Bush? Stirred but Not Shaken; Past and Present Ramifications." *wlu.edu*. wlu.edu, N.d. PDF file.
- Pesta, Abigail. "War of the Wombs." *Newsweek* 160.1/2 (2012): 20-21. *Academic Search Premier*. Web. 1 July 2013.
- Purdy, Laura. "Medicalization, Medical Necessity, and Feminist Medicine." *Bioethics*. 15.3 (2001): Wiley Online Library. Web. 9 Dec. 2012.
- Purdy, L. "Women's reproductive autonomy: medicalisation and beyond." *J. Med. Ethics*. 32 (2006): *JME Online*. Web. 9 Dec. 2012.
- Sonfield, Adam, et al. "The Social and Economic Benefits of Women's Ability To Determine Whether and When to Have Children." *Guttmacher Institute*. Guttmacher Institute, March. 2013. PDF. file.
- Tone, Andrea. *Devices and Desires: A History of Contraceptives in America*. New York: Hill and Wang, 2001. Print.
- Watkins, Elizabeth Siegel. *On the Pill: A Social History of Oral Contraceptives, 1950-1970*. Baltimore, Maryland: The Johns Hopkins University Press, 1998. Print.
- Wardell, D. "Margaret Sanger: birth control's successful revolutionary." *American Journal of Public Health* 70.7 (1980): 736. *Academic Search Premier*. Web. 2 July 2013.

APPENDIX A. THE INSTRUMENT

“Contraceptive Rhetoric: Understanding the Ways Women Describe Birth Control Needs in the Wake of the War on Women”

1. What is your gender?
 - a. Female
 - b. Male
 - c. Transgender

2. What is your age?
 - a. 18-22
 - b. 23-26
 - c. 27-30
 - d. 31-35

3. What is your sexual orientation?
 - a. Bisexual
 - b. Gay
 - c. Heterosexual
 - d. Lesbian
 - e. Other, please describe _____

4. What is your relationship status?
 - a. Cohabiting
 - b. Committed Relationship
 - c. Dating
 - d. Divorced
 - e. Married
 - f. Single
 - g. Widowed
 - h. Other, please describe _____

5. Do you engage in PIV (penis in vagina) sexual activity?
 - a. No
 - b. Yes

6. If you engage in PIV, how would you describe your relationship to your current PIV partner(s)?
- Multiple casual partners
 - One committed partner
 - Single casual partner
 - Other, please describe _____
 - Not applicable
7. Are you currently, or have you ever, used any of these forms of birth control? Please check all that apply.
- Cervical cap
 - Contraceptive sponge
 - Diaphragm
 - Female condom
 - Male condom
 - Spermicides
 - I don't use birth control
 - I don't need to use birth control, as I do not engage in PIV
8. Are you currently, or have you ever, used any of these forms of birth control? Please check all that apply.
- Birth control implant (Implanon or Nexplanon)
 - Birth control patch (Ortho Evra)
 - Birth control pills
 - Birth control shot (Depo-Provera)
 - Intrauterine Device (IUD)
 - NuvaRing/Vaginal Ring
 - I don't use birth control
 - I don't need to use birth control, as I do not engage in PIV
9. Are you currently, or have you ever, used any of these forms of birth control? Please check all that apply.
- Calendar method/charting
 - Cervical mucus method
 - Post-ovulation method
 - Temperature method
 - I don't use birth control
 - I don't need to use birth control, as I do not engage in PIV
10. Are there any birth control methods that were not listed above that you have used? Please describe. _____

11. Here are some common reasons women offer regarding why they use certain forms of birth control. Please show your level of agreement regarding why you have used certain forms of birth control by choosing a number between 1 and 4, with 1 being strongly agree, 2 being agree, 3 being disagree, and 4 being strongly disagree.

a. I want to prevent pregnancy.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

b. I want to plan my family effectively.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

c. I have a physical illness that makes pregnancy dangerous to me

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

d. I have a mental illness that makes pregnancy dangerous to me

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

e. I take medication that is dangerous for a growing fetus

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

f. I want to lessen the effects of endometriosis

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

g. I want to lessen the effects of ovarian cysts

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

h. I want to lessen the effects of polycystic ovarian syndrome

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

i. I want to control my menstrual cycle

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

j. I want to have fewer, lighter periods

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

k. I want to lessen the effects of PMS

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

l. I want to control my acne, or clear up my skin

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

m. I want to prevent sexually transmitted diseases

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

n. Other(s), please describe _____

12. Is there anything else you want to say about these topics?

13. Would you be interested and available for a personal interview, regarding your experiences in using birth control?

No

Yes

14. If yes, please provide an e-mail address, so that I can contact you and potentially schedule an interview.

APPENDIX B. TABLES

Table B1

Relationship status (N=481). Must choose only one.

Choices	Number	Percent of whole
Cohabiting	50	8.74%
Committed Relationship	86	15.03%
Dating	21	3.67%
Divorced	7	3.67%
Married	242	1.22%
Single	68	42.31%
Widowed	2	0.35%
Other	5	0.87%
Skipped	91	15.91%

Table B2

Relationship to current PIV partner(s) (N=469).

Choices	Number	Percent of whole
No current PIV	50	8.74%
Multiple casual partners	9	1.57%
One committed partner	370	64.69%
Single casual partner	26	4.55%
Other, please describe	14	2.45%

Table B3

Relationship to current PIB partner(s) (N=469).

Choices	Number	Percent of whole
One committed partner	370	78%
All other relationships	99	22%

Table B4

Respondents who have used barrier methods of contraception (N=437). Respondents could answer yes to more than one option.

Choices	Number	Percentage
I don't use contraception	47	7.83%
I don't engage in PIV sex	21	3.5%
Cervical cap	2	0.33%
Contraceptive sponge	25	4.17%
Diaphragm	34	5.67%
Female condom	5	0.83%
Male condom	395	65.83%
Spermicides	71	11.83%

Table B5

Respondents who have used hormonal contraception (N=468). Respondents could answer yes to more than one option.

Choices	Number	Percentage
I don't use contraception	33	4.45%
I don't engage in PIV sex	15	2.02%
Birth control implant (Implanon or Nexplanon)	9	1.21%
Birth control patch (Ortho Evra)	48	6.47%
Birth control pills	412	55.53%
Birth control shot (Depo-Provera)	55	7.41%
Intrauterine device (IUD)	87	11.73%
NuvaRing/Vaginal Ring	83	11.19%

Table B6

Respondents who use “natural” methods of birth control (N=141). Respondents could answer yes to more than one option.

Choices	Number	Percentage
I don't use contraception	42	19%
I don't engage in PIV sex	19	8.6%
Calendar method/charting	84	38.01%
Cervical mucus method	29	13.12%
Post-ovulation method	20	9.05%
Body temperature method	27	12.22%

Table B7

Participants in relationships that include PIV sex who strongly agree to the following reasons for using contraception.

	Preventing pregnancy	Planning family	Endometriosis	Ovarian cysts	POS	Control menstrual cycle	Have fewer/lighter periods	Control PMS	Control acne
Committed relationships average (N=365)	90%	68%	6%	8%	7%	36%	31%	26%	15%
	(334)	(251)	(24)	(30)	(25)	(135)	(116)	(97)	(56)
All other relationships (N=99)	75%	48%	6%	15%	13%	50%	42%	37%	23%
	(75)	(48)	(6)	(15)	(13)	(50)	(42)	(37)	(23)

Table B8

Participants in relationships that include PIV sex who strongly DISagree to the following reasons for using contraception.

	Preventing pregnancy	Planning family	Endometriosis	Ovarian cysts	POS	Control menstrual cycle	Have fewer/lighter periods	Control PMS	Control acne
Committed relationships average (N=365)	>1%	4%	64%	59%	62%	21%	23%	24%	37%
	(4)	(16)	(235)	(220)	(230)	(76)	(86)	(88)	(135)
All other relationships (N=99)	5%	10%	49%	42%	44%	14%	16%	21%	23%
	(5)	(10)	(49)	(42)	(44)	(14)	(16)	(21)	(23)