Contraceptive conversations: power, discourse and the social construction of contraceptive use during nurse consultations with women in family planning clinics.

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Chapter 6

Discussion

6.1 Introduction

This chapter discusses the findings presented in Chapter 5 and places them in a theoretical context. The discussion is structured around an analysis of the two core categories: Surveillance and Compliance, presented in figure 11, which, although intended to represent a holistic process, can best be analysed from a theoretical perspective as discrete but closely-integrated categories. The discussion of the findings within this chapter will also be enriched by data obtained from interviews that the author conducted with family planning nurses working in the clinics where the consultations were recorded, data that will be used to substantiate and to add further understanding to the analysis of the power relations within the consultations.

This chapter firstly discusses the value that a Foucauldian perspective on power has in providing an analytical framework to explore the nature of consultations in family-planning clinics. It is proposed that the power relations and discourse operating within the nurse-woman discussion provides a detailed example of what Foucault means by the *'micro-power'* relations that operate during the individual engagement of a person with a health-care professional; power relations that, by conducting an *'ascending analysis'*, can be linked to wider structures of power.

Secondly, this chapter proposes that the data obtained in this study contributes a detailed insight into the concepts of *'productive power'* and *'subjectification'*. A Foucauldian perspective to the analysis of the nurse/woman consultation provides a detailed illustration of how power relations at the individual level, between health-care professional and client, *construct* a body and provide a *framework* of surveillance and discipline within which a woman wishing to use contraception becomes involved. The category 'Surveillance', it is proposed, demonstrates a clear example of how medical/scientific discourse is employed in the social construction of the reproductive system as vulnerable and in need of protection. It is suggested that, within the consultations, clear examples of Foucault's procedures of exclusion exist within the discursive strategies utilised by the nurse. Furthermore, 'Surveillance' demonstrates the intricate links between education of women about the reproductive system and development of the woman as the *'active patient'*.

It is also suggested that, within development of the *'active patient'* and self-surveillance, the disciplinary techniques of *'hierarchical observation, normalising judgement and examination'*, described by Nettleton in her work on dentistry (1994), are employed and that the nurse acts as interpreter or *'judge'* in relation to the meaning of the woman's observations. Within the category of 'Surveillance', it is proposed that, in addition to developing self-surveillance skills, nurses conduct far more direct forms of surveillance, particularly the utilisation of clinic records and case notes. It is further suggested that the clinic can be regarded as acting as some form of Panopticon.

'Compliance' is closely integrated with 'Surveillance'. It is proposed that many of the discursive practices operating in Surveillance are essential pre-requisites and/or integral elements in the development of compliance. Within the category of 'Compliance', the discourse utilised relating to side-effects is analysed, particularly the use of scientific and lay discourses and the notions of stoicism and perseverance. 'Compliance', it is suggested, provides a clear example of the notion of productive power and its role in the subjectification of the woman as a contraceptive user. 'Compliance' also entails a detailed exploration of the theme of regimen and disciplinary power within the consultation.

6.2 Power within the consultation

The overall picture from the consultation data presents a process of power relations within which the woman visiting the clinic is situated; power relations that appear to be geared towards constructing a body, particularly a reproductive system, that is *reproductively vulnerable* and that requires protection, whilst also generating a framework within which the woman is *'trained'* or *'tutored'* in body surveillance and body management by the nurse: a process represented by figure 11.

What requires further analysis and discussion is the precise nature of the power relations at work. Can an analysis from a Foucauldian perspective provide a framework of understanding by, as Driver (1994:117) claims:

> *'Asking questions about how power is exercised in particular sites and settings'*?

The data from consultations and interviews also enables the possibility of exploring and proposing links between individual consultations and wider social issues, analysing how power, operating through discourses aimed at the individual body and the individual person (*anatamo-politics),* relates to the wider population (*bio-politics*), following the Foucauldian concept that, in order to examine power one must:

> *'Conduct an ascending analysis, starting that is from its infinitesimal mechanisms, which each have their own history, their own trajectory, their own techniques and tactics, and then see how these mechanisms of power have been.... and continue to be...invested by ever more general mechanisms'. (Foucault 1980:198)*

As Shilling (1993) notes, one of the central aims of Foucault's work was to explore the relations that exist between the body and the effects of power upon it. As has been described earlier, Foucault's concept of power and its techniques have undergone a shift in his writings. Power, for Foucault, has evolved from a controlling or restraining force to become a force that is more positive in nature. Rather than the deployment through threat or force, power operates in a more positive manner, a productive power. As Sawicki (1991) notes, according to Foucault, productive power operates:

> *By creating desires, attaching individuals to specific identities and establishing norms against which behaviours and bodies are judged and against which they police themselves'. (Sawicki 1991:67)*

Neither does productive power rely on the docility of bodies; quite the opposite! As Sawicki (1991) identifies, productive power requires the active participation of the individual (the patient; the woman) in a process that is not essentially working against the will of the individual. Rather it is working with the desires and aspirations of the person to bring about a change in behaviour, this being a shared as a goal for the two parties. This is power as a process that seeks to regulate, more by persuasion and normalisation, than by coercion (Sawicki 1991).

However, it is important to recognise that, although Foucault developed his notion of power away from more repressive and coercive techniques towards a concept of power that utilised persuasion, normalisation and the creation of self-regulation, the role of institutions and professional disciplines as sites for the deployment of disciplinary power still persists.

It remains justifiable to argue that, although the techniques are different, Foucault's notion of the *effect* of power on the body when it enters an institution - as discursively constructed and subject to disciplinary power - still carries substantial resonance. Foucault's underlying concept is still relevant when he talks of an institution that subjects the body to:

> *' a machinery of power that explores it, breaks it down and rearranges it...so they may do what one wishes, but also that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines'. (Foucault 1977:138).*

However, it is the *specific* techniques and power relations employed to achieve this outcome that Foucault modified and developed within his writings. Foucault did not change the fundamental notion that power acts upon the body in ways that optimise its function individually, whilst also contributing to the regulation of the population. He refined and developed the power techniques and relations employed to achieve this; hence the changes from docility to the creation of the subject and from the *passive body* to the *active patient.* Linked to this shift was the move from mostly external surveillance of the body - by a Doctor or Jailer for example - to an increased development of self-surveillance and self-regulation by the person/subject themselves, although often under instruction by another. But of course, what is to be monitored and how, along with what the techniques, skills and motives for self-regulation are, remain the products of discourse and bio-power.

It is clear that productive power mechanisms are operating within the consultations in this study. These power relations are involved in constructing the body in such a way as to subjectify the woman as a contraceptive-user. The manner in which the woman's body is subject to the nursing gaze within the clinic together with the manner in which the woman enters into that discursive field which surrounds the consultation, reveals a host of power relations and techniques. It is through these discourses that power operates (Driver 1994) - a power that, although not repressive, according to Foucault:

> *'exerts a positive influence on life, that endeavours to administer, optimise and multiply it, subjecting it to precise controls and comprehensive regulations.' (Foucault 1981a; 137)*

Analysis of the consultation data led to development of the conceptual diagram illustrated in Fig 11. As previously discussed, the open and substantive codes comprising the three categories – 'Body Education', 'Body Surveillance' and 'Regimen' - can be placed in and around the intersection of two overarching core categories: 'Surveillance' and 'Compliance'. These two core categories represent what is a holistic process occurring during the consultations, within which women are developed into *'active but compliant, knowledgeable yet reproductively vulnerable patients'.*

Although it is necessary to keep visualising this process as a holistic one, in order to explore the theoretical dimensions of this process, the two categories will be discussed separately. However, this discussion will also include clear signposting of the way in which the two categories are closely integrated.

The key to exploring power within the consultations, then, is based upon the premise that power is inextricably linked to discourse and that an analysis of the discourses employed is central to understanding the power relations within the consultation, given that Foucault's analysis of power, according to Driver, is that power:

> *'does not exist prior to discourse and practices on some other plane or level; rather, it operates through them'. (Driver 1994:116)*

A starting point for this analysis is the way in which nurses educate women about the reproductive system and provide information about how particular contraceptive methods work, also how this education begins the process of developing the woman into the *active patient,* by constructing the *vulnerable* reproductive system.

'Surveillance'

6.3 Surveillance introduction

One of the central examples of power relations within the consultation is how the reproductive system is conceptualised as vulnerable to the threat of pregnancy, with a need to provide protection from this threat by using contraception. Women are encouraged to improve their understanding of how their bodies work by nurses explaining the anatomy and physiology of the reproductive system. This education is closely linked - and is a prerequisite for - the women developing techniques of body surveillance and examination as part of using contraception. One of the central themes of the consultation is how this body education sets the scene for surveillance by developing the woman into a *'knowledgeable but reproductively vulnerable patient'.*[1]

6.4 Body education and the *'knowledgeable/reproductively vulnerable patient'*

Nurses spend some time within the consultation explaining to women how the reproductive system works and how their own particular contraceptive method functions - a process that is an important aspect of teaching self-surveillance. The nurses interviewed in this study reinforced this, seeing education as part of the consultation:

> *Nurse C: ... I think it's part of our role... I think it is important to be aware of your body and how they function.*

During interviews, nurses justify this education by referring to the lack of knowledge amongst women, remarking upon the *'naivety'* of some women about their bodies, for example:

> *Nurse I: You still get a lot of naivety really..about their cycle and when people can get pregnant and when they can't get pregnant...and erm..I think they need some form of basic knowledge...*

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[1] A considerable amount of thought was involved in arriving at this phrase *'reproductively vulnerable'*. Numerous other phrases were tried and rejected, for example *'potentially fertile'* and *'risking pregnancy'* before the development of the term used here.

Nurses also mention how some women can be *'mixed up'* about the workings of their reproductive system and that they require teaching:

> *Nurse E: They're mixed up about their anatomy and things but, and they, they need to understand how their menstrual cycle works you know, how women that come expecting us to say if they're pregnant and they're only mid cycle 2 weeks in you know and they obviously don't understand periods.*

The nurses who were interviewed also make the link between education of the woman and her successful use of contraception, providing an early example of the link between body awareness, surveillance and compliance:

> *Nurse D: I think it's easier to use a method if you can actually erm.... understand how it works, I always find something you can follow something more logically if you understand how it actually works.. for example someone's come for emergency contraception and she's pre-ovulation You're going to talk to her perhaps for you this method will work by delaying or preventing ovulation*

However, as the last couple of lines of this quote illustrate, the knowledge that nurses want women to gain is linked closely to medical and scientific discourse. Furthermore, within interviews, nurses often remark upon the lack of knowledge displayed by women in the clinic about the anatomy and physiology of their reproductive system:

> *Nurse A: Yes, you'd be surprised how many don't know the word ovulation.*

> *Nurse E: You know, often I think women don't know that the uterus is separate from the vagina.*

> *Nurse J: we explain what the hormones are, explain what they are doing, talking about mucus and where that is, and how it gets thickened.*

Women also make incorrect assumptions about the menstrual cycle:

> *Nurse G: I don't think a lot of people understand, when they ovulate or anything like that..you know I saw a girl last week with a completely irregular cycle and still assumes she ovulates in the middle of it.*

Within the medical and nursing literature on contraception there is tacit acceptance that women should be given the medical and anatomical facts about contraception in order to help them use their chosen method (Rosenberg et al 1998, Rosenberg 1999, Moos et al 2003). This literature also claims that this education is linked to the development of appropriate behaviour related to successful contraceptive use (Rosenberg et al 1999, Dardano and Burkman 2000, Lachowsky and Levy-Toledano 2002, Aubney et al 2002, Pinter 2002). However, this literature does not explore, or question role that this utilisation of medical and scientific discourse plays in relation to power. Furthermore, it does not analyse in any detail the utilisation of medical knowledge in a critical way, or include attempts to analyse actual consultations, in order to explore *critically* what information about the reproductive system and contraception is given to women. Therefore, the *clinical* literature proceeds from the *philosophical* viewpoint that the knowledge provided to women reflects the only *'truth'* about reproductive anatomy and that providing this information is a positive act of empowering women through educating them about their bodies.

This study does not start with these assumptions, and attempts to problematise the power relations operating within the family planning clinic. The data in this study clearly shed light on what is actually said to women about their reproductive system; also upon how nurses see this linking into the wider issue of ensuring that women adopt patterns of behaviour that facilitate use of a contraceptive.

6.5 *Anatamo-politics*: discourse and the reproductive system

From the consultation data presented in Chapter 5 it is clear that a key aspect of the consultation is the discursive construction of the woman's reproductive system as vulnerable to pregnancy and requiring protection, in the form of a contraceptive method. The nurses utilise several discursive techniques to achieve this, particularly the use of terminology within body education - for example, the use of phrases such as *'at risk', 'covered', 'protection', 'precautions'* and *'danger'*.

The use of value laden terminology, including the use of metaphor, within the discourse around women's bodies is not new. It has a long history, and the power of this use of language in constructing the female body discursively has been recognised by numerous authors (Laquer 1987, Martin 1989, Weeks 1989, Laws 1990, Seale and Pattison 1994, Hawkes 1996, Shorter 1997). These discourses have also heavily influenced the development of medical/scientific discourse.

Lupton (1994) argues that women's bodies, in particular, have been a focus of close medical attention for centuries, the female body being regarded as both fragile and unpredictable, liable to go out of control if not kept in check. Foucault (1981:58), in his discussion of sexuality, identifies the *'hysterization'* of women's bodies as a key aspect of the *'scientia sexualis',* which saw the medicalisation of women's bodies emerge from discourses that have their origin within naturalistic or essentialist theories about the female body - theories that construct the female body as being unregulated and requiring control (Shilling 1993). These discourses have had a particularly lasting effect upon how the female body is represented. Several authors identify that the overriding discourses within scientific medicine surrounding the female body are those of its instability, weakness, incompleteness and unpredictability (Ehrenreich and English 1974, Laquer 1987, Martin 1989, Lawrence and Bendixen 1992).

According to Turner (1995) and Moscucci (1990), no part of female anatomy and physiology has been accorded more attention by medicine and science than that of the reproductive system. Both Turner and Moscucci argue that the 19th century medical practice of locating all female health problems as resulting from deficiencies or fluctuations in the reproductive system contributed to a pervasive medical and scientific discourse around the control of women, medically and socially. Indeed, several authors have argued that this perception of the female body can be seen as threads within contemporary medical and scientific texts (Nead 1988, Barret and Harper 2000) with possibly one of the most notable examples of this being the work of Martin (1989)

In her work exploring menstruation, menopause and childbirth, Martin argues that women, far more than men, suffer *'an internal fragmentation of the self'* (Martin 1989:21) in which women's bodies are conceptualised in medicine, science and consumer culture as a variety of parts rather than as a whole. For example, women are presented in advertising as having *'skin', 'hair', 'eyes'* etc.

Similarly, in science and medicine, women's bodies are often reduced to the characteristics of separate systems, which have attracted their own language and terminology. In fact, Brook (1999) argues that this is often the way in which women are taught to know their bodies.

Martin (1989) describes the way in which scientific and medical terminology, particularly metaphor, plays a powerful role in defining women's bodies in relation to menstruation and menopause. Martin argues that the prevailing metaphors of menstruation are of the '*production system that has failed to produce*' (Martin 1989:46); menstruation involves the '*expelling*' of '*waste*' and of the '*redundancy and death of tissue*'. Similarly the menopause is regarded as ' *a breakdown in the system of authority*' and an indication of the '*withering and failure*' of the woman's reproductive capacity (Martin 1989: 49). Martin points out that these terms are in the main negative and reinforce the way in which the female body is regarded in medical and scientific discourse as being weak, out of control and requiring regulation.

During contraceptive consultations, nurses do not explicitly use metaphor or employ terminology that reflects the discursive construction of menstruation and the menopause described by Martin. But they do employ certain terms when referring the reproductive system, language about the body that, instead of describing the degenerating body, utilises the terminology of *'guarding'* and *'protecting'* the reproductively vulnerable body. For example, nurses utilised terms such as the *'release of an egg'* or *'preventing'* the attachment of an egg, also, when describing how contraception works; '*a mucus barrier*' to sperm. The notion of the reproductive system requiring restraint or protection from vulnerability is reflected in these terms. Nurses also reinforce this by reminding women what this restraint of the body was guarding against - for example: *'Putting yourself at risk of pregnancy'* and *'the ovaries will wake up and start functioning'*

Martin (1989) also remarks that the scientific terminology utilised in relation to reproductive anatomy and physiology utilises the concept of a hormonal signalling system. However, whereas Martin's work emphasises the *breakdown* of a regulatory system resulting from age and declining fertility - hence the metaphors of a malfunctioning and obsolete machine - the use of hormonal signalling terminology in the contraceptive context centres more strongly upon the notion of *sustaining* the hormonal level of restraint.

This can be seen throughout the consultation process, particularly when nurses discuss compliance, *'because the hormones need to be kept up* (Consultation 6), also when nurses discuss interference with the regimen, '*cause if you vomit the pill back up or it passes straight through it won't get absorbed*' (Consultation 13).

Nurse 'K' also illustrates this when she refers to the need to *'switch off'* the hormone system. In doing so provides a good example of the link between body education that enables women to know about ovaries and hormonal signalling, and to comply with the 'rules' of contraceptive use, an aspect that will be revisited later:

> *but this switching things on and off, you know switching your ovaries on and off and why the 7-day rule applies to them, they need to understand it, get it in..(Nurse K)*

Martin's (1989) work, therefore, described how the female body is framed within medical discourse as a body breaking down and degenerating. The terminology and discourse around the reproductive system within the family planning consultation appears to exhibit certain distinct differences. The central theme to the discursive construction of the body is one of vulnerability and risk rather than degeneration and breakdown.

Several explanations for this difference are possible. Firstly, although Martin's (1989) work has had a significant effect on the analysis of the social construction of the female reproductive system and is widely cited, her work draws primarily upon analysis of medical/scientific texts on reproductive health and upon interviews with women about their experiences of menstruation and menopause. Crucially, Martin does not explore the way in which the medical/scientific discourse that she describes operates through power relations that exist between health professionals and women when they communicate about a reproductive health matter. Equally importantly, Martin does not explore contraception within her work.

Another possibility is that, in order to emphasise reproductive vulnerability nurses in this study, rather than utilise the terminology of a failing machine or disintegrating communication system, construct the notion of the reproductive system as a *fully* functioning machine, liable to *produce* if not kept in check, providing a more powerful description; a description that uses the terminology of a system requiring restraint or protection, rather than a system requiring repair or removal.

In other words, the differences in terminology between Martin's work and the contraceptive discourse in the consultations in this study are related to both the *target* and *purpose* of discourse. In Martin's (1989) work, the analysis is of medical texts designed to educate health professionals, texts designed to develop medical knowledge.

The discourses employed by the nurse in the consultation have a different purpose: that of providing the woman not only with knowledge, but also a motive to self-care. In other words, the terms and language employed are intended to convey the notion of risk, danger and the requirement for protection far more explicitly.

Interestingly, Martin does move a little closer to this concept in some of her later work. During an analysis of media representations of scientific explanations of the reproductive system (Martin 1991, 1992), she describes how, whilst the male reproductive system is represented by metaphors of strength and virility, the female reproductive system, as well being depicted as a system that revolves around a degenerative, wasteful process, is also commonly described using the stereotypically female traits of *'passivity'* - even waiting for the sperm to penetrate and fertilise the ovum (Martin 1991:486). However, Martin (1991,1992) does not develop this into a discussion about the female reproductive system being vulnerable or at risk of pregnancy, and she certainly does not use this metaphor in the context of contraception providing *protection.* However, other authors have explored how the concept of risk relates to women's reproductive health, particularly in relation to how the concept of susceptibility to disease and illness are linked to women's health behaviours.

6.6 Risk, the body and surveillance

Numerous authors have explored the discourse surrounding women's reproductive health, notably the relationship between surveillance and the development of risk in the fields of cervical cancer screening (Howson 1999, 2001a, Bush 2000), breast cancer (Umeh and Rogan-Gibson 2001) and Hormone Replacement Therapy (HRT) in menopausal women (Harding 1997). Both Bush and Howson identify that the cervical cancer-screening programme is representative of a surveillance system *par excellence*, and both refer to the intricate system of information-collection and the policing nature of the call and recall system, which operates to ensure that women comply.

Both authors also conduct interviews with women, in order to explore their embodied experiences of cervical screening, providing useful insights into women's thoughts and feelings. They also allude to the process of productive power operating within discourses of screening that instil women with a sense of obligation to participate, for the good of their own health.

However, as with Martin (1989), this work does not explore the discourses employed within the clinic, within the consulting room, between professional and woman - a key period of time when power relations are in operation at the micro-level.

Harding (1997:141) also proposes that development of the *'at risk'* body is an important factor in shaping discourse around the menopause. Utilising analysis of medical texts on HRT, Harding describes the impact upon women who face pressures to monitor their bodies for signs of degeneration and, subsequently, to seek medical help. Part of this involves the education of women about the health risks of menopause and the presentation of various modalities of treatment that can offset and ameliorate the menopause. Harding's work is important, as it analyses the way in which medical discourse incites the concept of risk and the need for vigilance but, as with the research by Bush and Howson, it does not explore the process by which women are encouraged and facilitated into this active role as part of their engagement with health-care professionals.

Lauritzen and Sachs (2001) did explore the way in which nurses discussed risk during consultations with male patients undergoing cholesterol testing in primary care. This research, however, was an analysis of how clinical test results are communicated and risk of heart disease presented and not how the patients were made aware of risk in the context of observing themselves. An interesting finding in this study was that nurses tended to *avoid* using language that overtly implied risk and used softer language, such as the need to be *'careful'* (Lauritzen and Sachs 2001:508). This finding was not replicated in this study. Within Body education nurses explicitly utilised the terms *'risk'* and *'danger'* and made no attempts to use *softer* terms. Perhaps the distinction here was that, in Lauritzen and Sachs' work, nurses were also giving abnormal blood results and were using strategies to minimise anxiety, whereas, nurses see discussion of risk in the family planning clinic as part of improving preventative behaviour, partly by developing the notion of the at-risk reproductive system.

Nettleton (1997) and Lupton (1997) argue that the creation of risk is a key element within the process of encouraging individuals to care for themselves and place the concept of risk clearly within modern discourses of health promotion and self-government.

Greco (1993) and Ogden (1995) both point out that the concept of risk links clearly with the notion of reconfiguring the individual from a passive to an active participant in care. In other words, risk and its reduction or management becomes the rationale for self-care.

6.7 Discursive techniques, surveillance and the *'active patient'*

Within the consultation data, it is apparent that nurses utilise a range of discursive techniques to develop both the knowledgeable and reproductively vulnerable *patient*. Many of which can be regarded as examples of what Foucault (1981b) refers to as to the discursive practices of *'power/knowledge'* that seek to control, regulate and separate discourse as part of the *'will to truth'*:

> *'Within every society discourse is controlled, organized and redistributed'. (Foucault 1981b:52)*

The way in which nurses frame the consultation within the scientific discourse of anatomy and physiology and seek actively to dispel *'myths'* and replace them with facts is representative of Foucault's *'procedures of exclusion'* (Sheridan 1980, Howarth 2000). Procedures and techniques that, according to Foucault, are central in the deployment of power/knowledge, acting to control, restrict, deny and promote various bodies of knowledge through the regulation of discourse.

Prohibition – we cannot say what we want when we want. The nurse's role is to educate the woman about her body, also to remove misunderstanding, and to dispel myth. In doing so, the nurse utilises *'power/knowledge'* to set the discursive limits of the consultation. It is the nurse who possesses the body knowledge, not the woman:

> *Nurse K :Yes I think we do have... and I think its not just how they function but its about the myths because when you got like somebody say on the progesterone method and their periods are stopping, or they've stopped, and there's a lot of women who think its bad for them because there's this backing up of blood somewhere and you need to explain to them how cycles work.....*

This separation of the woman's lay knowledge from the medical discourse also represents an example of the process of *division and rejection*, the way in which discourse continues and is formed around assumptions of relative importance. In the consultation, the nurse's anatomical knowledge is clearly regarded as more important than the woman's.

In addition, it reflects what Foucault refers to as the *'will to truth'* - a process by which discourse is valued in the terms of its ability to reveal the truth.

The issue of *'truth'* can also be seen quite explicitly when nurses use anatomical models and diagrams within the process of Body education, as a way of reinforcing their verbal descriptions of the reproductive system. Nurse 'B' illustrates how these models can also be used to strengthen the notion of reproductive vulnerability by including the terms *'protection'* and *'damaged'* in her comments, when using drawings to educate women:

> *Nurse B: I usually do drawings whatever as to..you know...how the cervix is and why it needs protection...we look at the fallopian tubes and how they can be damaged, so we do look at the reproductive system*

Models were also used in order to help explain the reproductive system to women. It is interesting to note that the models are only of the pelvic area, as Nurse 'J' describes:

> *Nurse J: We've got a big latex pelvic model*
>
> *MH: right...so you can use it...?*
>
> *Nurse J: to look at it and feel the cervix and that kind of thing*

The use of diagrams and models, combined with anatomical and physiological descriptions, demonstrates quite a powerful discursive process in the construction of the reproductive system. The use of anatomical models can be seen as a further extension of the *'will to truth'*. The models are representative of medical discourse, they are the texts produced by the 'discipline' of medical science that speak the truth about the body. The woman can *'see'* the *'truth'* with the nurse. In other words, the models are a way in which the *'gaze'* is displayed to the woman, developing her understanding. Armstrong (1983:2) refers to the use of anatomy in developing the medical gaze by using the term *'atlas'*, when describing the role of anatomical diagrams in medical education. Here we can see an example of the nurse sharing the *'atlas'* with the patient.

Perhaps this sharing is a subtle, but important example of the way in which power has moved from repression to production. Foucault's (1973) notion of the medical gaze referred to the development of a specific way of *seeing* the body, a process that contributed significantly to the development of medical power, partly because it marked a way of seeing that was not available to the patient. Productive power and the development of the *'active and vigilant patient'* require much more a sharing of the gaze, a gaze still determined by medical and scientific discourse, but utilised in power relations in new ways.

The models and diagrams are also powerful tools in the process of *'division and rejection'*, the separation of the *'true'* anatomy and physiology of the body as represented in the diagrams, from the *'myths and misunderstandings'* of lay knowledge sometimes held by the women who, of course, have no diagrams and models. Although there are no examples of this tension between lay and medical discourse on contraception in the literature, there is evidence that similar issues exist in other areas of women's reproductive health. Several authors remark on the increased medical and technical aspects of childbirth and pregnancy, contributing to the dilution of lay beliefs about the body and pregnancy (Cartwright 1995, Georges 1996, Mitchell and Georges 1997). Duden (1993) argues that, within the development of health education this medicalisation of body discourse has been presented as *giving* women knowledge about their pregnancy and has been regarded as a positive and enabling process. However, Duden (1993) also claims that this 'giving' of knowledge has paradoxically meant that women are drawn more closely into the medical arena, within which they must discuss health and their body utilising medical discourse. However, in so doing, almost inevitably, they have to submit to the clinician's greater knowledge.

Parallels with this can be drawn with the consultations in this study. Women are equipped with knowledge of their body, including the *correct* terminology for the reproductive organs and exposure to the *'atlas'* of anatomy and physiology, relating to the reproductive processes of the body. However, at the same time, women are drawn into the discursive field of medical/scientific discourse, a place where they engage with a health professional far more versed in that discourse and much more comfortable with the terminology, also a health professional in possession of additional knowledge, beyond the level to which the woman has been taught, that is ready to be brought into play: certainly a clear example of what Foucault means when he refers to the link between power and knowledge.

6.8 Self-surveillance

The discursive strategies employed and discussed above provide numerous examples of a process that sees women embrace scientific and medical discourse about their bodies. However, within the discussion, it has also been briefly eluded to that body education is closely linked with women's engagement in self-surveillance. This next section will explore in greater detail how women are helped to develop into *'active patients'*, in a process that encourages both the close monitoring and, sometimes, self-examination of their bodies.

It seems clear from the data that one of the key reasons why women are educated about their bodies is to enable them to monitor them, something that was supported by interviews with nurses. For example, in this extract a nurse clearly indicates that a woman has no idea about anatomy, but requires this information in order to monitor and examine herself:

> *Nurse C: Yes and you often, you still find the woman who has the coil fitted and if you say 'we advise you to feel for the threads and this is the way to do it', they have no idea about the anatomy of their body.*

6.9 Developing the *'active patient'*

A significant element of the consultation consisted of nurses building upon body education by advising women how to monitor their bodies, asking them about their bodies and teaching them body techniques. Women are, therefore, required to put the body knowledge that they have gained into practice, by becoming active participants in the monitoring of their bodies. This activity therefore projects the *'gaze'* out from the consulting room and clinic into the woman's daily life; the woman becomes an extension of the surveillance practices of the clinic. Women are required to report signs and symptoms that they have observed to the nurse at subsequent clinic visits, often in response to close questioning by the nurse:

> *Nurse I: we talk about periods and things and any bleeds when they should not be expecting to get bleeding, that it's worth them (*the woman*) making a note of so we can look at it when they come back, I think if you go through the symptoms you may well pick up when they come back, they may mention the symptoms that you've mentioned.*

However, there are limits to the woman's role in monitoring her body. This limit appears to exist at the point where a *diagnosis* or interpretation of the sign or symptom being reported is concerned. Nurses encourage women to report symptoms, but not to interpret the relative importance of the body information they are supplying. This process is a further representation of the employment of power/knowledge within the consultation, inasmuch as the woman has only the knowledge of her *own* body to report. As seen earlier, she is often unfamiliar with the medical terminology for this.

However, the nurse is in possession of, firstly, the terminology and secondly, the knowledge base that she has acquired through training. She also has the ability to compare reports from the woman with norms drawn from her consultations with other women and from medical texts. An example of this can be seen from an interview with nurse 'K':

> *Nurse K: when she listed these things (*symptoms*) I said to her, I think these are side effects, I don't think these are..I think you're bloating, your mood swings, spots and changes to your skin and hair....its linked to your hormones.*

This is a clear illustration of the *'normalising judgement'* operating within the consultation. Both Nettleton (1994) and Rabinow (1984) identify that one of the discursive practices within disciplinary power is a process that involves the comparison of individuals with a norm. Nettleton (1994) proposes that a key element of disciplinary power is the way in which medical practitioners observe, record and take histories from individuals and subject these observations to interpretation, utilising records, experience and knowledge drawn from training - training that includes knowledge gained from scientific texts, bodies of knowledge such as epidemiological statistics and the teachings of more experienced practitioners. Against these criteria, a judgement can be made about the relative importance of signs and symptoms reported by the patient. Nettleton (1994:82) refers to the practitioner being the *'normative judge'*, against which patient reports and clinical examinations are compared and identified the *'dentist judge'* in her analysis of the social construction of the mouth in dentistry (Nettleton 1994:82). Here, we can certainly add the *nurse judge.*

In this extract, the nurse illustrates this process by indicating her role in telling women what is normal and what is not:

> *..and that periods on hormonal contraception are not natural periods 'cause there are lots of women that say 'but my periods have changed on the pill', so you need to tell them its not a normal period its a withdrawal bleed that sort of stuff and what's normal.....(Nurse K)*

Within this process, it is the patient's role to report accurately and the practitioner's role to interpret. The consultation data demonstrated several examples of this. Nurses would encourage women to be active observers and reporters of body signs, but would then act as the interpreters of those signs, helping women to gain a better understanding:

> *Nurse: Yes, because the side you're pointing to and the place you are pointing to, that's where your bowel erm...comes down the side before you actually open your bowels*
>
> *Woman: oh yes...*
>
> *Nurse: and sometimes if you've had constipation that's where you can often get aches and pains 'cause it all blocks up so it can actually be related to your bowels rather than periods*
>
> *Woman: oh I didn't realise that*
>
> *(Consultation 27)*

One of the most significant physiological functions that served as a target for this education and interpretation was the menstrual cycle. From the consultation data it can be seen that menstruation is a central issue in the monitoring of the body. In nearly all the consultations with women, the menstrual cycle is discussed and women questioned about its timings, characteristics and associated discomforts. These reports are interpreted by the nurse, who frequently uses terms such as *'normal'* or *'proper'* to make a judgement about the menstruation described by the woman. This interpretation is also often accompanied by an explanation and further body education.

Laws (1990) claims that menstruation, although an obdurate fact of physiology, is also subject to intense social construction in both medical and social discourse. She gives examples of the notions of cleanliness and hygiene problems constructed around menstruation and discusses the role that menstruation plays as a marker of fertility and infertility in medical discourse.

Laws (1990) makes the point that medical discourse has, in fact, constructed the notion of a *'proper'* 28-day menstrual cycle, whereas many women do not experience menstruation in this way. Laws also adds that an exploration of medical texts reveals clear evidence that this *'normal'* cycle is used by doctors to assess menstruation and to place it in the domains of either the normal or abnormal (Laws 1990).

This is evident within the surveillance *training* that women undergo in the consultation. They must learn to monitor their bodies in ways that are compatible with medical discourse and they are discouraged from alternative monitoring techniques. A clear example of this is reflected in this exchange:

> *Nurse: And you have a period every month are you, pretty spot on.. or more or less?*
>
> *Woman: Erm... usually every 28 days, 24 days*
>
> *Nurse: From the beginning or are you counting from the end?*
>
> *Woman: From the end.....*
>
> *Nurse: Yes, well we always count actually from the beginning, so you're about 27 days, thank you.*

In this extract the woman is taught to conform with the accepted way of monitoring her menstruation; she is made aware of the need for accuracy, also of the requirement to utilise the nurses, and by the use of the word '*we*', inferring the health professions method of monitoring. It would seem, therefore, that one element of creating the active patient is ensuring that the information that they provide is *useful* to the health professional; in other words, in a form that can supplement their gaze, compatible with the dominant medical discourse.

Kleinman (1988) argues that, in his discussion of the medical gaze, Foucault identifies the crucial importance of the interpretation of a symptom or a sign described by a patient within the process of medical power:

> *'Clinicians sleuth for pathognomonic signs- the observable telltale signs to secret pathology..the patient-physician interaction is arranged as an interrogation. What is important is not what the patient thinks, but what he or she says'. (Kleinman 1988:16)*

Kleinman is referring to Foucault's earlier work here, with regard to the rather limited patient contribution to diagnosis. The patient in this encounter is merely responsive to medical questioning and remains otherwise passive. However the emergence of the more *active patient* does not necessarily diminish the principle of patient's reporting symptoms for medical interpretation.

Indeed, Silverman (1987) identifies development of the *active patient* as a broadening of medical surveillance and power. The key difference from earlier models of medical practice is that rather, than *'docile'* patients being *'pounded'* by questions, there is a more subtle *'incitement to speak'* to the *'active patient'* within the consultation (Silverman 1987:226). Silverman argues that greater involvement of the patient is:

> *'both emancipating and constraining. The mistake is to treat surveillance purely as a function of professionals treating patients as objects of the clinical gaze. Surveillance works no less efficiently when we are constituted as free subjects, whose freedom includes the obligation to survey ourselves'. (Silverman 1987:225)*

However, the outcome of this freedom to survey ourselves is a requirement to understand more about our body, and our health, and to develop skills of examination and surveillance in order to speak of them in the medical encounter. The interpretation of this information still lies with the professional, who knows the body and is, therefore, able to decipher the information. As Fox (1993) notes, bodily symptoms:

> *'Cannot be read correctly by just anyone: the reader must be an expert'. (Fox 1993:29)*

This process is clearly related to what Turner (1995:271) identifies as the *'Foucault paradox'*: that the price for greater individual freedom is the paradoxical requirement to submit our bodies to greater surveillance. This also resonates strongly with Frank's (1991) concepts of body practices being both simultaneously liberating and restraining.

6.10 Self-examination

In addition to body observation, some women were also encouraged to conduct self-examination techniques as part of contraceptive use. This process is closely integrated with body education and self-surveillance and involves the teaching of body techniques, such as breast examination, diaphragm or cap insertion and vaginal/cervical examination for coil threads. All of these body techniques are examples of a process in which the woman is constructed as an active participant in the surveillance of her body, representing the way in which she becomes an extension of the nursing *gaze* - a *gaze* that extends beyond the clinic, into the woman's daily life.

Women's bodies as sites of self-examination have been discussed throughout the literature on women's reproductive health, particularly in relation to breast cancer. Teaching women about breast anatomy and physiology, in order to detect abnormality, has a relatively long history in the medical and nursing literature, the general consensus being that breast-awareness and the practice of breast examination increases the chances of the early detection of breast cancer. Breast self-examination is, therefore, generally seen as a positive aspect of women's health (Alagna et al 1987, Kline 1996, Baines 1997, Champion and Miller 1997, Epstein et al 2001) a view that is reflected in the literature on how this self-monitoring can be taught and encouraged in both clinical encounters and health education (Wordon et al 1990, Holmberg et al 1997, Solomon et al 1998, Janda et al 2003).

There is less literature on how breast examination can be linked into the wider issues of surveillance medicine, although there are increasing attempts to problematise breast examination from the perspectives of its capacity to create levels of anxiety and fear in women that are disproportionate to the health benefits that it brings (Kline and Mattson 2000, Babrow and Kline 2000).

The value of breast examination is also explicitly present in family planning literature because of the increased risk of breast cancer in women who are using hormonal contraception (Louden et al 1995). As such, it has become an integral element in contraceptive advice.

Within the consultation data, the teaching of breast examination provides a good example of the links between Body education and Body surveillance:

> *Nurse: Depending on what time of the month you do your breast examination you might find that your breasts feel a little bit lumpy and that could be around period time, you're probably better off doing it a few weeks later' (Consultation 20)*

It also demonstrates how contraceptive use requires the woman to become increasingly aware of her body. The above extract also provides evidence of the link between menstrual surveillance and self-examination. However, although self- breast examination is a component of the consultation process, it is, to an extent, tangential to the development of the woman as the *active patient* with regard to contraceptive use. A more direct link with contraceptive use can be seen by the development of vaginal and cervical self-examination techniques for women who are using methods of contraception that require physical insertion (the diaphragm and cap) or physical checking (the IUD or coil).

In order to use a diaphragm or cap, a woman must be able to insert the device that fits over the cervix that, with the addition of a spermicidal cream, prevents conception. Women who use a coil are encouraged to feel for threads which protrude a few millimetres through the cervix, this technique is used to check that the coil is still in place. Part of body education and surveillance for some women therefore includes nurses addressing the issue of vaginal and cervix self-examination.

There is certainly far less emphasis upon vaginal/cervical self-examination than breast examination in the medical and nursing literature. This is probably due to the fact that breast examination is deemed medically important because of the presence of self-detectable anomalies, whereas vaginal/cervical abnormalities are not generally self-palpable, but are diagnosed through microscopy and laboratory techniques. Because of this, vaginal examinations are usually the domain of the clinician. Indeed, this fact is clearly reflected in the literature, which is mainly related to women's experiences of *being* examined, either during gynaecology procedures (Kerssens et al 1997, van Elderen et al 1998, Zuckerman et al 2002) or as part of pregnancy (Lai and Levy 2002) rather than examining themselves. This literature tends to conclude that women dislike vaginal/cervix examinations, and find them uncomfortable and, sometimes embarrassing, particularly if the examiner is male.

In the family planning literature, only a couple of papers have addressed vaginal/cervix self-examination directly and both of these explored the use of the diaphragm and cervical cap. No papers were focused upon vaginal examination to check coil threads. Roizen et al (2002) explored the ease with which women could use a new type of contraceptive cap, but did not explore how women were instructed in its use, nor did they discuss how women felt about the practice of vaginal self-examination. Similarly Bounds and Gillebaud (1999) explored the ease of use of a contraceptive diaphragm in a small group of women (n=10) who had received instruction on the technique, however, as with Roizen et al, they did not describe or analyse how the instructions were given, or discuss women's feelings about inserting the device. However, given that these two papers were aimed at a clinical readership, the emphasis was upon discussing the method, not the women's experiences. Both papers did, nonetheless, argue that women required instruction in the clinic relating to use both of the cap and of the diaphragm.

The topic of vaginal/cervix self-examination in the non-clinical literature is also fairly limited. Where it is addressed, there is a difference of opinion as to the value of women becoming more aware of their reproductive system in this way. Some early feminist literature does argue, within the context of women's health, that women should be more aware of their bodies, particularly their genital and reproductive system, with some authors proposing that, in order to do this women could use mirrors etc. to visually locate and observe the cervix (Phillips and Rakusen 1971, Ruzek 1978, Gardner 1981). However, Birke (1999) argues that this aspect of women's health does not persist strongly within the feminist literature on the body in the following two decades.

Interestingly, this concept has re-emerged a little more recently, in response to developments in medical technology. Kavanagh and Broom (1997) describe how, when women are undergoing biopsy of the cervix, an image of the cervix is visually relayed to a video screen in the clinical room. This image is primarily for the clinician, but Kavanagh and Broom argue that it is empowering for the woman to glimpse part of her body that has usually been only visible to a clinician, proposing that the woman can actually see the focus of medical attention, therefore becoming more aware of her reproductive anatomy.

However, others have argued that this image actually reinforces medical power, by placing the cervix within the whole domain of medical technology, and that this can increase anxiety by highlighting an area of the body that has the potential for disease, but as an area that can only be inspected by medical experts (Posner and Vessey 1988, Stafford 1991).

In the only sociologically-based paper to address this Howson (2001b) agrees with the stance about the limited scope for empowerment within medical imaging of the cervix. Howson (2001b) interviewed women undergoing procedures to visualise the cervix and argued that women increasingly referred to the cervix as a medically-defined space, vulnerable to disease, and proposes that, in order for such imagery to be useful, there is a requirement for it to be separated from medical discourse. Howson's paper sheds interesting light on a topic that has received scant attention and makes some valid points about women's feelings about their bodies.

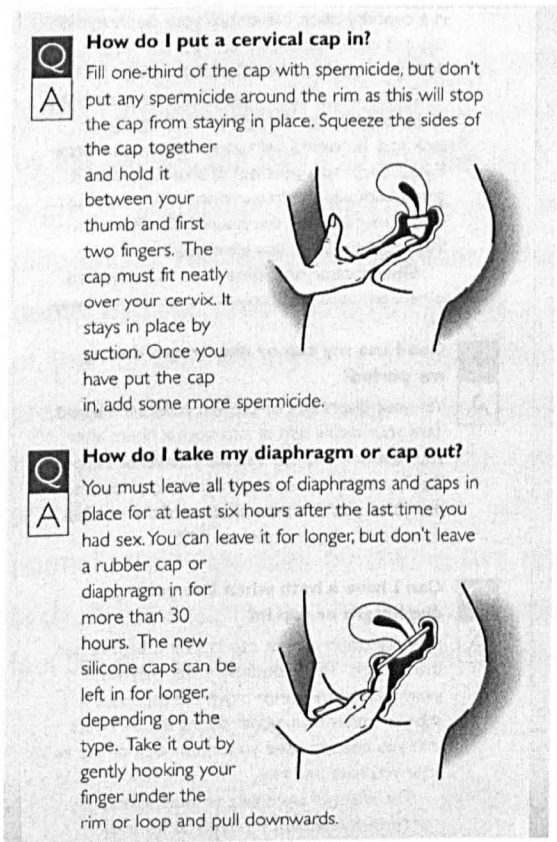
However, within the family planning consultation, the issue of vaginal/cervix self-examination occurs in a somewhat different context. Firstly, women are not being examined by the nurse, neither are they able to view their own cervix. In the family planning consultation, women are being encouraged to further the knowledge of their bodies not by visualising them but by physically examining themselves, an aspect that Howson (2001b) did not set out to address. The purpose of this examination is not the detection of disease, as in Howson's research; but effective use of contraception and therefore could be regarded as enabling. It could, however, be claimed that this process is also constraining, in that it also places the cervix within a clinically-defined space - that of reproductive health - an issue that seems to form part of nurse's strategy for encouraging women in the techniques of self-examination.

Within the consultation several approaches are utilised by nurses when encouraging women to self-examine. Firstly, the notion of being *reproductively vulnerable* is revisited. For example, the coil-user is urged to check so *'you know that it's still there'* and also that this checking can alert the woman to problems*: 'if you feel any more plastic then come back immediately'*. With the diaphragm, women are informed that, if fitted correctly it provides protection: '*you see, it's covered all the cervix there*'.

This extension of body education creates the rationale for self-examination, that of policing the body against pregnancy which, to some extent, resonates with Howson's (2001b) argument that, in visualising the cervix it becomes a medicalised site of disease. Here the cervix is visualised as a vulnerable site for pregnancy: *'you might get some sperm swimming around it'* a woman is cautioned. Thomas (1992) proposes that, in medical and scientific literature, the cervix is seen as both the functional and symbolic '*gateway*' to the womb. If this is accurate, then it would seem logical that, in contraception, guarding of this gateway performs an important functional and symbolic act.

Nurses in the family planning clinic do not have access to video technology to aid their teaching, but they do make use of models and diagrams to help instruct women in the techniques of self-examination. The diagrams are in the form of leaflets, that women can take home, and are quite detailed (see figs. 12 and 13). The diaphragm image, in particular, provides a good illustration of the guarding of the *'gateway'* mentioned above.

Figure 12: Cervical cap/diaphragm



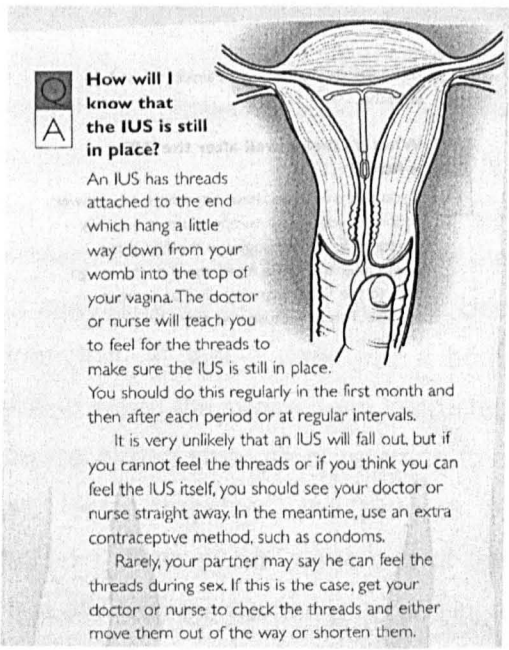
How do I put a cervical cap in?

Fill one-third of the cap with spermicide, but don't put any spermicide around the rim as this will stop the cap from staying in place. Squeeze the sides of the cap together and hold it between your thumb and first two fingers. The cap must fit neatly over your cervix. It stays in place by suction. Once you have put the cap in, add some more spermicide.

How do I take my diaphragm or cap out?

You must leave all types of diaphragms and caps in place for at least six hours after the last time you had sex. You can leave it for longer, but don't leave a rubber cap or diaphragm in for more than 30 hours. The new silicone caps can be left in for longer, depending on the type. Take it out by gently hooking your finger under the rim or loop and pull downwards.

Figure 13: Intra-Uterine system



How will I know that the IUS is still in place?

An IUS has threads attached to the end which hang a little way down from your womb into the top of your vagina. The doctor or nurse will teach you to feel for the threads to make sure the IUS is still in place. You should do this regularly in the first month and then after each period or at regular intervals.

It is very unlikely that an IUS will fall out, but if you cannot feel the threads or if you think you can feel the IUS itself, you should see your doctor or nurse straight away. In the meantime, use an extra contraceptive method, such as condoms.

Rarely, your partner may say he can feel the threads during sex. If this is the case, get your doctor or nurse to check the threads and either move them out of the way or shorten them.

These texts provide a further example of the sharing of the *'anatomical atlas'* (Armstrong 1983) as mentioned earlier. Here, the diagrams provide clear anatomical instruction for women to take away and refer to. When Armstrong (1983, 1993) proposed that the medical gaze extends beyond the clinic, he was referring, in the main, to how individuals could be encouraged to be observant of body symptoms, in order to project the medical gaze into daily life. Not the projection of the medical *examination* itself, yet this is what is taking place here. Nurses share the *'anatomical atlas'*, the diagrams, with women for this purpose - a process of instruction that starts in the clinic but takes place elsewhere, projecting the clinic into the bathroom or bedroom.

In addition to utilising the notion of reproductive vulnerability to contextualise self-examination, nurses also attempt to normalise the techniques involved. This takes the form of referring to tampon use when discussing vaginal examination by women:

> *Nurse: do you use tampons?*
> *Woman: yes*
> *Nurse: OK, so you're comfortable about inserting and pulling things out*
> *(Consultation 14)*

Nettleton (1994:82) argues that normalisation is a powerful element within the deployment of disciplinary power. In medical practice, normalisation often takes the form of the practitioner not only acting as a *'judge'* in response to reported symptoms by the patient, but can also take the form of the practitioner placing the patient within a group, population or, indeed, gender in order to make comparisons and highlight differences. Nettleton uses the example of the dentist using his/her knowledge of the dental hygiene practices of '*others*' as a way of instructing patients in oral care. Use of the tampon example is slightly different from this, in that it does use a body practice with which most women are familiar, and in which they have been instructed from an earlier age (Laws 1990), but it also has the added strength of referring to a practice that the woman carries out herself. Here, therefore, the process of normalisation operates by linking two acts that take place at the same site of the body, but are performed for different reasons, one of which the woman is versed in, a fact the nurse uses to pave the way for the insertion of the diaphragm.

The development of body techniques, then, provides an illustration of how, in some cases, body surveillance incorporates more than just 'visual surveillance' and 'reporting sensations'. For some women, Becoming the *active patient* means conducting examinations and techniques that are normally restricted to the medical domain. The teaching and encouragement surrounding self-examination techniques is a further example of the deployment of productive power in the consultations. It forms an additional strand in the recruitment of the woman into the role of the *'active patient'* and is an illustration of the manner in which individuals are developed into an extension of the clinical gaze. However, not all surveillance of women was conducted through the development of self-surveillance skills.

6.11 Body surveillance by the nurse

There is no doubt that a significant aspect of the consultation is focused upon encouraging women to self-monitor. This is evident within the consultation data and the subsequent analysis, and also in the discussion thus far. The nurse's role in this process is to tutor the woman in the skills of self-surveillance and to encourage the woman to be vigilant. This aspect of creating the *active patient* is, therefore, presented as an excellent example of the manner in which productive power is utilised to supplant the traditional historical role of the clinic and its practitioners, as the sole instruments of surveillance, exemplified by the early work of Foucault (1973, 1977). However, the consultation data did demonstrate that the nurse is also engaged in traditional direct techniques of surveillance when the woman visits the clinic. Indeed, the data analysis towards the end of the previous chapter illustrated how it was mainly the *direct* surveillance activities conducted within the consultation that fell outside the intersection of the two core categories and was best situated exclusively within 'Surveillance'. A great deal of this direct activity was the collection and use of information. Nurse 'J' provides one indication as to its purpose:

> *MH: There seems to be an awful lot of information recording going on (*in the consultation).....
> *Nurse J: Yes, oh yes*
> *MH: Why is that done?*
> *Nurse J: Really to try and keep a proper control...*

When attending clinic, women routinely have numerous measurements and observations about their bodies recorded by nurses. This information is stored on the woman's own personal file or record that is kept by the clinic, a record that is retrieved by the nurse prior to the woman's clinic visit and is used in the consultation. Nurses routinely weigh women, calculate body mass, measure blood pressure and record information about any illness that the woman may have had. The files also contain other items of information, such as the woman's contraceptive use in the past, previous clinic attendances, also lifestyle information - such as cigarette smoking. The records kept by the clinic provide, sometimes over years, a mass of information about the woman, records that enable the clinic to undertake, through the nurse, direct surveillance of the woman. Indeed it can be said that when attending the clinic women place themselves into, as Foucault notes:

> *'A field of surveillance...that situates them in a network of writing; it engages them in a whole mass of documents that capture and fixes them....a system of intense registration and documentary accumulation (Foucault 1977:189)*

This documentary evidence clearly plays a role in the deployment of power within the consultation. It provides a reminder that, although the women are tutored in self-surveillance, the clinic is still engaged in a more direct form of monitoring. It is during the consultation, through the nurse, that this documentary information is utilised in this manner, raising the question: is the clinic acting as some form of Panopticon?

Nettleton (1994) and Lupton (1994) both refer to the development of disciplinary power being closely allied to close observation of patients through detailed record-keeping and examination. As discussed previously, Foucault identifies three elements of disciplinary power, *hierarchical observation*, *normalising judgement*, and *the examination* (Foucault 1973: 184) elements that Nettleton uses in her analysis of dental practice and disciplinary practices (Nettleton 1994: 83).

Hierarchical observation refers to the development of specific geographical sites where individuals can be observed - for example schools, barracks and prisons - which then operate as *'laboratories of power'* where disciplinary training takes place (Nettleton 1994:84).

Clearly, contemporary health clinics do not reflect the austere and regimented routines of which Foucault was thinking of here. However, Nettleton argues that the modern dental clinic does exemplify the key features of an observational site and describes how the dental surgery is the geographical space in which the mouth is observed, mapped, recorded and treated. Pryce (2000, 2001) makes similar claims for the Genito-Urinary Medicine (GUM) clinic, in that the treatment of sexually-transmitted infections occurs within the clinic, where the patient is observed, investigated and treated. Furthermore, although Pryce did not research the actual clinic consultation, he did undertake a detailed analysis of case-notes and other documentary evidence and he argues that clinic records are used to police both the individual and, through contact-tracing, the population. Both Pryce and Nettleton argue that, although the *active* and self-monitoring patient exists, this existence occurs alongside the disciplinary framework of a more traditional *Panopticon-like* system of surveillance.

Utilising this view, it is possible to suggest that the family planning clinic acts as a site of hierarchical observation, in similar ways to the dental or GUM clinic. The clinic places the woman into a location where observations are made and training is given. Additionally, although dental patients are invited to return, and GUM patients may return with a new infection, the family planning clinic builds in the necessity of clinic re-attendance in order to obtain more contraception - for example, a re-issued pill, repeat Depo-Provera or more condoms, thereby ensuring continuation of surveillance. Additionally, as an extension of Nettleton's and Pryce's work, this data gives *specific* examples of how records and case-files are *discursively* utilised as techniques of surveillance within the actual interface between the clinic and the patient; the consultation.

Within observational sites, disciplinary power is exercised through the application of both a *'normalising judgement'* and the *'examination'* (Nettleton 1994:82). Comparing patients to norms is a key element of surveillance and disciplinary power. Within the family planning consultation, this process can be seen when nurses undertake body measurements from women, for example measuring a body mass:

> *'that makes your body mass 23...you are in the green band (referring to chart on wall), this is healthy...this is underweight, this is overweight...so you're fine (Consultation 3)*

Also blood pressure:

'That's fine 120/66...that is within the normal range (Consultation 1)

In addition to comparing with a norm, disciplinary power is also deployed through the examination, a process which *'introduces individuality into the field of examination'* (Foucault 1973:189). One example of which is the development of individual case-files, which, in dentistry provide the clinician with an intricate and meticulous record of the patient's mouth and teeth (Nettleton 1994:83), which are then used to compare and contrast with the patient's actual mouth at each clinic attendance. Similar work, undertaken by Cheek and Rudge (1994a, 1994b) and Poirer and Brauner (1990), used textual analysis to analyse the discursive construction of medical case-files. They found that case-files were used to collate statistics and measurements that could be employed in future consultations and, although they did not research the actual discursive techniques used to do this, they suggested that case files are important examples of power within consultations. These authors, in addition to Nettleton, make the entirely reasonable assumption that practitioners utilise records in this way, but they did not explore *how* records were used discursively *within* the consultation. The data from the consultations in the family planning clinic does provide some examples where this occurs in practice.

In the family planning clinic, the woman becomes *a case, a file.* She becomes an amalgamation of information that is utilised within the consultation. The woman is often made aware that this collection is ongoing, an act that reminds her of the surveillance she is under. An example of this can be seen when nurses record information. Quite often, when doing so, the nurse mentions to the woman that she is recording the information she has just obtained: *'I'm going to write that down', I'll just record it'.* She also makes the woman aware that this information will be used to compare present recordings with previous ones: *'I'll just see what you were last time'; 'I will just compare it to last time'; 'you've actually, since '97, put on three pounds'; 'actually you've lost a kilo since last time'.*

Throughout the consultation, nurses make reference to the fact that they can refer to a body of information about the woman held by the clinic. For example, *'I just need to check your records'; 'let me just look at what your comments (*written comments by previous nurses*) say'; 'now...let me just get your history up'.*

This use of the case-files is interesting, since it indicates that not only do the files provide statistical information for the nurse to use in surveillance, but they are also utilised in a discursive manner. In other words, the files exist for use purely as a form of reference, example enough of direct surveillance, but they are also used as tools, to indicate to the woman that she is being monitored. Thus, the case files can be seen as having a subsidiary purpose, that of providing a subtle reminder that the clinic is watching.

The development and use of case-notes in the consultation mark a shift away from the more productive power relations utilised to develop self-surveillance in the woman. The case-files provide an example of the direct surveillance undertaken by the clinic, surveillance that is utilised to *check up on* the woman at clinic visits. Productive power is employed to develop the *'active patient'*. However, in the background, the surveillance duties of the clinic are deployed through the nurse to monitor this. The case-files and, crucially, the manner in which they are specifically deployed within the consultation act as a constant reminder to the woman that she is being monitored and her actions, certainly in the field of her reproductive behaviour, are forming a set of records to which she will be compared to, measured against and, to some extent, answerable to at subsequent clinic visits.

Of course, the clinic, acting through the nurse, does not confirm to the absolute notion of the Panopticon, envisaged by Bentham and utilised by Foucault as a *'diagram of a mechanism of power reduced to its ideal form'* (Foucault 1977:205). Women are not under the constant and direct observation and control of the clinic, far from it. Indeed, the discussion so far has focused upon the process by which women are developed into self-monitoring individuals and are recruited into being the active extension of the clinic in their daily lives. Indeed, some authors have suggested that, because of the notion of the *active patient,* the concept of the Panopticon is now redundant (Baumann 1999:23), having been replaced by more *'seductive'* forms of control for example, the forces of persuasion, consumerism and pleasure seeking. Bogard (1996:76) also claims that *'simulation',* in the form of anticipating events and preparing for their occurrence, is replacing the *Panoptical* process of first observing and then acting to correct a problem. This trend can be seen in elements of health education, for example, preparing people to identify early signs of heart disease and to take remedial action. A specific example of this from contraception will be discussed later, in section 6.17.

However, Boyne (2000) argues strongly that although there are definite trends in Western society to support the dilution of the Panopticon, there is also evidence to the contrary, and citing the growth of electronic surveillance of groups and individuals in modern societies, particularly in the workplace (Taylor and Bain 1999) and in public spaces (Webster 1999). Boyne (2000) also argues that it is easy to overestimate the extent of simulation and proposes that, in health care simulation co-exits, to a large extent, *alongside* more direct surveillance, a situation that is reflective of the role played by direct form of surveillance in the family planning clinic.

The debate between Boyne (2000) et al and Baumann (1999) et al seems to be about whether other forms of power have completely supplanted the concept of Panopticon or if the Panopticon continues to be a valid concept. Boyne's point is that the issue is more about the *degree* to which surveillance of the type envisaged by the concept of Panopticon is present and the *degree* to which surveillance has been supplanted by other methods. Certainly, within the family planning consultation, there are processes that are more akin to the deployment of productive power through discourses of persuasion and self-management. However, within this process, there is also evidence of a more traditional and direct form of surveillance taking place, one where clinic records are employed in order to place women under surveillance. This *'Panopticon-like'* system, it is proposed, provides a checking mechanism against which the self-care practices of the woman can be measured. Pryce (2000) claims that the GUM clinic act as some form of Panopticon. The data in this study suggests that the same can be said of the family planning clinic. An aspect of the clinic that is also closely linked to developing the *'compliant patient'* in addition to the *'knowledgeable'* one.

'Compliance'

6.12 'Compliance' introduction

As illustrated in figures 8 to 11, 'Compliance' is closely integrated with 'Surveillance'. The techniques utilised by the nurse within the consultation in educating women about their bodies and in developing the ability to observe and monitor their bodies are both pre-requisites and closely allied to the development of compliance. The core category 'Compliance' is a holistic process, but one that can be best illustrated by analysing the elements of 'Body Education', 'Body Surveillance' and 'Regimen' within it. 'Compliance' is primarily about utilising body education to address the issue of side-effects, developing a disciplinary framework within which the woman can adhere to a contraceptive regimen and helping her to recognise and manage threats to that regimen.

The literature on this topic is dominated by clinically-based work in which compliance is regarded uncritically as an essential element of successful contraceptive counselling. There is significantly less literature that explores contraceptive compliance from a perspective other than its medically-defined importance to women's health. Some feminist authors have explored the relationships between compliance and contraception, patriarchy and the control of women's fertility and reproductive health. This literature argues for a more critical stance to be taken with contraception and women's health, arguing that compliance with contraception can be linked to debates around population control and the increased medicalisation of women's lives (Arditti et al 1984, LaCheen 1986, Hartmann 1987, Forrest and Kaeser 1993, Steinbock 1995). This literature, however, takes a broader societal or population approach and does not include any type of analysis that explores the actual process of contraceptive counselling and the relationship to issues of compliance.

Within the clinical family planning literature, compliance is a central issue. The literature is replete with research that identifies the importance of encouraging compliance in women who are using contraception (Balassone 1989,Rosenberg and Waugh 1999, Dardano and Burkman 2000, Rasch 2003). It also sets out the dangers of non-adherence to contraceptive regimens (Rosenberg et al 1995, Oakley 1997, Playle 2000, Pinter 2002, Lachowksy and Levy-Toledano 2002, Moos et al 2003).

Indeed, some of the work has explored how approaches in the family planning clinic can improve compliance, although these studies focus mainly on evaluating either different types of service provision or differing levels of information provision within the clinic, with subsequent follow up interviews (Namerow et al 1989, Adams et al 1990, Winter and Breckenmaker 1991, Jaccard et al 1996).

Compliance with contraception is regarded as a positive goal in contraceptive care and methods to enhance it are laudable. No attempt is made, therefore, to problematise and analyse compliance from a more critical angle within the clinical literature. Thus, this body of literature focuses mainly upon the numerous, diverse factors that are claimed to impact upon contraceptive compliance. Provision of information about the reproductive system has been identified as helpful by some (Oakley and Bogue 1995) who argue that knowledge of how a method works can influence compliance. This aspect, discussed earlier within the Body education section, provides an example of how education given for the purposes of self-surveillance is also linked to improving compliance.

The issue of age, demographic factors, educational status, frequency of sexual activity and the attitudes of male partners have all been suggested as having an impact upon compliance (Zabin et al 1993, Moos at al 2003). However, within the medical literature, there is an acknowledged lack of statistical data to support this (Moos et al 2003) and some studies have suggested that age and demographic factors play no part in contraceptive compliance (Oakley and Bogue 1995). However, despite these debates there is a generally-accepted consensus in the literature that regards the process of increasing compliance as a positive element of contraceptive counselling. The literature, working on this premise, sets out to identify barriers to compliance and to suggest how they can be overcome, not to critically discuss compliance from any other standpoint.

Therefore, although the clinical literature debates the multi-factorial nature of compliance, there is a consensus that developing the ability of the woman to incorporate a contraceptive regimen into her daily life is a key element in encouraging compliance. Two significant factors emerge from this consensus, these also being reflected as strong themes within the contraceptive consultations in this study. One was how women could be helped to develop a consistent and regular approach to taking contraception (discipline and regimen) and will be explored in detail later; the other was the impact side-effects can have on compliance.

6.13 Side-effects and compliance

The adverse and unwanted effects of contraceptive methods are seen as one of the most significant factors in the interruption or discontinuation of contraception by a number of authors (Adams-Hillard 1989, Makkonen et al 1992, Tyrer 1994, Rosenberg et al 1998). These papers propose that managing side-effects with women in contraceptive counselling is an important aspect of encouraging compliance, although none of the research suggests ways of doing this, beyond giving what they refer to as *'balanced information'* about side-effects.

Within the clinical literature on contraception, there are very few attempts to explore the precise way in which the issue of side-effects is discussed with women. Dodge and Oakley (1989) audio-taped 12 nurse/client interactions in a family planning clinic in the United States and, although the purpose of this study was to explore satisfaction with care, it did include an analysis of information about contraceptive side-effects given by the nurse. This analysis, not undertaken from any sociological perspective, lacked detail and depth and did not explore discourse, or make any links between giving this information and wider issues of contraceptive self-care. Similarly, Kim et al (1998) analysed the transcripts of 176 audio-taped family planning consultations in Kenya, but was concerned principally with a content analysis, related to the accuracy and extent of information given by nurses and volunteer family planning counsellors in consultations. This study did look at side-effects, but was primarily concerned with whether or not women were given accurate information about them. It did not include an analysis of *how* they were discussed. Similar limitations in this respect also apply to the work of Bessinger and Bertrand (2001) when researching contraceptive consultations in Ecuador, Zimbabwe and Uganda.

The importance of side-effects and adverse drug reactions has been discussed in literature that adopts a less medical, more critical stance, but this is related mainly to the way in which contraceptive methods are evaluated within clinical trials (Hardon 1992, Cottingham 1997, Kammen and Oudshoorn 2002) and does not attempt to analyse how this relates to contraceptive counselling. However, this work does explore the relationship between method efficacy and side-effects in contraceptive clinical trials and does make reference to the type of language used in clinical trials in relation to side-effects.

This element resonates with aspects of the discourse around side-effects seen in the data on nurse/client consultations that were described earlier and will be discussed shortly. Some literature explores side-effects from a contraceptive-user perspective, whilst numerous authors discuss how many women are often dissatisfied with the adverse effects of contraception, yet in the absence of problem-free alternatives continue to use it (Bruce 1987, Sivho et al 1995, Cottingham 1997, Hardon 1997) This is an issue that links closely with some of the discussions that nurses have with women about persevering with side-effects, an aspect of the consultation that will be explored later in section 6.16.

6.14 Side effects: dilemma and discourse

One of the clearest ways to illustrate how the two core categories - Surveillance and Compliance - are closely integrated is by exploring the issue of side-effects in the consultation. Earlier, it was suggested that nurses were confronted by a dilemma when it came to discussing side-effects with women. This dilemma involved the striking of a balance between providing women with information about side-effects, and avoidance of an approach that may adversely affect compliance. Nurses are required to make women aware of side-effects as part of developing the techniques of self-surveillance. Women need this element of body education in order to be able to observe and report symptoms accurately at subsequent consultations.

However, nurses are also aware that the adverse effect of a contraceptive method could impact upon compliance: women may be put off methods by the description of side-effects or they may cease to use contraception in the face of uncomfortable or noticeable symptoms. The data obtained from the consultations about side-effects was strengthened by interviews with nurses, which revealed that giving women information about side-effects was considered important, particularly with women who were starting a method:

> *Nurse D; Erm...well side-effects always...before anybody starts on a method I would always discuss side-effects...*

This information, as discussed in body education, is clearly linked to developing the *active patient,* a woman capable of monitoring her body for side-effects.

Women are educated about possible specific signs and symptoms associated with their method of contraception:

> *Nurse F; just simple things like D.V.T's (*Deep Vein Thrombosis: blood clots*) and you know..being aware of leg problems and things like that and er...breast changes and things..*

This education, although closely allied to surveillance, is also an integral aspect of encouraging compliance. Nurse D remarks that women are advised as to the risks of stopping contraception in the light of uncomfortable side-effects, and stresses the importance of women carrying on and then discussing them in clinic:

> *Nurse D: You know...not to suddenly stop taking it and risk getting pregnant, but to come and talk about it with us sort of thing.*

However, nurses also are aware of the need to forewarn women about side-effects in order to prepare them. Nurses often regard women as being in need of this:

> *Nurse F: because they don't tend to think there will always be a...any problems at all. I think if they know they are going to get these things* (side effects*) they're prepared for it.*

> *Nurse G:I think a lot of people expect it to be a dead easy ride, they take one pill a day and there's going to be nothing amiss with them*

Furthermore, Nurse G points out that one of the issues that creates a dilemma in side effect education is the idea that, although some women may expect none, some women may be the opposite. This is an issue that clearly raises concerns about the fear of side effects and their impact upon compliance:

> *Nurse G: and, some people are quite frightened and almost change there mind when you've gone through the side effects and they anticipate they're going to get each and every one of them.*

In chapter five it was suggested that two closely-integrated strategies seemed to be involved when nurses discussed side-effects with women. Both seem concerned, one way or another with managing the risks and benefits of contraception. One of these was the role that nurses played in persuading women to keep going with contraception in the face of uncomfortable symptoms, a strategy that drew upon the notions of perseverance and stoicism, an aspect that will be discussed shortly.

The other strategy involved the way in which nurses discursively managed the discussion around the risks and benefits of contraception when covering side-effects in the consultation.

6.15 Side-effects: risks and benefits

The use of language in the consultations where side-effects were discussed revealed that nurses utilised differing discourses when mentioning the benefits and drawbacks of contraceptive methods. When nurses discussed efficacy, they utilised a medico-scientific discourse that employed statistics and made reference to research. For example:

> *Nurse: if used correctly it can be 98% efficient (Consultation 15)*

However, when discussing the impact side-effects, a different discourse was employed. Nurses did not utilise science or statistics to make their case, nor did they refer to research. They employed language that was drawn from a more lay perspective, utilising terms that minimised risk. For example:

> *Nurse: when you come to have a coil fitted, there's always a small...it's absolutely minute, the risk is very, very small, but it's still classed as a risk (Consultation 15)*

Also:

> *Nurse: a very small chance of feeling a little bit queasy (Consultation 9)*

As mentioned earlier, there is no literature that explores the precise way in which side-effects are discussed in contraceptive consultations, but certain authors have become increasingly critical of the way in which the adverse effects of contraception are minimised, alongside the effectiveness of the method in preventing pregnancy. Hardon (1992) and Kammen and Oudshoorn (2002) point out, from an analysis of contraceptive clinical trials, that side-effects are often offset against efficacy. Both argue that this is reflective of a pharmaceutical industry that evaluates contraception more from the standpoint of effectiveness than the absence of side-effects.

From an analysis of clinical trail reports into contraceptive methods, Kammen and Oudshoorn (2002) claim that, when side-effects are referred to, there is a *'tendency to qualify side-effects by users as minor and transient'* and that there was a pattern of *'downplaying the seriousness of contraceptive side-effects'* (Kammen and Oudshoorn 2002: 444). Although this work explores the terminology utilised in clinical trial reports, not client consultations, it is interesting to note the parallels between this research and the findings related to side-effect discourse from nurse-client consultations in this study. It also provides an interesting example of how discourse in medical and scientific texts impacts upon discourse employed in the clinical consultation.

From a Foucauldian perspective this approach to side-effects is a clear illustration of the deployment of power/knowledge, operating through procedures to control and manage discourse (Howarth 2000). As with discourses around anatomy and physiology, Foucault's *'procedures of exclusion'*; techniques for managing and regulating discourse, can be observed at work here.

Firstly: *division and rejection*; the separation of discourses based upon their assumed importance. Clearly, the nurses utilise statistics and research to stress the benefits of contraceptive methods. This strategy may also be indicative of the *'will to truth'*, proposed by Foucault (1981b: 62) in his descriptions of how value is ascribed to knowledge. In using scientific research and statistics, nurses ascribe medical value to their descriptions of the effectiveness of contraception. In contrast, nurses do not utilise similar scientific discourses when discussing side-effects.

The use of division and rejection is clearly represented by the switch to the use of lay discourse to relegate the importance of side-effects to below that of effectiveness. It could also be an example of what Foucault refers to as *'disciplines'*: the process whereby a subject or proposition must refer to a certain accepted body of theory in order to be important, for example, medico-scientific theory. In using statistical examples for effectiveness, nurses emphasise importance by drawing upon the dominant scientific theory. Side effects, on the other hand, are minimised by the nurse choosing to utilise lay terminology, a theory base not normally accorded equal status to medico-scientific discourse in clinical encounters.

It could also be suggested that discussion of side-effects in this manner is a result of nurses drawing upon their reading of the research reports described by Kammen and Oudshoorn (2002). Although there was no direct evidence from data to support this, nurses do have access to clinical journals in the clinic and such reports are utilised in family planning training.

Minimising side-effect symptoms in discussions with women can, therefore, be seen as a discursive strategy that separates the efficacy of contraception from the adverse side-effects of the method within the consultation. Powerful scientific terminology, drawn from an authoritative source, is employed against a lay discourse that, therefore, minimises and down-plays the symptoms. Linking with this approach is the manner in which nurses manage the side effects experienced by women. This second aspect relates to the encouragement of women to be stoical in the face of the discomfort and pain sometimes caused by contraception.

6.16 Side effects: perseverance and stoicism

When discussing side-effects with women, there were numerous examples of a process that often occurs alongside the discursive strategy of minimising symptoms, a process by which nurses exhort women either to persevere with, or put up with, the adverse effects of their contraceptive method.

Before exploring this further, it should be emphasised that it would be unfair to suggest that women are not helped to choose an alternative if they experience severe side-effects. Nurses routinely ask women if they are *'happy'* with their method and will discuss alternatives. Unfortunately, these also have side-effects but may be more tolerable. One nurse indicated that part of her record-keeping was to:

> *'make a note of what tolerances women have because it helps you choose (another method) if, maybe it's not the right method' (Nurse J).*

Indeed, part of the surveillance noted earlier is to detect, sometimes quite serious adverse effects (blood clots for example) of a particular method being used by a woman.

Nonetheless, alongside this, women are encouraged to live through many of the milder symptoms that many contraceptive methods cause. A possible factor in this is the recognition by nurses that there is no such thing as the perfect, side-effect-free contraceptive and often, when choosing a method women are required to pick what nurse 'A' refers to as *'the lesser of two evils'*. The nurse's role then becomes one of providing encouragement to keep going:

Nurse F: in the first few weeks we tell them to persevere

Nurses seem to recognise that the early stages of taking some form of contraception, particularly hormonal methods, can be difficult. Women need careful monitoring during this time, to ensure that they are complying with the method and are able to live with the side effects until they become accustomed to them. For example, in this extract from the consultation data, a nurse discusses side effects with a woman. In it, she explores the woman's ability to cope and her willingness to persevere:

Nurse: Are you managing to cope with it?

Patient: Just about

Nurse: Are you happy to persevere with this one .....?

Patient: I'll stay on it a bit longer

Nurse: Yes....OK that's fine, sometimes it does just take erm... a couple of packets of the same pill before you actually warm to it a little bit, it can take a while once you've changed over...

Patient: I think I'm on the last one now, yes

Nurse: So its taken all six really to settle things down OK, so your periods are regular but there just a little bit heavier, you probably find it does settle down, (Consultation 42)

The woman in this next extract mentions how she felt proud of her stoical response to side-effects and was able to persevere, although she does indicate that she received some encouragement to continue,

*Nurse: are you happy with it (*a coil*)*

Woman: no, not really

Nurse: why is that?

Woman: It made me feel sick and I'm really quite proud of myself, I mean I could have had it removed but they talked me out of it really...(Consultation 30)

Within the strategy of encouraging women to persevere, nurses occasionally reverted to using examples of other women who are using the same contraceptive method, implying that they manage to keep going. This tactic clearly both indicates the use of power by the nurse, in referring to her wider range of knowledge about other women, and provides another excellent example of the process of normalisation within the consultation. Nurses have the knowledge of how other women manage side-effects and use this to compare women with others:

You've got to think that there are a lot of women on the pill that are quite happy (Consultation 29)

And for Depo-Provera:

People keep coming back for more so it can't be too bad (Consultation 28)

Comparing side-effects with symptoms in pregnancy was also a tactic employed by some nurses. In consultations, nurses used the possibility of illness in pregnancy as a benchmark against which to judge the likelihood of side-effects. In this extract, the nurse strengthens this by referring to the authoritative source of '*research*':

Nurse: research says you have just as much chance of having one (a blood clot) during pregnancy (Consultation 29)

In interviews some nurses indicated that women should accept some contraceptive side-effects because if they were pregnant, they might experience the same symptoms - or worse:

Nurse K: You might have some breast tenderness..but those are symptoms that would be acceptable in early pregnancy

According to both Hardon (1992, 1997) and Kammen and Oudshoorn (2002) this approach closely echoes a common theme in the study of contraceptive side effects within clinical trial literature. Both argue that this is an unfair and unrealistic comparison made by researchers and they propose that contraceptive side-effects should be compared to other methods not to the risks of pregnancy.

They go on to argue that one of the key problems with contraceptive research into side-effects is that a *'maternal mortality model'*, where the potential harm due to unwanted pregnancy is seen to outweigh contraceptive discomfort, is utilised, rather than a *'well-being'* model, that focuses upon the acceptability of one method over another (Kammen and Oudshoorn 2002:440), citing Bruce (1987), who proposes that:

> *'The health risks of women seeking to become pregnant cannot be exchanged for the health risks of women seeking to avoid pregnancy. These two groups of women should be seen as carrying distinct risks derived from their reproductive intentions'. (Bruce 1987:364)*

The requirement of women to accept the adverse effects of contraception, in order to gain the benefit of fertility control, is, argues Lupton (1994), a message that pervades some of the popular discourses about contraception. Wajcman (1991) proposes that, for women, freedom from worry about pregnancy comes with the costs of long-term medicalisation and potentially health-threatening side effects, whilst Newman (1985) claims that the male-dominated pharmaceutical industry relegates side-effects to below the importance of efficacy in research into contraceptives - a view shared by Kammen and Oudshoorn (2002).

Within the literature on contraception, there is no research that explores how side-effects are discursively constructed in family planning consultations. However, although not exploring consultations, Sihvo et al (1995), in a study of women contraceptive-users, found that, even though many women reported uncomfortable side-effects, they continued with the method because they perceived that the only alternative was pregnancy. They also suggest in their paper that side-effects are not always dealt with sympathetically by clinicians.

Although it would be inaccurate to suggest that nurses in the family planning consultations are unsympathetic, it is suggested that discussion of side effects in the contraceptive consultation does provide a useful extension to the debate proposed by Kammen and Oudshoorn (2002) and Sihvo (1995), particularly by providing a specific *clinical* example of their suggestion that the discourse employed within contraceptive research is mirrored by clinicians in family planning settings.

At this point, it is also interesting to refer back to the role that 'Body education' plays within the consultations in this study. In educating women about their reproductive system, the terminology utilised is one of risk and vulnerability to pregnancy. It is argued that this approach develops the notion of *'reproductive vulnerability'*, that creates or heightens the requirements for vigilance and, subsequently, contraceptive compliance by the woman. In the discussion of side-effects, it can be seen - in some cases explicitly, and in others implicitly - that the construction of the vulnerable reproductive system is not only about developing vigilance, but it is also about providing a background risk of pregnancy that pervades the consultation: a risk of which account needs to be taken when side-effects are discussed, also a risk that can be utilised in the encouragement of perseverance.

It must also be noted that putting up with pain and discomfort is not limited to women using contraception. Being stoical in the face of pain and discomfort is a relatively common theme within the literature on women's health generally. Miles (1991) and Brook (1999) both suggest that the medical profession has, historically, seen the female body as weak and therefore prone to long term disorders and maladies that have to be borne with fortitude. Laws (1990) and Martin (1989) both describe how menstruation, childbirth and the menopause are seen as inevitable causes of pain and discomfort within medical discourse. Laws (1990) also makes the point that women are often caught in a dilemma. If they complain about menstruation and related problems, this leads to medicalisation and social sanctions, but if they do not, arguing that it is a natural aspect of female embodiment, then the discomforts are seen as part of being a woman and something that has to be endured.

Lupton (1994) adds a further dimension by describing how her research into the popular media in Australia revealed a discourse that described the side-effects of the contraceptive pill as some form of *'bodily punishment'* (Lupton 1994:140) for not fulfilling the traditional feminine role of child-bearer. Wellings (1985) noted a similar reaction during the *'pill scare'* in the United Kingdom, where fears attached to using the contraceptive pill had the moral overtones of retribution associated with contraceptive-driven *'promiscuous'* sex not leading to motherhood. Contraception, therefore, is sometimes popularly regarded as a process that must have some form of reciprocal discomfort associated with its advantages of reproductive control. In other words; there is a price to pay. From the consultations in this study, there is no clear, explicit evidence of this view being expressed with women, neither is there any evidence from interviews that nurses share this view.

However, there is evidence, presented in this section, that nurses do impress upon women that using contraception is not an activity free from risk or discomfort and that it does often require some degree of forbearance, although this process does seem to be related more closely to ensuring compliance than it is to some notion of punishment or even of: *no pleasure without pain.*

Finally, the issue of side-effects does seem to resonate particularly closely with Frank's (1991) triangular analysis of the body described in Chapter 2. It is interesting to explore how the issue of persevering with side-effects provides a more contemporary example of Frank's (1991) conceptualisation of the body, given substance by his example of spirituality in medieval women. Frank (1991:49) proposes that the body exists within the space formed within the triangular elements of *'Discourse', 'Institution' and 'Corporeality'.* In his description of this typology Frank (1991) uses an example drawn from medieval ascetic practices, involving diet and spirituality, a process that he identifies as important because it recognised that the *'Corporeality'* of the body placed limits upon its discursive construction. No examples were found in the literature of attempts to utilise this framework in the study of the body, or to provide a more contemporary example and it is suggested that the way in which the nurse uses the discourse of stoicism and perseverance has distinct parallels with Frank's description as shown above.

The clinic is the *Institution*; it creates and promulgates the discourses around contraceptive use that are employed in the consultation. In the consultation, the *'Discourse'* between nurse and woman is in the form of an exhortation to bear the discomfort of the side-effects and to persevere with a regimen. The value placed upon this is not spiritual, but is the value of achieving control over one's fertility. The regimen here is not diet, but contraception. The *'Corporeality'* is not the body's capacity to endure starvation, but its ability to bear other types of discomfort. Frank (1991) argues that the physical body sets limits to the extent to which it can bear these privations. Obviously, the medieval woman could starve to death. In women who use contraception, the effects are clearly not normally so severe, but life threatening side-effects will curtail the use of some methods of contraception[2].

[2] However, there have been cases of women suffering fatalities as a result of contraceptive side effects, mainly through the development of deep vein thrombosis and subsequent pulmonary embolism. It was a few of these relatively rare cases, reported in the popular Press, that prompted the so-called *'pill scare'* in the U.K. during the 1980's.

However, a slight difference to the bodily deprivation described by Frank and that associated with contraception is that the attainment of spirituality is an act of asceticism, not a form of punishment, which, according to Wellings (1985) and Lupton (1994) is a dimension to the stoicism connected to some popular contraception discourses. Nonetheless, this does not detract significantly from the close links between the medieval and modern processes, a fact that possibly highlights the neglected value of Frank's approach, an issue that will be returned to later.

Another element of contraceptive use that closely reflects Frank's typology is the notion of regimen. Frank refers to the regimen of diet but,, in the family planning clinic, the regimen is contraception. Discussion of side-effects, either through the minimisation and normalisation of symptoms or encouragement of perseverance, plays an important role in ensuring compliance. However, an equally important aspect in ensuring women are reliable contraceptive-users is the process by which nurses, building upon body education, surveillance and the management of side-effects, prepare women to incorporate a regimen of contraception into their daily lives.

6.17 Disciplinary power: Regimen

The consultation is not only a clinical space where women are tutored in body knowledge and self-surveillance; it is also a site where disciplinary training takes place, a *'laboratory of power'* (Nettleton 1994:84). The construction of the *knowledgeable but reproductively vulnerable* woman and the *active patient* is extended by the instruction of women in the disciplinary practices of contraceptive regimen. Nurses spend a considerable amount of time and effort encouraging women to comply with these regimens and utilise various techniques to aid this process.

Close adherence to regimen is crucial to effective compliance with contraception and, as such, it is not surprising that this issue occupies a central place in the medical and nursing literature on family planning. This literature tends to fall into one of three categories, albeit with overlap. One category focuses upon the need for women to be given verbal and written guidance on their regimen in clinic, as a way of improving compliance (Peterson et al 1996, Burke and Blumenthal 2001, Lachowsky and Levy-Toledano 2002).

The second concerns efforts to assess compliance by measuring adherence to regimen, sometimes even by electronic monitoring of pill packets, in the case of two studies into regular pill use (Potter et al 1996, Oakley et al 1997) studies that remind us strongly of Boyne's (2000) point about the growing, rather than diminishing use of electronic surveillance discussed earlier. Thirdly, attempts have been made to find out from women contraceptive-users themselves about the factors that affect regimen compliance (Forrest and Fordyce 1992, Oakley 1994, Oakley et al 1999). Some have suggested that the client-provider relationship impacts upon regimen compliance (Nathanson and Becker 1985) although this work tends to interview women about their views on how understandable the information was, or whether or not the information was imparted in a pleasant manner and whether or not they felt comfortable with the clinician, generally, rather than exploring the detailed *discursive* aspects to regimen instruction.

As before, with the literature on side-effects, education and compliance, the focus is upon maximising regimen adherence in contraceptive-using women. This literature is based upon the premise that achieving full compliance is a universally positive goal in contraceptive care. Given this assumption, it is not surprising that there is a dearth of literature that explores regimen instruction within clinical interactions from any sort of critical perspective.

The data from the consultations in this study clearly redresses this and illustrates the specific approaches utilised in the clinical setting to encourage compliance with contraception. As described in Chapter 5, the process of regimen can broadly be separated into three closely-integrated themes. Firstly, women are instructed in the disciplinary frameworks related to successful use of their particular method. Nurses often use the term *'rules'* for this, rules that, among other things, entail the importance of time-keeping. These rules are often monitored and revisited in subsequent clinic visits. Secondly, women are taught to recognise any threat to their regimen. They are versed in the scenarios that may threaten their contraceptive protection and their understanding of these threats is checked during subsequent consultations. Thirdly, building on the first two, nurses instruct women in the techniques of managing such breakdowns, should they occur, by rehearsing courses of protective action, thereby ensuring that contraceptive protection is maintained.

6.18 Disciplinary power, regimen and the *'rules'*

Regimen is closely allied with body knowledge. Nurses indicate during interviews that they consider information about the reproductive system to be important in helping women to comply with a regimen, a fact that supports the previously-described notion of body education helping women to understand, among other things, how there is a requirement to ensure contraceptive *'protection'* is *'kept up'*:

> *MH: do you think that the more women have an understanding about the way their body functions the more likely they are to adhere to the methods?*
>
> *Nurse A:I think so absolutely, yes, yes I really do*

Nurse 'A' also makes the point that the consequences of not being protected against pregnancy are often caused by women not complying properly with a regimen, by their failure to follow the *'rules'*:

> *Nurse A: a lot of unintended or unplanned pregnancies is down to not complying with the rules for that particular method*

The use of the term *'rules'* occurs frequently in the consultation data and refers to the set of instructions relative to the use of a particular method of contraception. For example: *'there are rules'; 'it's important you follow the pill rules'* and : *'are you aware of the rules?'* Therefore, instructing women in the rules for their method and helping them to fit this framework into their daily lives is important, a fact supported by nurses when interviewed:

> *Nurse G: but I think if they understand that as long as they don't leave it late every day they have got a bit of a window to mess around with, then they are quite sensible, and I usually, last thing at night as long as, you know they might go out till 3 o'clock in the morning but important that they take it the minute they get in, as long as they understand that, or its finding a time in their schedule that's regular, so if its breakfast in a morning - then take it in a morning,*

The issues of time-keeping and time-awareness occurred frequently in the consultations, nurses stressing the importance of a regular regimen. For example: *'exactly 12 hours later'; 'same time every day'; 'mustn't make that seven days any longer'; 'leave it in for six hours'* and: *'you know you've only got three hours'.*

This advice was often accompanied by warnings of what may happen to the contraceptive protection if regimen wasn't followed. For example: *'if you go messing around the times then it's not as effective'*. Part of regimen, therefore, is to place women within a time schedule when using contraception, a schedule that they must always be conscious of and adhere to. This was the case for all methods of contraception; the only variation being that for some methods time was measured in either hours (pill, diaphragm and cap), weeks (Depo-Provera) or months to years (coils). Using contraception, therefore, along with providing women with the benefits of controlling their fertility, brings with it the requirement to order ones life, to some extent, around its regimen. This is clearly a further example of what Frank (1991:48) refers to when, he speaks of body techniques being simultaneously *'enabling and restricting'* and a further example of the previously discussed *'Foucault Paradox'* identified by Turner (1995:217), in that, in exchange for increased freedoms, we also submit simultaneously to new restrictions.

An added part of this restriction is the requirement for women to re-visit clinic regularly to obtain more contraception. This entails another consultation, during which the nurse uses the opportunity to reinforce the instruction of regimen, an issue that nurses highlight as important, given that women often forget the *'rules'*. Here, nurse 'H' talks of *'confronting'* women when they return to clinic, as they must do to receive another prescription:

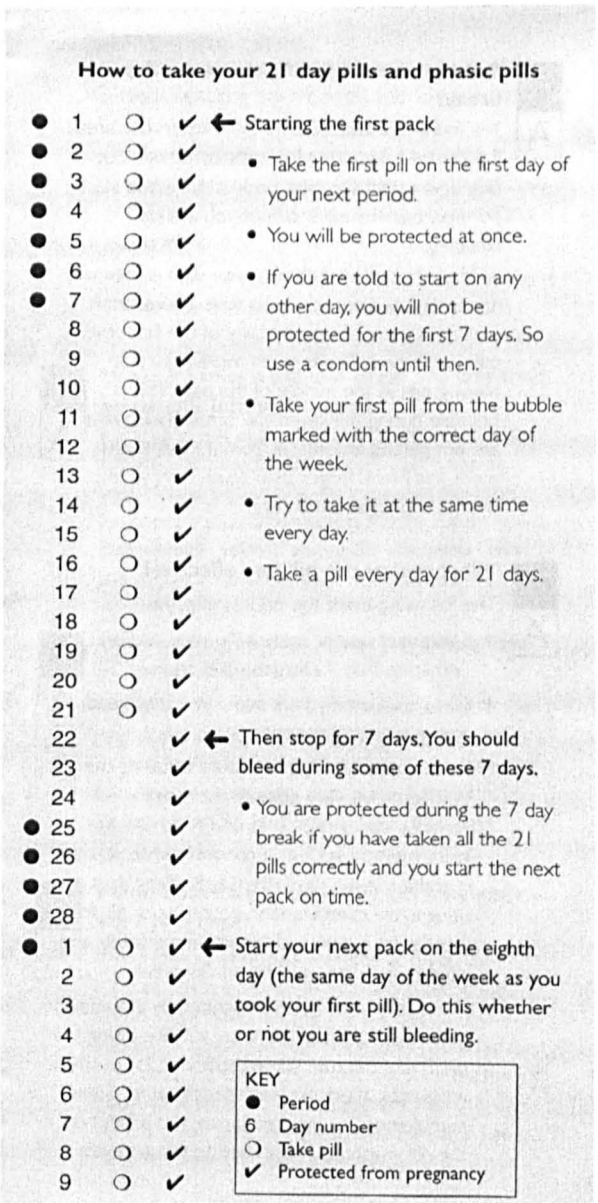
> *Nurse H: it's surprised me that, talking to a number of women that have been taking the pill for a number of years when you confront them with...do you know your pill rules, can you remember it?...*

Nurse 'J' also comments upon the need to check that women are retaining information from previous consultations by asking questions, also mentioning the *'pill teach'*:

> *Nurse J the first time she's done that, the nurse will go through all of the pill teach with them, I mean we try to check that they've got the key messages.....sort of say erm... go through the pill teach and then sort of ask questions through out that to make sure that they understand*

Another important aspect of instructing women in regimen was the use of written guidelines and schedules. As well as covering regimen in the consultation nurses also made sure that women were provided with written information to take home, thus projecting the disciplinary practices of regimen instruction beyond the consultation. For example: *'I'll give you a leaflet on that'* and *'this is the leaflet we give you'*. This is also linked with the marking out of days on the actual pill packet women use. These leaflets give clear instructions of regimen, often in the form of a flow-chart for the woman to follow. For example, Figure 14 is taken from a leaflet given to women using the combined pill:

Figure 14: Regimen for the combined contraceptive pill



The regimen described in this leaflet nicely summarises and confirms the clear link with a number of themes described in the consultation data. For example, the chart uses the terms *'protected'* and *'not protected'* in the comments alongside the regimen, a clear parallel with the terms used by nurses in the construction of reproductive vulnerability. The chart is clearly based upon the previously-discussed, medically-defined 28 day cycle, with a helpful key symbol of a black dot indicating when the woman should expect to menstruate. Additionally, the comments illustrate that, on day 22, the women is required to look for bleeding when taking a seven-day break, and then to recommence her pills; a clear example of the link between body surveillance and regimen. The diagram also acts as a written instruction and *aide memoire* for the woman to refer to after her visit to the clinic; in doing so, the leaflet reinforces the instructions given by the nurse, helping to project the disciplinary power of the consultation beyond the clinic.

In his early work on discipline, Foucault (1977, 1981a) often refers to the role that timetables, taxonomies and schedules play in the deployment of power toward the body, with the specific purpose of:

> *'Its disciplining, the optimisation of its capabilities'. (Foucault 1981a: 139)*

Here, Foucault is clearly referring to the schedules and timetables of austere and regimented institutions, represented by prisons, workhouses, asylums and even early hospitals and schools. In his later writings, he moves towards discussion of more productive, less coercive strategies that came to be deployed towards the body, although these still make numerous references to the importance of regimen and timing, particularly in his analysis of Greco-Roman *'techniques of the self'* (Foucault 1986:100). This aspect of his work will be explored later, in greater detail. At present, it is sufficient to say that Foucault did not really make clear links between this more productive use of regimen and more contemporary health and medical practices.

However, Nettleton (1994: 81) cites an illustration of this, referring to the example of teaching children the *'toothbrush drill'* in the early 20th Century; a systematic regimen of teeth cleaning that consisted of correct method, timing and equipment. These techniques were taught and observed in the dental clinic, but were also accompanied by instruction in regimen and record-keeping.

Nettleton uses this example to illustrate the disciplinary practices of *'hierarchical observation'* in the deployment of power within institutions, but she also makes the point that the 'drill' was intended to provide ongoing instruction and regimen-compliance outside of the direct observation of the clinician, although this ongoing projection of power was through memory reinforcement and was not accompanied by written instructions. However, it is hard to avoid drawing close comparisons between the unlikely pairing of dentistry and contraception when one reads, in the handbook of family planning, that nurses should stress the importance of:

> *'The need for regular pill-taking when it is easy to remember, such as when cleaning one's teeth in the morning or evening (Louden et al 1995:59)'*

Where the comparison ends, of course, is that forgetting to clean your teeth does not result in the possibility of pregnancy! One key aspect of the process of encouraging women to comply with a contraceptive regimen is the tutoring and rehearsing for a possible future regimen breakdown. This includes nurses addressing women's knowledge of firstly, factors that can threaten their contraceptive protection and, secondly, what they can do to manage this. An aspect of the consultation that further illustrates the integration of body knowledge, surveillance and compliance.

6.19 Recognising and managing threats to regimen

Closely integrated with the instructions on how to comply with a regimen was the training nurses gave women about how to act if they made a mistake; *'what do you do if you forget?'* or should they encounter a situation where their regimen was compromised*; 'what sort of things can interfere?* As can be seen in the consultation data, nurses used a fairly confrontational set of questions in order to ensure that women were aware of what was necessary to manage any breakdown in the regimen, an aspect that was revisited at subsequent clinic visits:

> *Nurse F: .....when they come back certainly for the first few times and again quite regularly we go through the pill rules and we reinforce things all the time because you know they haven't always grasped it*

After helping women to identify threats to their regimen, nurses moved on to providing women with strategies for dealing with such a contingency, one of the key elements of which is the use of emergency contraception.

Emergency contraception consists of taking two tablets, twelve hours apart, the first of which must be taken within seventy-two hours of intercourse. In other words, the failure of one regimen leads to the requirement to adhere to another, a regime with its own, unique time schedule. With contraceptive pill takers the *'rules'* also apply to the action to take if a pill is missed; *'you know what to do...if you miss one?'* Women are given clear guidance on what to do in order to manage this, by using condoms, taking two pills and if necessary taking emergency contraception. To successfully use this women must therefore, firstly, draw upon their knowledge of regimen to identify the threat, then they must also be aware of the passage of time since intercourse, and act within that timeframe.

The process of regimen, then, contains an aspect that is about training women to act in order to continue contraceptive protection beyond the direct surveillance of the clinic. This relies on discussing future possible threats to the regimen and rehearsing the techniques women need to deal with these, a process that is quite reflective of the act of *'simulation'* described by Bogard (1995:76), discussed earlier, in section 6.11. To recap briefly, Bogard claims that simulating and predicting health events with individuals and preparing them to meet potential threats has supplanted the more traditional and direct process of 'monitor and then correct' employed by the Panopticon. The way in which potential regimen failures are rehearsed with women in consultations seems to be a good reflection of this. The rules employed to instruct women in dealing with contingency provide a good example of simulation in a health care environment, in that they provide women with the anticipatory knowledge that enables them to act independently, beyond the direct surveillance of the clinic.

However, as before, this process does not occur in isolation. It *is* an example of simulation, but one that still exists within a system of more direct surveillance. Women's understanding of the rules is constantly checked at clinic visits. Women realise they will be asked these questions. They also are made aware that their ability to comply with a regimen is monitored and that any failures will be documented and recorded, and will be referred back to in subsequent consultations. For example: *'I'm just documenting that you missed a few pills'.*

Another factor that emerged from interviews with nurses was the fact that women, at least initially, are not given the *full story* about the rules concerning the contraceptive pill. The early instructions given to women are simplified inasmuch as they are not told that missing certain pills during the 21-day regimen is actually safe, as nurse 'K' reveals:

> *Nurse K: you know actually you can miss quite a few pills and not need emergency contraception, but we would say because it is very complicated, at first visit when your taking in all this other stuff, they're better coming back to us saying do I really need to have emergency contraception because I've missed pill 13, well if they take the previous 7 normally no they don't, but we'd rather give them it un-needed 'cause its safer than confuse them and its easier to say, if you miss a pill you need to use condoms for 7 days and if you don't you need to come and see us*
>
> *MH: Even though technically or physiologically they might not need it?*
>
> *Nurse K: (nods)...yes.*

Nurse 'K' is saying here that the pill rules given to women are actually more open to flexibility and interpretation than they sound when told to women. The pill rules are simplified and standardised for women to easily use, and also for the nurses to say:

> *Nurse J: Its quite a complicated carry on for some women, so we try and make it simple, you know the 7-day rule.*

Nurses, therefore, recognise that some regimens are quite complex, if described with total accuracy, and they feel that they may confuse women. It seems that, because of this, they err on the side of caution when telling women the *'rules'*. As nurse 'K' indicates, it is better that they return to clinic unnecessarily than not return at all. Nurse 'K' also indicates that, although women would perhaps receive more instruction about the finer points of the regimen at this point, she still indicates that this is a decision best left to the clinic:

> *Nurse K: Its better when you get them there, then in front of you, to have them come, have them sat in front of you and explain it through and show them the flow chart and let them make the decision as to whether they're happy or not*
>
> *MH: Oh, so you would use a chart to maybe explain things to them?*
>
> *Nurse K: Yes at that stage.....But I would still say to them you're better coming and asking us than making the decision for yourselves*

The issue of simplified rules, then, is an interesting one. It seems to be closely linked to Foucault's notion of power/knowledge. Nurses are in possession of the full facts about the pill, yet choose if and when to instruct women in these details. The regimen that women are taught gives the impression of a process by which self-management is being promoted, yet it also reveals a backdrop of disciplinary control and surveillance. The pill rules, therefore, give the impression of a *simulation-type* process replacing direct surveillance, but the issue of building in, at least during the early stages, a subtle technique of disciplinary power through simplification of the *'rules'*, reveals that the nurse retains some element of control over the extent to which the woman is able to apply the rehearsed and simulated strategy.

Encouraging women to comply with a contraceptive regimen is the goal of the contraceptive consultation. If women do not follow the rules and instructions that they are given, relating to use of their particular method, then they are clearly *reproductively vulnerable*. The theme of regimen within the consultations illustrates neatly how the strands of body knowledge that the woman has gained and the surveillance skills that she has developed result in her ability to use her contraception reliably. Regimen also illustrates how the clinic monitors the women, by asking questions, documenting failure, or by providing simplified rules to restrict the chances of becoming *'confused'* - a clear illustration of the development of the *active but compliant patient.*

6.20 Discussion summary

This chapter has placed the findings presented in chapter 5 into a theoretical context. The consultation process revolves around productive power relations that encourage the woman to understand her body, particularly her reproductive system in order to use a method of contraception effectively. The two overlapping, closely-integrated core categories of 'Surveillance' and 'Compliance' provide the theoretical framework within which this process occurs.

It is clear from the data that educating women about the reproductive system is important, since this enables women to understand more clearly how their method of contraception works but, equally importantly it enables women to be able to monitor their bodies more effectively.

It is also clear that *body education* by the nurses utilises a medical/scientific discourse and that women are encouraged to view their body from this perspective. When interviewed, nurses often remarked that women knew very little about their reproductive anatomy and physiology and that *'myths'* had to be corrected in the consultation. This body education involved discursive techniques, reflective of Foucault's (1981a) description of *'procedures of exclusion'.* Body education is also a key factor in creating a heightened awareness of the need for vigilance by women. This was achieved by utilising terminology that constructs the *vulnerable* reproductive system, a system that requires *'protection'* and *'cover'* by contraception. This discursive construction of the reproductive system is somewhat different from the disintegrating and failing reproductive system described by Martin (1989).

Within the consultation, women are taught to monitor their bodies, for signs either of side-effects or of pregnancy. Self-surveillance skills are taught, that sometimes includes self-examination, involving techniques that contribute additional dimensions to the literature on other aspects of body-examination by women. This aspect of the consultation is where women put their body knowledge into practice; they become the *active patient.* However, creation of the active patient does not mean that the woman is completely free of the surveillance practices of the clinic. It is also clear from the data that nurses act as interpreters of the signs that women report at clinic, a process that is reflective of Nettleton's (1994) dentist judge. Nurses use discursive practices, including *normalisation* and *examination,* to control this discourse. This control of self-surveillance is used to illustrate the limits to the concept of simulation and it contributes to the debate between Boyne (2000) et al and Baumann (1999) about the relevance of the *Panopticon.* This issue is developed further by descriptions of how the clinic, acting through the nurse, conducts a more traditional surveillance of the woman. Records and measurements of the woman's body and contraceptive history are used as tools, both to monitor the woman closely and to make her aware that she is being monitored.

Body education and self-surveillance are also closely integrated within the process of encouraging women to comply with contraception. Within the consultation, it seems important that women should be educated about the side-effects of contraception. This is to enable them to recognise and report these signs at clinic. However, nurses also seem aware that side-effects are a potential source of non-compliance.

In order to manage this dilemma, nurses utilise the two discursive practices of separate discourses for efficacy and side-effects, minimising side-effects and utilising scientific data to describe effectiveness, again reflective of Foucault's discursive procedures. Secondly, nurses encourage women to be stoical and to persevere with adverse symptoms, in a process that reflects Frank's (1991) description of the medieval aesthetic and that adds an interesting example of the role of the corporeal body and its link to discourse.

Lastly, a key element of compliance is regimen. A significant element of the consultation is how nurses encourage and educate women to adhere to their contraceptive regimen. This often includes written instructions and also the teaching of the *'rules'* for that particular method. Women also have their knowledge of regimen tested by nurses during return visits to the clinic. This aspect of the consultation demonstrates clearly the deployment of disciplinary power and, furthermore, provides a tangible example of Turner's (1995:217) *'Foucault paradox'* and Frank's (1991:48) *'simultaneously enabling and restricting'* body techniques.

The next chapter takes this analysis forward and draws some theoretical conclusions from the study. It utilises the discussion that has occurred in this chapter, which has identified the particular threads of the consultation and their respective theoretical links, to place the contraceptive consultation in a broader, more substantial theoretical context.

Chapter 7

Conclusions

7.1 Introduction

This chapter presents the conclusions from the study. It is in two sections. Section one draws together the threads of the contraceptive consultation set out in the previous chapter and explores the way in which the closely-integrated processes operating within the consultations provide a tangible and contemporary example of Foucault's (1984, 1986, 1987) *techniques of the self.* To demonstrate this, comparisons and links are made between the consultation process and the development of body practices and techniques framed within Foucault's analysis of the Greco/Roman principles of the *'askesis'* and *'technologies of the self'.*[3] Furthermore, the relationship between these practices and the formation of a *'contraceptive habitus'* is also explored.

In section one, it is also suggested that these body practices provide an example of what Frank (1991) refers to as body techniques that are simultaneously enabling and restricting. However, it is also proposed, that the body and *'active patient'* that are constructed in the family planning clinic consultation, do not sit comfortably within any one of the four body types identified by Frank (1991, 1995) in his typology of body use in action. Nevertheless, it is suggested that Frank's concept of the body, existing as a mid-point between the three elements of *'Institution'*, *'Discourse'* and *'Corporeality'*, is a useful typology with which to illuminate the overall elements of the contraceptive consultation; the possibilities for this somewhat neglected model in future body research are also discussed. Finally, section one sets out clearly the main findings and contributions that this study makes to sociological theory, particularly the contribution that this research has made towards a *'sociology of contraception'.*

Section two discusses the limitations of the study and suggests areas of research that could further develop understanding of contraceptive discourse, power and the body.

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[3] *'Askesis'*: the Greco-Roman process linking body awareness with body practices as part of the *'cultivation of the self'* - through the instruction of regimen and body techniques (Foucault 1986:67).

This section proposes firstly that a useful extension to this study would be an experiential account of women's embodied experiences of using contraception. Furthermore, the lack of a contraceptive-user's perspective to this study limits the extent to which *resistance* to power may be explored. This is a widely-cited criticism of Foucault's work on power and is an area where further work would be useful. However, it is proposed that this study provides certain key elements of contraceptive use that could form the basis for exploring resistance.

Section two also explores the possibility of links being established between the data in this study and wider social structures influencing sexual health, family planning and the reproductive health of women. To do this, the work of Turner (1992) is engaged, particularly his *'societal task'* model, which is presented as a possible framework for linking the micro-processes of power deployed in the individual contraceptive consultations with wider power structures. Foucault's work on Governmentality is also explored in this section.

Lastly, recent developments in contraception are explored briefly and suggestions are made for future research, particularly in the area of new contraceptive methods for women, for example, implants and the rapidly emerging subject of male contraception.

Section One:

Surveillance, Compliance and the *'contraceptive-using body'*

The whole process of the contraceptive consultation outlined in figure 11 is representative of a complex, integrated set of power relations with the intended outcome of helping women to develop into effective users of contraception. The discussion in the previous chapter outlines and analyses the various elements within the two closely-integrated core categories 'Compliance' and 'Surveillance', making links with the theory and literature, illustrating areas where the data from the nurse/client consultations contribute to those theories or bodies of literature. Throughout the discussion so far, references have been made to the relationship of the data to wider theory, particularly the later work of Foucault (1984, 1986, 1987,1991). These links and relationships can be placed particularly around Foucault's notion of *'subjectification'* and around the *'cultivation of the self'* and his use of Greco-Roman texts to develop his work on productive power. There are also clear links with the work of Frank (1991, 1995), particularly his typology of the body and body types.

The next sub-section in this chapter proposes that this work can be utilised in a two-fold manner. Firstly, it can provide a useful framework to draw together and further explain the threads of the theoretical discussion thus far. Secondly, in doing this the findings from this study provide a useful contribution to the value of this body of work in understanding and analysing the body and the effects of power upon it.

7.2 The *'technologies of the self'*

> *'In order to really care for oneself, one must listen to the teachings of a master'. (Foucault 1987:118)*

In his study of ancient Greco-Roman texts, Foucault (1984, 1986) outlined his thinking on the creation of the ethical and spiritual self within the process of subjectification. Foucault's analysis of this centred on the concept of *'askesis'*, the linking of body awareness and body practices as part of the *'cultivation of the self'* (Foucault 1986:67). Foucault identifies specific elements within this process that, it is proposed, are clearly evident within clinic consultations.

The *'cura sui'* refers to the philosophical doctrine, which holds that, ethically, one should make oneself into an object of care. Armstrong (1994) and Petersen (1996) both refer to the development of *'surveillance medicine'* and Public Health as a process that saw the medical gaze move from concerning itself exclusively with pathology to an interest in seemingly healthy bodies. Within this process Armstrong (1994:400) refers to the creation of the *'at-risk state'*, meaning that although an individual is not presently presenting with illness, disease or altered pathology, the person has the potential to do so. Thus, the medical gaze has developed into the practice of *'health promotion'* (Armstrong 1994:399). Gastaldo (1997) argues that health promotion can be regarded as a further extension of disciplinary power, in other words, that it is a manifestation of bio-power. Gastaldo proposes that health education is:

> *'an experience of being governed from the outside and a request for self-discipline'. (Gastaldo 1997:118)*

The *'epimeleia'* refers to the development of habitual daily activities practised within a regimen of self-care; these activities are linked to the *'mia chora'*, the meeting of the two philosophies that require bodily care and management to be linked intimately with knowledge of the body.

Burkitt (2002) however, although accepting that Foucault's exploration of Greco-Roman philosophy is useful, claims that the focus is more towards hermeneutics and ethical practices than towards providing a clear picture of the precise mechanisms that instil *'practical'* social capacities and skills into the human body. In other words, Foucault does not explore the actual practices that *'instil habitus'* in the individual, but concentrates on philosophical and spiritual cultivation (Burkitt 2002: 220).

Turner (1992) does make moves towards this in his analysis of bodily regulation in the 19th Century, by identifying how dietary regimens emerged during this period that were aimed at combating what were seen as the damaging effects of some social groups being *'exposed to overabundance'* (Turner 1992: 192). In other words, Turner points out that there were concerns that over-consumption caused deficiencies in the conduct of a productive life and that *'healthy'* dietary regimens were required in order to address this.

A common aspect of these regimens was the consumption of less palatable food, as a replacement for more indulgent, richer fare. However, Turner is referring here to the application of a regimen, rather than to the more complex set of practices, skills and knowledge that are necessary, according to Burkitt (2002,) in order to develop *'habitus'*, which he defines as:

> *' The capacities and skills in the human body along with certain attitudes and beliefs' (Burkitt 2002:221)*

Also that it involves individuals developing:

> *'Acquired modes that predispose individuals towards particular forms of practical actions in certain situations' (Burkitt 2002:225)*

Burkitt goes on to suggest that a study of Aristotelian writings develops Foucault's ideas around the technologies of the self, by providing a more practical framework to explain the development of *'habitus'*. Aristotle, Burkitt claims, describes how humans can be trained in predisposition towards good or bad *'habitus'* by developing the body *'hexus'*, the habitual disposition of the body, achieved through the technologies of *'poiesis'* and *'techne'*, which are about the development of a *'productive attitude and the knowledge and skills that accompany it'* (Burkitt 2002: 226).

Burkitt does not give a detailed example of how this process would work in contemporary health care - that is not the focus of his paper - but his thoughts on the Aristotelian concepts above are an interesting addition to Foucault's writings on the development of the self. Burkitt (2002) suggests that, although Foucault does not use the term *'habitus'*, he does allude to a set of bodily practices that are influenced by the following of regimen and instruction within a process of training. The main difference being that Foucault was referring to cultivation of the ethical self through spiritual and physical regimens of self-discipline and reflection, not to the development of more practical body techniques.

The data from the contraceptive consultations in this study provide an excellent contemporary example of the processes outlined by both Foucault and Burkitt. It can be proposed that what is taking place in the family planning clinic is the development of a contraceptive *'habitus'*, or the development of a *contraceptive-using body.*

During consultations, women are clearly encouraged to develop a working knowledge of their bodies, particularly of the reproductive system. There is also evidence of this education creating or heightening the sense of vulnerability to pregnancy and the requirement to develop practices to contain this threat; in other words, creating the both an awareness of the *'at-risk'* state and thus providing the rationale for self care: the *'hexus'*. Furthermore, within the consultations, there is clear evidence that body education plays an additional role to that of creating awareness of *'reproductive vulnerability'*. It is also closely linked to the development of self-care practices, for example self-surveillance, self-examination and adherence to regimen: the *'techne'*. Importantly, both Foucault and Aristotle identify that, within the process of the *'cultivation of the self/habitus'* body technique, practices and disciplines are developed by tuition and training. Developments within the *'self/hexus'* are facilitated by an instructor or an expert, in the case of the consultations in this study, the instructor is the nurse. It seems, therefore, that what is taking place in the consultation is the development of a contraceptive *'habitus'* consisting of body knowledge, techniques, skill that equip women with the ability to use contraception effectively.

To explore this further the work of Frank (1991, 1995) will now be utilised, firstly by exploring the relevance of his *'body types in action'* to the consultation data and secondly by using his triangular framework of the body as a means to summarise and display the processes involved in the development of the *contraceptive-using body.*

7.3 Body types and contraceptive use

Frank (1991, 1995) proposes that body techniques develop when the body meets resistance and has to act through developing socially-given *'body techniques'*, techniques that can be simultaneously restricting and enabling. This process is reflective of the development of *'habitus'*.

Frank develops his theory by suggesting that body action occurs within a framework of body types, and puts forward a typology of the body based upon four differing *'body types in action'* presented earlier, but summarised here as;

- **The 'Disciplined body'** – The problem of control for the disciplined body is resolved by regimentation; regimen ensures predictability. The disciplined body is monadic, closed in; it is isolated in its performance. It is also dissociated from itself; for example; the ascetic is in, but not of, the body.

- **The 'Mirroring body'** – is predictable, not through discipline, but by 'mirroring' all that is around it, via consumption. The mirroring body is constantly producing *'superficial desires through consumption'* (Shilling 1993: 96). The mirroring body is monadic: external objects are viewed purely in terms of their use for the mirroring body.

- **The 'Dominating body'** – As Frank argues, is impossible to theorise without giving weight to masculinity and lack. When a dyadic *'other relatedness'* is combined with a sense of lack, the body turns to *'domination as its expressive mode of relating to others'*. (Williams and Bendelow 1998:63). The world of the dominating body is warfare, by definition contingent, one where the body must be dissociated from itself to absorb and inflict punishment on others.

- **The 'Communicative body'** – this body type is *'less a reality than a praxis'* (Frank 1991:79) or a future possibility (Shilling 1993), more difficult to define in an empirical way than the other body types. As Frank explains, the nature of the communicative body is that it is a body in the process of creating itself. Frank uses the example of the performing arts, also the caring practices of medicine, to illustrate the communicative body. The communicative body produces desires, but for dyadic expression rather than monadic consumption.

Frank's notion of body techniques being simultaneously *'enabling and restricting'* seems highly reflective of the development of the *'knowledgeable/ reproductively vulnerable, active yet compliant patient'* within the contraceptive consultation.

When attending the clinic, women are seeking assistance in their aim to manage their fertility and to prevent pregnancy, whilst at the same time being able to conduct sexual relationships. Contraception enables women to express their sexuality without the threat of unplanned pregnancy. Contraception and the ability to use it effectively is, using Frank's definition, an *'enabling'* body technique. However, the data from the consultations also demonstrates how women come to be involved in a disciplinary system of surveillance and regimen when they visit the clinic. Women are required to develop body-monitoring skills, to persevere and cope with the side-effects of contraception and to adhere to a regimen that requires discipline. In other words, they are required to develop body techniques that also, simultaneously, place *'constraints'* upon the body. Furthermore, given that women who are using contraception are *'acting'* by utilising and developing body techniques, to what extent does the contraceptive-using woman reflect Frank's body types?

Certainly, with its propensity for domination and oppression created by fear and the unknown, the *'Dominating body'* seems an inappropriate body type for the contraceptive-using body. Frank also makes a rare reference to gender with regard to the dominating body, remarking that *'dominating bodies are overwhelmingly male bodies'* (Frank 1991:61); the typical body action for the dominating body being warfare and conflict. This does not seem to reflect the type of body use in this study, although the necessity for the dominating body to be able to bear pain and discomfort does link somewhat with the issue of side effects and stoicism.

Similarly, the *'Mirroring body'*, with its propensity for consumer culture and the treatment of the body as a surface to be adorned and decorated, seems to be an unlikely space for contraceptive behaviour, although the mirroring body, claims Frank, can be a body that is treated as an instrument of sensual gratification without any sensual communication with others. So, it could be argued, albeit without evidence, that contraception is a means to facilitate this by removing the inherent threats associated with sexual behaviour: pregnancy. Alternatively, it could equally be proposed, again without any evidence, that sexual relationships are *about* sensual communication, contraception being a means to achieve this in a less risky manner. The *'Communicative body'* is the least well-defined of Frank's body types, and, although Frank remarks that this type is about bodies expressing themselves, using the example of *'post modern dance'* or caring for others he also proposes that the *'Communicative body'* is unconcerned about its unpredictability. This aspect of body usage does not immediately resonate with the use of contraception.

The closest comparison would appear to be with the *'Disciplined body'*. For Frank, the disciplined body is the controlled body, disciplined to the point that it becomes predictable, a predictability that is achieved through regimentation. The disciplined body strives to overcome the contingency of the body to act in unpredictable way by the adherence to drills and rules; Frank (1991) cites the example of military regimentation to illustrate this. It seems reasonable to propose that compliance with a contraceptive regimen is compatible with the notion of the body striving to become predictable and to avoid the contingency of pregnancy. Frank also proposes that the disciplined body in terms of *desire* is lacking, meaning that the disciplined body is incomplete, inefficient. Certainly, the elements of body education that engender a sense of vulnerability would reflect this. The notion of the reproductive system lacking protection was a key theme in the development of the sense of *reproductive vulnerability* in women.

The disciplined contraceptive regimen is, therefore, the answer to this lack of predictability and control. However, it could also be argued the *'contraceptive- using body'*, far from lacking, is actually producing desires. Women attend the clinic because they are, or intend to be, sexually active and require the means to do this safely. Frank also claims that the *'Disciplined body'* is monadic in terms of its relation to others, isolated in its performance, closed in upon itself, as opposed to a dyadic body, that understands itself as a medium through which *'self and others are connected'* (Frank 1991: 52). The notion of a monadic body does not seem compatible with the contraceptive-using body. Certainly, women are utilising contraception in a disciplined manner, in order to reduce the contingent threat of pregnancy, but they are doing so in the context of sexual relationships with others; in other words, the body here is disciplined to an extent but can also be thought to be dyadic, rather than monadic.

Frank's body types, then, do not appear to be a robust set of typologies with which to compare and discuss the contraceptive using body, which seems rather than fitting neatly into any category, to be a body type that is an amalgam of various characteristics of body type. For example, possessing some, but not all, of the attributes of the: *'Dominating'*, *'Disciplined'* and *'Communicative'* bodies.

Frank does make the point, when discussing his typology and its applicability to the body, that the *'truth is a mess'* (Frank 1991:53) and that the framework he provides is intended to provide heuristic guides to order empirical behaviours, also that:

> *'No typology of ideal types can ever capture the richness of the empirical world' (Frank 1991:53).*

Frank (1991) also suggests that body use may fluctuate between body types over time, but he does not expand on this or give examples, beyond some anecdotal descriptions of individuals with illnesses in his later work (Frank 1995), where he still maintains that body types may merge or alter, without any detailed account of how this occurs. In addition, no evidence was found from the literature of any empirical work utilising or testing Frank's typology as a framework for describing or analysing the body or body use. Therefore, this study becomes the first to do so. Applying the empirical data from the family planning consultations to Frank's typology does illustrate that his body types are in fact *'ideal types'* and that his framework would be better were it to include some form of recognition that there are shades of grey rather than distinct lines between the body types.

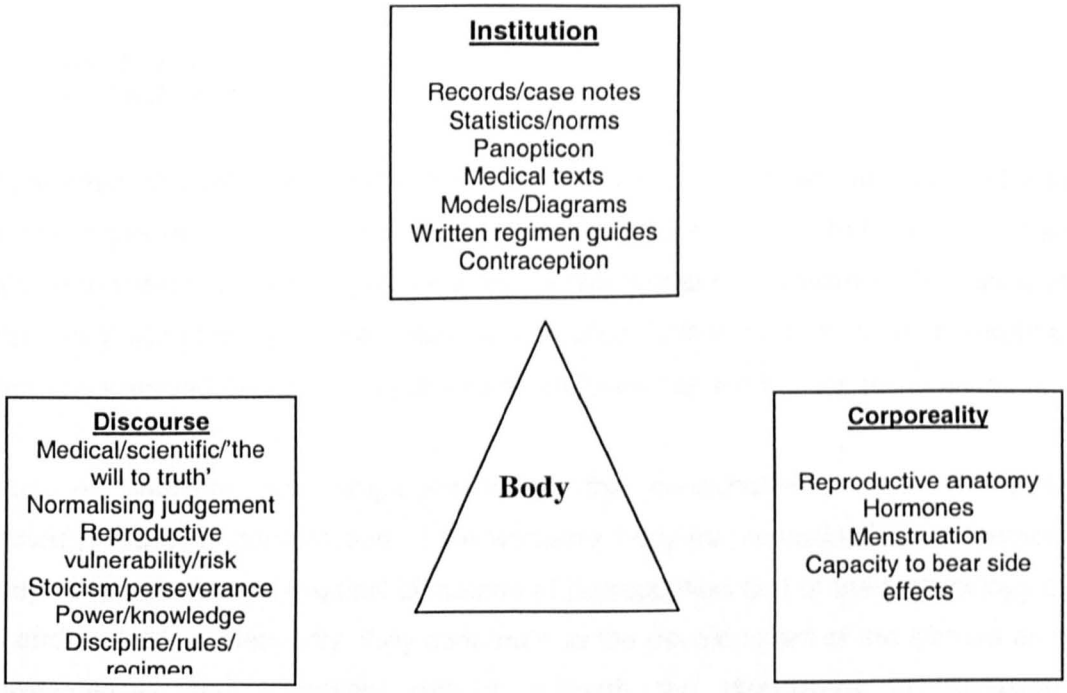
Closely allied to Frank's (1991, 1995) work on body types is his attempt to map out a theoretical framework in which the body can be placed for analysis (Frank 1991). The result of this was his adoption of a *'geometrically elegant'* triangular framework (Howson and Inglis 2001: 301), described in detail within Chapter 2. Earlier, this theoretical framework was utilised to discuss the issue of women's perseverance and stoicism in the face of contraceptive side-effects. Alongside Turner (1992), Frank, is one of the few body theorists who have attempted to map out any theoretical model/framework to provide an understanding of the body. Turner's work seems better suited to a societal/population analysis of bodies and as such is beyond the scope of this study, but will be discussed later with regard to future research. Frank's model, on the other hand, seems particularly well suited to use as a framework to illustrate the processes involved in the development of the *'contraceptive-using body'.*

7.4 The *'Contraceptive-using body'*

Frank (1991) proposes that a useful way of conceptualising the body is to see it constituted at the intersection of an equilateral triangle, the points of which are *'Discourse', 'Institution'* and *'Corporeality'.*

Figure 14 provides a diagrammatic representation of the family planning consultation, utilising this framework, providing an illustration of the network of micro-power relations involved in relation to developing the *'Contraceptive-using body'* as it exists within the elements of the consultation most closely associated with *'Institution'*, *'Discourse'* or *'Corporeality'*.

Fig. 14: The '*Contraceptive-using body*' (after Frank 1991)



Corporeality – bodies, argues Frank (1991:48) *'do not emerge out of discourses and institutions, they emerge out of other bodies'*. In saying this, Frank is reminding us that the corporeality of the body cannot and should not be ignored in any analysis; bodies as physiologies are *'an obdurate fact'* (Frank 1991:49). Women attending the family planning clinic are physical entities; they have a body. This body has a reproductive system; it menstruates, has physical mass and weight, experiences pain and discomfort, and is capable of reproduction. It is this corporeality that impacts upon the discourse of the contraceptive consultation. The point that Frank seems to making here is that all bodies do have physical limits and realities that affect the way in which they are constituted by discourse; for example a man's body cannot be discursively constructed as *reproductively vulnerable* to pregnancy or having to persevere stoically with the discomforts of menstruation.

Discourse – Even if we accept that empirical bodies have limits, the body is clearly subject to discursive processes. Frank (1991) identifies that even physiology has at any given time, produced discourses that differ markedly in terms of what is the *truth* about the anatomical and physiological properties of the body. Frank proposes that discourse is the way in which the body *'can understand itself'* and identify its *'possibilities and limitations'* (Frank 1991:48). What Frank seems to be implying with this is that although the physical body exists, how it is understood and used is dependent on *'socially-given body techniques'*, which, according to Frank:

> *'are as much resources for bodies as constraints on them; constraints enable as much as they restrict' (Frank 1991:48).*

This element is clearly reflected in the consultation data. Women are equipped with the pre-requisite skills and knowledge to control their fertility, but they are also required to submit to the disciplinary power of regimen and surveillance. The issue of restrictive body techniques can also be explored further from a wider theoretical perspective around the notion of patriarchy, an issue that will be discussed later.

Discursive practices are employed within the consultations; these practices contribute, firstly, to construction of the woman's body as *reproductively vulnerable* through the utilisation of medical discourse of reproduction and of the terminology of risk and protection. Secondly, they contribute to the development of the woman as a *knowledgeable and compliant patient*, through the discourses of discipline, surveillance and regulation within the consultation.

Thirdly, the resultant development of body techniques, such as regimen, self-surveillance and examination, demonstrate the role of discourse in the development of the woman as the active, vigilant 'patient'. Fourthly, the discourse around the physical side-effects related to contraception reveals the way in which responses to pain and discomfort are managed discursively, particularly through the use of differing language and the notions of perseverance and stoicism, discussed in detail earlier.

Institutions- Frank proposes a clear relationship between an institution (a physical place) and discourse, a relationship about mutual elaboration,

> *'Institutions are constituted in and through discourses, and discourses are instantiated and modified in institutional sites' (Frank 1991:49).*

The contraceptive consultations take place within the physical space of an institution - the clinic. Family planning clinics emerged out of discourses around population and related social policy concerning parenting, women's health and sexuality, but were also developed within the field of medical and scientific discourse around women's bodies and reproductive anatomy and physiology. The clinic does not just represent a physical building; it is the physical manifestation of discourse, whilst also acting, in a mutually constitutive way, as a creator and perpetuator of discourse. The clinic provides the 'texts' by which practice is influenced; the leaflets, diagrams and models used in the clinic reinforce medical discourses of physiology. The regimen for contraceptive use is provided in written form - both for the nurse in the protocols that guide practice - and in the printed literature given to women as reminders and instructions.

The clinic as an institution also places the woman under surveillance. The clinic, through the nurse, collects, collates and compares information from the woman. This information forms the basis of reports, epidemiological data and analysis of trends that provide the link between the individual woman and the population. It is through this role of surveillance, by the creation of epidemiological data, of norms and averages; also by collated observations of bodies, that the clinic contributes to discourse; a simple example of this process is weight. Women have their weight recorded in the clinic, but this data then contributes to a field of knowledge related to weight gain in contraception; it contributes to body mass data. This information subsequently presents itself within the clinic procedures as the taxonomy of normal and abnormal, with which other women are compared.

Last, but by no means least, the clinic prescribes, provides and, in some cases, administers the actual contraceptive pills, Depo-Provera injections, coils, intra-uterine devices and condoms that women require in order to put their contraceptive and reproductive knowledge and skills into practice.

7.5 Summary of the main findings of the study: towards a *'sociology of contraception'*

The central contribution that this study makes is to towards a *'sociology of contraception'*. This area of women's reproductive health is seriously neglected within the sociological literature, an omission that this research has gone some way towards addressing. This study demonstrates how contraceptive use and the reproductive system are socially constructed through discourse aimed at the body of the woman when she attends a clinic consultation. Integral to this is the operation, at the micro-level, of productive power techniques during the interaction between the nurse and woman. It is suggested that Foucault's (1984, 1986,1991) *techniques of the self*, linking with the Aristotelian notion of *habitus*, provides a useful framework within which the social construction of the *contraceptive-using body* can be placed. In doing so, this addresses one of the criticisms of Foucault's work on this topic: the lack of clear contemporary examples of the *'techniques of the self'*.

This study neatly illustrates how women are tutored in body techniques and practices that have simultaneously constraining and enabling facets, techniques that also, throughout the consultation, provide evidence of Foucault's analytics of power and discourse (1981a). Furthermore, the nurse/women encounter is an excellent example of productive power in operation. Women are not coerced or pressured to comply with contraceptive regimen; they are instructed, encouraged and supported toward the development of the body knowledge and practices necessary for them to use contraception effectively.

This study provides a detailed account of the social construction of the contraceptive use. It is concluded in the study that consultations in family planning clinics discursively construct the *'knowledgeable/reproductively vulnerable'* and *'active/compliant'* 'patient' within the overarching core categories of 'Surveillance' and 'Compliance'.

Within the study a number of key features - situated within the three categories of: 'Body education', 'Surveillance' and 'Regimen' - can be highlighted as being important in the discursive construction of the *'Contraceptive-using body'*, particularly because of the contribution that they make to existing work in related areas of women's reproductive health.

7.5.1 *'Body Education'*

How women are educated about their reproductive systems is an important aspect of the consultation process. The manner in which the reproductive system is discursively constructed as *reproductively vulnerable* builds particularly upon the work of Martin (1989) and identifies key ways in which the terminology of the contraceptive-using body differs from that of the menstruating, pregnant or menopausal body described in her work. For example, instead of a failing or disintegrating system; the reproductive system is constructed as *potentially fertile* and requiring restraint. Furthermore, this study demonstrates how this terminology is deployed within health care interactions as a component of *Body education.* Body education also adds to the work of Laws (1990) on menstruation. In particular, it demonstrates specifically how medical discourses around *'normal'* menstruation are utilised in encounters between women and health professionals. Both of these are clear examples of *power/knowledge* operating through discourses aimed at the body.

7.5.2 *'Body Surveillance'*

Body education is closely integrated with the development of surveillance, both by the woman herself and by the clinic. The study demonstrates how the construction of *reproductive vulnerability* is linked to the process of developing the *active patient*, central to which is the issue of *body surveillance.* It is acknowledged that the creation of health risk as a pre-requisite to self-surveillance is not a new idea (for example; Lupton 1994, Nettleton 1997, Harding 1997, Howson 1998). However, within this study there were a couple of interesting additions to this work.

Firstly, this study illustrates how self-examination techniques are included within the encouragement to self-monitor. This aspect adds new dimensions to the literature on self-examination, which has previously been dominated by breast examination, whilst also contributing to the debate - discussed by Howson (2001a, 2001b), about whether the ability to visualise and examine the body is a liberating or constraining act - by proposing that it is probably *both.*

Secondly, the study demonstrates interesting limitations to self-surveillance. Women are encouraged to self-monitor, but do so under the overarching surveillance activity of the clinic. The clinic, acting as Panopticon, particularly through the use of case notes, illustrates that surveillance *of* self-surveillance is a key role within the family planning clinic, adding to the work of Boyne (2000) with regard to the debate over the relevance of the Panopticon in contemporary healthcare. Women are encouraged to self-monitor, but this activity is monitored and overseen by the clinic in order to, in the words of Nurse J: *'keep a proper control'.* Furthermore, the manner in which nurses utilised specific discursive techniques to limit self-surveillance, in order to allow them to make the final interpretation about the validity and meaning of the woman's observations, provides an interesting example of how power techniques *control* the *'active patient'* and transform her into the *'active but compliant patient'.*

7.5.3 Regimen

The study also provides interesting examples of disciplinary power techniques operating through discourse that provide clear examples of the Foucauldian concept of power/knowledge. These discursive practices are particularly evident in ensuring *compliance.* As with self-surveillance, the concept of disciplinary practices operating in health care is not new. Nettleton's (1994) descriptions of dentistry provides one example, Howson's (1998, 2001a) work on cervical smears another. However, the study did reveal a couple of discursive processes not described elsewhere in the literature.

One was the way in which side-effects are managed in the consultation. This aspect provides one of the most interesting illustrations of the micro-power relations operating within the consultations. The side effect *'dilemma',* as it is phrased, demonstrates how different discourses are employed when addressing side-effects in the consultation. In order to ensure that women are vigilant in relation to side-effects (an important aspect of surveillance) women are taught about side-effects. However, nurses seem aware this could affect compliance. Therefore, to stress method effectiveness scientific discourse is employed, yet to address side-effects lay terminology that minimises symptoms is utilised; thereby supporting compliance. This aspect of the consultation contributes to and develops the work of Hardon (1992) and Kamen and Oudshoorn (2002), in that it provides evidence to connect the discourse employed in contraceptive clinical trials to contraceptive consultations. It is also highly reflective of Foucault's discursive *'procedures of exclusion'.*

Secondly, the way in which women are instructed in *regimen* was interesting. As well as the use of the term *'rules'* within the process of teaching women how to comply with contraceptive regimens, the issue of managing contingencies was particularly revealing. At first glance, helping women to plan for and manage potential breakdowns to their regimen seems strongly indicative of Bogard's (1996) notion of simulation, a process where individuals are trained to manage health contingencies themselves, without direct observation and instruction from the Panopticon. However, on further analysis, the manner in which nurses simplified the *'rules'* for women, not giving them the full facts about managing contingencies, revealed that, even in apparent cases of simulation, the clinic ensures some direct control over women's actions.

7.5.4 Body theory

On a wider theoretical note, the study provides the first empirically-based critique of Frank's (1991) body types and body use in action typologies. The study demonstrates how Frank's body types do not seem robust in providing a framework within which the *contraceptive-using body* can be placed. It is suggested nonetheless that, if room were made for the *blending* of body types across less *rigid* boundaries, this typology, - which has been rather neglected - would be of use in body research, for example, as a tool to explore how bodies may *change* from one type to another.

Frank's other theoretical contribution, his triangular model of the body, proved to be a useful way in which to illuminate the whole process of constructing the contraceptive using body. This study is the first research study to apply this neglected typology empirically. It is suggested that it provides a useful structure within which to explore the social construction of the body, particularly as a way of exploring how the two, very Foucauldian, notions, of discourse and institution fit with the body as a *corporeal reality,* an aspect that will be explored further in the next section.

Section Two:

Limitations of this study and suggestions for further research

In any qualitative research study, it is important to acknowledge that there are limitations to the understanding that it can claim to bring to any phenomena or situation (Denzin and Lincoln 2000). Highlighting these limitations is also important because, due to the exploratory nature of qualitative research, particularly grounded theory, new areas for inquiry may be developed that enable the social phenomena under investigation to be tested, amended or explored in more depth by other researchers, in different settings (Strauss and Corbin 1990, Guba and Lincoln 1994). This next section both sets out the limitations of this study and, in recognition of the last point, makes suggestions for further work in the area of contraception and family planning.

7.6 The embodied experience of contraception

The data from the consultations and interviews provides a detailed account of the discourses and power relations deployed when developing women into effective and compliant contraceptive-users. However, because of the early decisions, outlined in Chapter 4, to concentrate on the consultation data and nurse interviews, the study does not provide an account of the women's experience of the family planning consultation, or of using contraception as part of their lives. In other words, this study does not include an exploration of the embodied experience of contraceptive use.

Howson and Inglis (2001: 302) identify that a significant shift in the sociological study of the body has been the move way from *'structural accounts of the body'* towards the study of experiences and action. This *'phenomenological shift',* they argue, is an attempt to redirect attention away from the body as a *'reified object',* formed through processes, forces and theory, towards an understanding of the way in which the body is lived. Williams and Bendelow (1998:8) describe this shift as one towards the '*experiential'* view of the body, a principle that has guided the direction of a large amount of work on the sociology of the body. This trend can be seen in the focus of more recent work on women's health, which has seen many aspects of women's embodied experiences explored.

Experiences of pregnancy and childbirth are discussed quite well, for example, by Martin (1989), Duden (1993) and Root and Browner (2001). Menopause and menstruation have also received attention (Martin 1989, Laws 1990). More recently, women's experiences of cervical smears have been explored (Bush 2000, Howson 2001a, 2001b) and attention has been given to the growing use of reproductive technologies such as artificial insemination along with women's experiences of them (Haraway 1997). Additionally, emerging health issues that are the result of the ageing female body, are the focus of experiential research; for example work on hormone replacement therapy (Harding 1997), osteoporosis (Leysen 1996, Wingerden 1996, Kirby 1997) and disability (Bradiotti 1997). Research into experiences of women's embodiment has also moved onto other body practices, such as cosmetic surgery (Davis 1995, Brush 1998) and fitness and bodybuilding (Balsamo 1996, Hall 1996).

Although these examples provide a broad range of discussion about the embodied experiences of women, contraception is quite conspicuous by its absence, and certainly, in the light of the findings and discussion within this study, is a topic that deserves more attention in future. The data from the family planning clinic revealed numerous threads that could be explored in interviews with women. For example, how do women describe their experiences of contraceptive side-effects, to what extent do women see contraceptive regimen as a restrictive aspect in their lives? And do women perceive their body any differently when using contraception?

Furthermore, such work could expand some of the theoretical aspects of the discussion outlined earlier, particularly around the notion of stoicism. Frank's triangular model was suggested as being useful in framing the issue of side-effects, and it was proposed that women are required to be stoical in the face of adverse symptoms. Frank argues that this illustrates how the corporeality of the body is important, in that it places limits on the body practices promulgated through discourse and institutions by its ability to endure physical distress. Interviews to explore women's embodied experiences of using contraception would add to this. For example, in what way do women perceive this when using contraception? To what extent do women see themselves as having to persevere? Adding such data to this study would usefully extend the understanding of contraceptive use, and is certainly an area that is considerably under-researched.

However, Howson and Inglis (2001) advise caution when proceeding entirely utilising strategies to explore experiential notions of embodiment. They argue that what results can be the neglect of *structure* in research that explores embodiment from an experiential perspective, pointing particularly to the use of *'Merleau-Pontian based phenomenology'* in this respect (Howson and Inglis 2001: 305). What Howson and Inglis appear to be saying here is that any attempt to explore embodiment also needs to recognise the impact of structure in shaping body experiences. Shilling (1993:98) proposes, when analysing theoretical frameworks for the study of the body, that what is required is a *'bridging of the gap'* between the structures, processes and power relations involved in constructing the body and individual experience of embodiment.

Earlier, it was suggested that Shilling (1993) unfairly criticised Frank's theory of body types as being as functionalist as Turner's societal task model, neglecting to discuss the value of Frank's triangular typology, which is designed explicitly to *'bridge the gap'* between structure and embodiment. As discussed earlier, the value of Frank's approach appears to have been overlooked as researchers turn to methods of analysis that describe experience, but not structure.

What this study of the family planning consultations has shown is that there is, indeed, some merit in Frank's approach, in describing both the structural and discursive effects upon the body and the role that physical embodiment (corporeality) plays in the construction of bodies.

What it provides is the opportunity, through the dimension of corporeality, to add a strand to body analysis that takes account of the embodied experience, but that does so in the context of structural factors. Therefore, a valuable extension to the study of women and contraceptive use would be to expand on the aspect of corporeality in Frank's triangular typology by in-depth interviews with women attending clinics, and, given the gender issues outlined within Chapter 4, it is suggested that this work would be most productive when undertaken by researchers who are women. Such work would also be able to provide a further angle to the understanding of contraceptive use, one that would also address a common and widespread criticism of Foucault's notion of power: that of resistance.

7.7 Foucault, power and resistance

One of the most pervasive criticisms of Foucault's writings on power is the alleged lack, within his writings on power, of a place for resistance (Rabinow 1984, Lupton 1997, Macleod and Durheim 2002). Foucault is often accused of analysing in great detail the effects of power upon the body, particularly the docile body, in his earlier work, without exploring the processes by which that power is resisted. To a certain extent this criticism has been applied most vociferously to his earlier works, and centres upon his discussions of repressive and coercive power relations epitomised within Discipline and Punish for example (Foucault 1977) which, according to some, does not sufficiently explain or identify techniques of resistance (Minson 1986, Wickham 1986). Lupton (1997) claims that, as Foucault (1984, 1986, 1991) developed his work towards the notion of productive power, such claims lost much of their currency, arguing that the premise of productive power is that it is *seductive* rather than oppressive. Lupton argues that this means that traditional forms of resistance, in terms of overt revolution or revolt, are not applicable to an understanding of resistance from a Foucauldian standpoint.

Nevertheless, Foucault did respond to these criticisms within his work. For example, he did acknowledge that resistance occurred but, given the capillary and omnipresent nature of power, argued that there is: *'No single locus of great refusal, no soul of revolt' (Foucault 1981a: 96).* But he did propose, as Macleod and Durrheim (2002: 55) note, that there are *'shifting points of resistance'* that:

> *'Inflame certain parts of the body, certain moments in life' (Foucault 1981a: 96).*

Therefore, Foucault's notion of resistance is closely allied to his concept of power, it exists at the micro-level, and occurs fleetingly, taking various guises that, rather than taking the form of outright resistance or refusal, take the form of what Macleod and Durhheim term:

> *'Reverse or subjugated discourse and practice subverting hegemonic discourses and practices' (Macleod and Durhheim 2002:55).*

In other words, this means that, for Foucault, resistance takes the form of localised *discursive* resistance through, for example, lay discourse, which challenges or subverts by providing alternative frames of reference and knowledge. This process is, of course, subject to counter-resistance from dominant systems of knowledge.

To explore resistance within the study of health care, therefore, it is necessary to analyse the power relations at the point at which there is interaction and also analyse resistance from the patient/client's point of view, by exploring their reactions to discourse and power/knowledge. Within the literature on women's reproductive health there are examples of research that explore resistance, particularly during pregnancy (Press and Browner 1997, Abel and Browner 1998, Root and Browner 2001), and in cervical screening (Howson 1998, Bush 2000). However, no literature was found that illustrates resistance in contraceptive use.

Interviews with women about their experiences of contraceptive consultations and using contraception could usefully explore the nature and extent of resistance to the power techniques operating in the family planning clinic. There were some tantalising examples of this in the consultation data in this study. For example, the woman who monitored her menstruation in a different way (Consultation 43); the woman who was reluctant to examine herself (Consultation 3), also the woman who tried to modify her pill regimen (Consultation 28), suggesting that there is resistance operating within the consultations. What this study does, however, is to provide a framework that could be utilised to explore resistance in more detail, perhaps within the study of women's embodied experiences of contraception mentioned earlier. Certain issues in particular spring immediately to mind, for example, how do women respond to and modify regimen outside of the clinic? How do they (if at all) combine their lay beliefs with the body education that they receive? Do they amend or prioritise body surveillance in some way?

7.8 *Anatamo-politics* to *Bio-politics*: links to wider power structures?

One of the central elements of Foucault's work on power is his assertion that the body is *the* link between power relations that operate at the micro-level and wider social structures. In his work on Bio-power, he proposes that the process of *'anatamo-politics'*, the disciplining and regulation of the individual body, was closely linked to the wider issue of societal regulation: the *'bio-politics of the population'* (Foucault 1981:151).

Dreyfus and Rabinow refer to this when they argue that that the importance of the body for Foucault is that it:

> *'is not simply a focus of discourse, but constitutes the link between daily practices on one hand and the large scale organisation of power on the other'. (Dreyfus and Rabinow 1982, cited in Shilling 1993:75)*

However, although Foucault sets out this link in his work, he is often criticised for concentrating upon the *micro-physics* of power between individuals and failing to set out clear examples of precisely how this link operates. This has led to numerous authors arguing that Foucault left more global issues in power un-theorised (Wickham 1986, Gordon 1991) This alleged omission led researchers, particularly feminists, to criticise Foucault for not accounting for overall structures of domination, for example patriarchy (Sawicki 1991, Ramazanoglu and Holland 1993).

Macleod and Durrheim (2002) take a somewhat different stance. They argue that such criticism neglects to either take consideration of Foucault's later work on the creation of the *'subject'* or acknowledge his work on Governmentality (Dean 1994, 1999). Furthermore, they identify that Foucault does not deny that,

> *'Micro-level practices of power are taken up in global or macro-strategies of domination. He merely refused to privilege a centre of power which then permeates into the everyday lives of people' (Macleod and Durrheim 2002: 43-44).*

Foucault's point is that an *ascending* analysis is required in order to explore how micro-power relations, operating through discourse, are linked with wider power systems. In other words, his analysis is that power, operating through discourse at both micro and macro levels, exists in a complementary, co-existing manner and that it is also mutually influencing and perpetuating. To explain this link, Foucault proposed that the art of Government, which he defined as the *'conduct of conduct'* (Gordon 1991:2), operates through an extremely complex, multi-level process. Foucault (1991) proposes that *'government'* is exercised through an intricate network, consisting of institutions (e.g. clinics), procedures, analyses, reflections, calculations (e.g. research, policy and discourse) and tactics (e.g. discursive strategies).

This network is simultaneously the *product of* and *creator of* discourse in a mutually constitutive way, a network that, suggest Macleod and Durrheim (2002), provides the link between individual and population, stating that,

> *'On the one hand governmentality is simultaneously subjectivising (it concerns itself with the constitution of individualised subjectivity). On the other hand, the individual is implicated in large-scale normalising structures and regulatory controls. Governmental analysis, thus, attempts to link the micro-effects of power with the macro-strategies of power without privileging one or the other' (Macleod and Durrheim 2002: 45)*

This aspect of individual and population links closely with Turner's (1992) attempt to provide an analytical framework of the body in his societal task model discussed earlier. To recap briefly, Turner proposes that the body presents Society with a number of *'problems'*, particularly the problems of *'restraint'* for the individual body and the allied problem of the *'regulation'* of the population. In his work, Turner does not attempt to provide a more detailed analysis of his framework, and in particular does not give any examples of how restraint of the individual body is *linked* to regulation of the population, although he does mention the need to think of *'bodies singular and bodies plural'* (Turner 1992: 58). This is a clear reference to the links that Foucault makes between the *'anatamo-politics'* of the body and the *'bio-politics'* of the population.

The data from the consultations and interviews with nurses, it is suggested, provides excellent examples of the *tactics* of government, particularly demonstrating how micro-power relations operate within individual consultations to construct the *contraceptive-using body.* Examples are also provided which indicate how medico-scientific discourse informs these micro-power relations. However, because of the nature of the study and of subsequent data collection/analysis this study does not explore *explicitly* how the power relations within the individual consultations link with any wider power structures. In other words, what are the roles of the consultation and the clinic in terms of wider issues of governmentality?

It is suggested that, although the empirical data in this study primarily provides a picture of power relations within the *individual* consultation, certain tentative claims can be made about possible links to wider, societal issues, aspects that are certainly worth exploring in further research.

When attending the clinic for an individual consultation, it could be argued that the woman also becomes involved in the regulatory processes of the population. Rose (1994:55) refers to the regulatory activity that medicine performs at societal level as consisting of two *'axes of policing'*, interdependent collection of statistics from individuals, that are collated, compared and contrasted in the practice of epidemiology and the development of administrative systems for regulating events within the population.

Rose (1994) argues that the collection of information - for example habits and behaviours of individuals - not only served a purpose for the individual consultation between patient and practitioner but also enabled the development of statistical data that allowed observations to made about the population as a whole. When individual information was collated and analysed, medicine was able to set itself the task of *'improving the social body'* (Rose 1994:57).

More research into clinic structure and sexual health policy would be able to explore how individual consultations are linked to strategies at the population level. Suggestions can be made, but more work would enable a more detailed exploration of the mutually constitutive roles of clinic, discourse and policy. A legitimate question to ask at this point is; are the individual consultations, when taken as being integral to the wider duties of family planning, contributing to a broader system of surveillance, In other words can the clinic be regarded as some form of Panopticon?

This question was posed earlier, in the context of the individual women. Women are shown to be under direct surveillance by the clinic, mainly through their clinic records. Nurses draw on this information with all the women whom they see in clinic. It could be suggested that the clinic acts very much as Panopticon. Women are seen individually, without seeing each other, although the nurse has the collective view to hand. She can compare the women both statistically and from her own clinical experience.

In his work analysing the role of Genito-Urinary Medicine clinics Pryce (2000) demonstrated that the sexually-transmitted diseases clinic (*STD*) provides a clear example of the links between the individual body and wider social surveillance. He describes how the *STD* clinic not only has the role of diagnosing and treating individuals, but, also by reporting infection-rates and other epidemiological data, contributes to the monitoring of sexually-acquired infections across society.

Also, the *STD* clinic performs an even more overt surveillance role through contact tracing activities. This practice involves the notification of persons exposed to an infection and the subsequent follow-up of their sexual partners, thus creating *'networks of sexual relationships in the community'* (Pryce 2000:106). It is suggested that the family planning clinic acts in a similar way to this.

Although the empirical data-collection in this study does not include an exploration of how the clinic utilises the pool of information that it holds on individual women in a *collective* way, certain propositions about this can be made. Family planning clinics contribute to the epidemiology of sexual and reproductive health in numerous ways. Clinics, often through audit, report on contraceptive prescribing patterns, rates of pregnancy, rates of abortion etc. This data feeds into the national epidemiological picture that, in turn, informs policy. A clear example of this is the Social Exclusion Unit report into unplanned teenage pregnancy, which identified the links between social deprivation and high rates of unplanned pregnancy, also the United Kingdom Department of Health's *'Sexual Health Strategy'* (Dept of Health 2002).

Further work could explore in more detail the links and mutually-constitutive processes at work between individual practice in the consultations and wider power structures. For example, to what extent are family planning clinics and contraception products of Patriarchal power? This study has made a start in describing the discursive tactics employed in the individual consultations and made some suggestions as to how this may link with institutions and wider procedures.

What is required is further work that analyses the relationship between the tactics aimed at the individual body and wider social power structures. In what way do the micro-power relations and discourses at the individual level flow from *and* influence wider strategy? Table 13 sets out the types of relationship that may exist between micro-power relations within the contraceptive consultations in this study and wider power structures.

Table 13 Contraception: micro-relations to macro-structures

Mutually-constitutive relationships? ⟷		
Macro-power structures		**Micro-power relations**
Population/discourse-	**Institutions/procedures**	**Individual bodies-tactics**
Discourse on sex *Patriarchy* *Discourse on unplanned pregnancy* *Discourse on sexuality of women* *Sexuality of young people* *Population control* *Discourse on the family* *Parenting discourse* *Child development*	*Health policy* *Clinics* *Sexual health research* *Epidemiology* *Sexual health strategy* *Sexual health and contraceptive services* *Reporting of statistics and rates (e.g. pregnancy etc.)* *Staff training*	*Individual consultations* *Nurses' discourse on contraception* *Micro-power relations* *'Surveillance'* *'Compliance'* • *'Body education'* • *'Body surveillance'* • *'Regimen'*

Table 13 is intended to provide a starting point for future research. The contents of the first two sections (population/discourse and institutions/procedures) are suggestive and by no means complete. The intention is to demonstrate the kinds of links and mutually constitutive relationships that could be usefully explored. What this study into the contraceptive consultation has done is to provide one useful starting point for this analysis.

7.9 Other settings and professionals

Strauss and Corbin (1990) maintain that one of the strengths of grounded theory is that it provides a theoretical framework for other research. Theories are not 'de-bunked' but enriched and expanded by other researchers. This study is focused on only one system of providing contraceptive advice and on one group of health care professionals. A useful area of further work would be to test out the frameworks generated in this study in other settings, for example General Practice.

Large numbers of women attend either a General Practitioner or a Practice Nurse for contraception; do these consultations differ in any way from the ones held in family planning clinics and does advice given by the Doctor differ from that given by he nurse? However, as outlined much earlier, such work would require time and patience given that most General Practice surgeries do not run specific *family planning clinics* but see contraceptive-users within the broad range of consultations that occur within a particular surgery. Similarly, midwives provide contraceptive advice during post-natal discussions, and gynaecology nurses after termination of pregnancy. These other settings and practitioners provide further opportunities to develop and test the conceptual framework outlined in this study.

7.10 Contraceptive practices: emerging issues for future research

Contraceptive development is an ongoing field of research and practice and, as such, will always present new research opportunities. Two of the most interesting areas in family planning practice are the development of new methods of contraception and the debate around a male contraceptive: the so called *'male pill'*[4]. Both of these areas offer intriguing opportunities to develop understanding of contraceptive discourse.

7.10.1 New methods

Two forms of contraception that are becoming more popular, but that did not figure in the consultation data in this study, are contraceptive implants and *'natural'* family planning.

7.10.2 Implants

Contraceptive implants work on a similar principle to Depo-Provera, in that they are inserted by a clinician and are long-acting. Implants, however, consist of a plastic rod about 4-5 cm in length, containing hormone that is placed under the skin by a minor surgical procedure. Once in place it provides contraception for around 5 years. It also requires a minor surgical procedure to remove it.

[4] Although this form of contraception is often referred to as the *male pill* in the popular press, it is more likely to be administered by injection, implant or adhesive patch than by a pill.

This method of contraception will certainly entail many of the aspects of contraceptive use outlined in this study, such as side-effects and efficacy, being discussed in consultations. Indeed, recent clinical literature suggests that side effects with this method are still a problem for some women (Ortayli 2002, Reuter and Smith 2003) as is the need to teach women the *'seven-day rule'* of taking extra *'precautions'* if the implant is inserted at certain points of the menstrual cycle (Smith and Reuter 2003:195). It may also require the woman to examine her self physically in order to check that it is in place. However, it would be interesting to explore women's feelings and experiences of having this device implanted into their bodies. An anecdotal example of this was recounted by a family planning nurse, when mentioning that one women she saw in clinic refused to have one because it would make her feel like a *'robot'*.

This issue is reflective of one trend in body literature, that of new technologies and the creation of the *'cyborg'* (Brook 1999: 136). Turner (1992) alludes to this when he remarks about the fact that bodies, because of the increase in artificial implants and transplants, become more difficult to define. Similarly, numerous feminist writers have begun to explore the implications of such technology (though not contraceptive implants) for study of the female body (Sophia 1992, Klein 1996).

7.10.3 'Natural' family planning

Natural family planning actually covers a range of contraceptive practices that are based upon some of the oldest methods for avoiding pregnancy. The term *'natural'* refers to the lack of any use of drugs or barrier devices (coils, condoms, diaphragm etc.) and is based upon careful monitoring of the body in order to identify *'safe'* times for sexual intercourse. This body-monitoring can take the form of detailed, daily temperature-recording, monitoring the nature and consistency of cervical mucus, meticulous recordings of menstruation and other monitoring practices (Flynn and Brookes 1988, Louden et al 1995).

Although not commonly addressed in family planning clinics, specialist centres exist where women can be trained in these techniques, which can involve a process of learning that takes up to three months to perfect (Louden et al 1995) - certainly indicating that body education and surveillance play a significant role in these methods. Louden at al (1995: 193) also refer to the problem of compliance with natural methods, stating that *'couples often break the rules'*.

Despite these similarities, it would be interesting, as contraceptive techniques evolve and develop, to explore the robustness of the features of contraceptive use mapped out in this study. Indeed, perhaps nowhere is that robustness going to be tested more strongly than when it is applied to contraception in men.

7.10.4 Male contraception

An emerging field within contraception is the development of male-controlled methods beyond the condom. The subject of male contraception has been discussed in journals since the 1970's. During the '70's and 80's, the prime consideration was that a male contraceptive would be helpful in augmenting female contraception to control populations. For example, Gombe states:

> *'An effective male contraceptive would influence future family planning much more than refinements in existing female methods. Conscious efforts by governments and scientists must be directed towards achieving this goal' (Gombe 1983: 203).*

Quite why the development of male contraception would have this influence is under-developed by Gombe. However, Oudshoorn (2002), in her study into contraceptive research, identifies an increase in the study of male contraception. Indeed, numerous authors have also suggested that male contraception is an issue to redress the inequity of women who bear the contraceptive burden, particularly the side effects and inherent medicalisation of most contraceptive methods (Aldhous 1990, Handelsman 1991, Gelijns and Pannenborg 1993). It is only relatively recently, however, that research into male contraception has proceeded in earnest, and the research into this aspect of family planning is extremely limited.

Usually, Men will only attend family planning clinics when accompanying their female partners, or to obtain condoms. As such, were not the focus of this study. However, if, say, men were to use contraception that worked on similar lines to the methods that many women use, it would provide a fascinating opportunity for study.

Indeed, Oudshoorn (1999, 2003) has already detected differences in the discourse employed within male contraceptive research when compared to that of female methods, particularly noting that side -effects are taken more seriously, also that the impact upon sexual well-being, in other words libido, is taken far more seriously when evaluating male contraceptives.

This preliminary work hints that there may be quite considerable differences in the discourses operating around male contraception and it would, indeed, be intriguing to analyse future consultations between family planning nurses and male contraceptive-users. Such a comparison could also shed more light on the exploration of the issue of Patriarchy and population control through sexual regulation touched on earlier.

7.11 Summary and Conclusion

This chapter has set out the conclusions from the study. Section one draws together the threads of the contraceptive consultation by exploring the way in which the closely-integrated processes operating within the categories of Surveillance and Compliance provide tangible, contemporary examples of Foucault's (1984, 1986) *techniques of the self.*

Comparisons and links are made between the consultation process and the development of body practices and techniques framed within Foucault's analysis of the Greco/Roman principle of *'askesis'* and *'technologies of the self'.* The relationship of these practices to the formation of a *'contraceptive habitus'* is also explored. It is suggested that Foucault's (1984,1986, 1991) *techniques of the self,* linking with the notion of *'habitus'*, provides a useful framework within which the social construction of the *contraceptive-using body* can be placed. In doing so, it also addresses one of the criticisms of Foucault's work on this topic: the lack of clear contemporary examples of the *'techniques of the self'.*

The data from the study illustrates how women are trained in a set of body techniques and practices that have simultaneously constraining and enabling facets, an aspect that is reflective of Frank's (1991) body techniques, techniques that also, throughout the consultation, provide evidence of Foucault's analytics of power and discourse. This is particularly evident in the manner in which the productive power relations within the consultations compare with the processes that Foucault sets out within techniques for *'cultivation of the self'* (Foucault 1986:67). Furthermore, the nurse/women encounter is an excellent example of productive power in operation. Women are not coerced or pressured to comply with contraceptive regimen, they are instructed, encouraged and supported toward the development of the body knowledge and practices necessary for them to use contraception effectively.

It is concluded in the study that consultations in family planning clinics discursively construct the *'knowledgeable/reproductively vulnerable'* and *'active/compliant'* patient within the overarching core categories of *'Surveillance'* and *'Compliance'*. The manner in which the reproductive system is discursively constructed as *reproductively vulnerable* builds particularly upon the work of Martin (1989, 1991) and identifies key ways in which the terminology of the contraceptive-using body differs from that of the menstruating, pregnant or menopausal body described in her work.

Body education also adds to the work of Laws (1990) on menstruation. In particular it demonstrates specifically how medical discourses around *'normal'* menstruation are utilised in clinical encounters between women and health professionals. Both clear examples of *power/knowledge* operating through discourses aimed at the body. Body education is also closely integrated with the development of surveillance, both by the woman herself and by the clinic. The study demonstrates how the construction of *reproductive vulnerability* is linked to the process of developing the *active patient*, central to which is the issue of *body surveillance*.

The study also demonstrates interesting limitations to self-surveillance. Women are encouraged to self-monitor, but do so under the overarching surveillance activity of the clinic. The clinic, acting as Panopticon, - particularly through the use of case-notes - illustrates that surveillance *of* self-surveillance is a key role within the family planning clinic, adding to the work of Boyne (2000) with regard to the debate over the relevance of the Panopticon in contemporary health care.

Furthermore, the study provides interesting examples of disciplinary power techniques at work. As with self-surveillance, the concept of disciplinary practices operating in healthcare is not new, Nettleton's (1994) descriptions of dentistry providing one example and Howson's (1998, 2001a) work on cervical smears another.

However, the study also reveals a couple of discursive processes that are not described elsewhere in the literature. The side effect *'dilemma'*, as it is phrased, demonstrates how different discourses are employed to ensure that women are vigilant in respect of side-effects (which is an important aspect of surveillance) but that they are educated about side-effects in a way that utilises scientific language for the efficacy of the contraception and lay terminology that minimises the severity of side effects, thereby supporting compliance.

This aspect of the consultation contributes to and develops the work of Hardon (1992, 1997) and Kamen and Oudshoorn (2002), in that it provides evidence to connect the discourse employed in contraceptive clinical trials to contraceptive consultations.

On a wider theoretical note, the study provides the first empirically based critique of Frank's (1991, 1995) *body types* and *body use in action* typology. The study demonstrates how Frank's body types do not seem robust in providing a framework within which the contraceptive using body can be placed. Although it is suggested that, if room were made for the *blending* of body types across less *rigid* boundaries, this typology, which has been somewhat neglected, would be of use in body research.

Frank's other theoretical contribution, his triangular model of the body, proved to be a very useful framework to illuminate the whole process of constructing the contraceptive using body. This study is the first research study to empirically apply this neglected typology, and it is suggested it provides a useful structure within which to explore the social construction of the body, particularly as a way of exploring how the two, very Foucauldian notions, of discourse and institution fit with the body as a *corporeal reality.*

Section two of this chapter discusses the limitations of the study and, integral to this, suggests areas of research that could further develop the understanding of contraceptive discourse, power and the body. This section firstly proposes that this understanding could be usefully extended by an experiential account of women's embodied experiences of using contraception, for which this study provides a useful framework or reference point. Furthermore, the lack of a contraceptive-user's perspective in this study limits the extent to which *resistance* to power can be explored.

This is a widely-cited criticism of Foucault's work on power (Rabinow 1984, Lupton 1997, Macleod and Durheim 2002) and an area where further work would be useful. However, it is suggested that this study provides certain key elements of contraceptive use that could form the basis for exploring resistance, for example, resistance to regimen and/or surveillance.

Section two also explores the possibility of links being made from the data in this study to wider, social structures that influence sexual health, population control and the health of women. To do this, the work of Turner (1992) was engaged, particularly his '*societal task*' model, which, together with Foucault's work on '*Governmentality*' is presented as a possible framework to link the micro-processes of power deployed in the individual contraceptive consultations with wider power structures.

Finally, although this study has explored an under-researched aspect of the body and has made contributions to a *'sociology of contraception'*, the nature of modern health-care means that clinical developments always add new dimensions to any research study. Contraception is used by millions of women in England, many of whom visit a family planning clinic. However, other professionals provide contraception within different clinical settings. This aspect, coupled with the numerous new contraceptive methods emerging from clinical research, provides a rich area of reproductive health care for further research. Nonetheless, this thesis provides a useful reference and starting point for this work.

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Appendix I

Initial Nurse Interview Schedule

Could you tell me a little about your nursing background?

How long have you been involved in family planning practice?

Do you know what each woman has come to the clinic for, or do you have to find out in the consultation?

Do consultations tend to follow a specific pattern or is each one different?

Could you talk me through a typical consultation?

Do you use different types of approaches with different types of women?

Examples: Age, level of intelligence?

Do you think your own views can influence the discussion?

How do you approach the topic of sexually transmitted infections with women who are attending the clinic for contraception?

I've noticed that the computer and protocols seem important aspects of your practice; do they help or hinder your consultations with women?

Do you sometimes feel that you are going through the same old routine?

Do you think women need to know about their body in order to use contraception?

Is contraception sometimes about it having good and bad aspects to it?

How do you discuss this with women?

Do some methods suit some women more than others?

Do some women want to talk about things other than contraception when they come to clinic?

Would you include other things into your discussion if you had time?

Is there anything else you would like to say?

Appendix II

Client interview schedule

Is this your first visit to the clinic?

If no;

Have you seen more than one nurse on your visits to the clinic?

(If so);

In what way were they any different?
Did you prefer how one was compared to the other?

(If No and also);

Have any of your friends or family had experiences of the clinic?

What do you think about the clinic service here?

One of the things I am interested in is the use of the computer in the clinic, how do you think the computer affects your discussion with the nurse?

Prompts:

- Helps?
- Intrudes?
- Distraction/annoying?

What would you say was the best aspect of how the nurse was with you ?

What would you say was the worst bit of the discussion?

Prompt;

- Can you explain why?

Were you asked any questions that you wondered 'why did she ask me that'?

Did you feel that you had enough time with the nurse?

What changes or improvements would you like to see?

Would you prefer the nurse to be quite chatty and friendly, or more professional when talking to you?

Prompts

- Which type of health professional do you like
- Importance of nurse being a woman
- Able to share own (nurse) experiences

Would you be interested in discussing other aspects of your health with the nurse or do you just want to concentrate on the main thing you came to clinic for?

Prompts

- If yes, give examples

Do you feel that you would just like to get in and out for what you have come for without all the questions

Do you feel you got what you wanted from the nurse?

Prompts

- Do you see the discussion being about helping you to be in control of your life?
- (I want to put more here about being in control)

Were you able to ask the nurse all the questions you had?

- Were they answered?
- Did you understand everything?

Did you feel rushed in any way?

Were you in with the nurse longer than you thought?

Was the discussion with the nurse what you expected,

Prompts

- If not reasons
- What did you expect

What do you think are the most important skills family planning nurse has to have?

Do you think that it is important for the nurse to be a woman who shows she understands things from a woman's perspective?

How well did you feel that were able to ask any questions in the discussion?

Do you think that there is a danger of the nurses making Womans feel as though they are being judged in the clinic?

Prompts

- Made to feel uncomfortable?

Who would you prefer to see? (can you explain why?)

Have you ever been to see your GP or practice nurse about contraception?

If yes,

What was that like?

If no,

Is there a reason why you don't go to see your GP/Practice nurse?

Is there anything else you would like to say?

Appendix III

Patient Information sheet

Research Study: Nurse / woman communication in family planning clinics

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear to you or if you would like further information. Take time to decide whether or not you wish to take part.

Thank you for reading this sheet.

What is the purpose of the study?

This research study aims to explore how nurses and women discuss family planning matters. The study will look at things like whether the nurse enables the Woman opportunity to discuss the things that are important to her and whether or not women's questions are answered. The study will also explore how well the discussion helps the Woman able to make the right choices about family planning. This will involve the nurse audio-taping your discussion and inviting you to discuss your consultation with the researcher conducting the study after your clinic visit.

Why Have I been chosen?

This study will involve any woman over the age of eighteen who is making a first visit to a family planning clinic and who has agreed to take part. There is no other reason why you have been chosen for this study.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet and asked to sign a consent form. If you do decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect the standard of care you receive.

What will happen to me if I agree to take part?

If you agree to take part you will see the nurse as part of the normal procedure of the clinic. The only difference being that the nurse will tape record your discussion, the researcher will not be present during your discussion with the nurse.

Your discussion with the nurse will not take any more time should you decide to take part, and your care and treatment will be the same as it would be if you decide not to take part.

If you have 20 minutes or so to spare after your clinic visit the researcher would value a chance to talk to you.

Will my taking part in this study be kept confidential?
Yes. All information that is collected about you during the course of the research will be kept strictly confidential. Any information that can identify you will be removed from all material obtained during the study. Tape recordings will be transferred onto paper and the tapes then destroyed.

What will happen to the results of the research study?
The results of this study will be used to help family planning clinics improve the services they offer. The results may be published in medical and nursing journals; in all cases individual identities will not be revealed.

Who is organising and funding the research?
No commercial companies are involved in this study.

Contact for further information
You can obtain further information about this study from:

Mr Mark Hayter
School of Nursing and Midwifery
University of Sheffield
Winter Street
Sheffield
S3 7ND

Telephone: 0114 222 9783

Appendix IV

Consent form: taping consultation

Centre Number:
Study Number:
Client Identification Number for this study:

CONSENT FORM (Audio-taping Nurse consultation)

Title of Project: Nurse/client interaction in Family planning clinics

Name of Researcher: Mark Hayter

Please initial box

1 I confirm that I have read and understand the information sheet dated ..... for the above study and have had the opportunity to ask questions. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3 I agree to take part in the above study. ☐

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Name of Client	**Date**	**Signature**
----------	----------	----------
Researcher	**Date**	**Signature**

1 for Client; 1 for researcher, 1 to be kept with clinic notes

Appendix V

Consent form: woman interview with researcher

Centre Number:
Study Number:
Client Identification Number for this study:

CONSENT FORM (Interview with researcher)

Title of Project: Nurse/client Interaction in Family Planning clinics

Name of Researcher: Mark Hayter

Please initial box

1 I confirm that I have read and understand the information sheet dated ..... for the above study and have had the opportunity to ask questions. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3 I agree to take part in the above study. ☐

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Name of Client	**Date**	**Signature**
----------	----------	----------
Researcher	**Date**	**Signature**

1 for Client; 1 for researcher, 1 to be kept with clinic notes

Appendix VI

Consent form: nurse interview with researcher

Centre Number:
Study Number:
Client Identification Number for this study:

CONSENT FORM (Nurse Interview with researcher)

Title of Project: Nurse/client interaction in Family Planning clinics

Name of Researcher: Mark Hayter

Please initial box

1 I confirm that I have read and understand the information sheet dated ..... for the above study and have had the opportunity to ask questions. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3 I agree to take part in the above study. ☐

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Name of Client	**Date**	**Signature**
----------	----------	----------
Researcher	**Date**	**Signature**

1 for Client; 1 for researcher, 1 to be kept with clinic notes

Appendix VII

Amended Interview schedule (nurse interviews)

Introduction

Can you just tell me a little about your nursing background (length of time in family planning practice)

How long have you been working at this clinic?

Firstly can I just ask you few questions about how you carry out discussions with clients?

Conduct of the interviews with clients

Do the interviews tend to follow a specific pattern, or all they all different?

There seem to be a lot of information recording and checking going on.....

Do you use different approaches with different types of women?

Prompts – Age etc

Women's Knowledge etc

One of the things I am interested in is the way in which women regard contraception and am keen to find out how you feel about some of the things that I have picked up from the interview tapes so far...

From the tapes it seems that women are expected to absorb a lot of information about the do's and don'ts of contraception, what do you think about this.

- Prompts form example knowing what to do if things go wrong with their method
- The pill rules...(testing/checking knowledge)
- Back up with written info

From the tapes I have listened to so far it seems that women really need to know a lot about their bodies and cycles to use contraception, would you agree?

Do you see it as part of your role to get women to be more aware of their bodies?

Does this help them to comply with their method better?

In what ways do you include this in the discussion?

Are some women more receptive than others about this kind of information?

Do you ask women to be aware of certain changes in their bodies when taking contraception?

Can you give me some examples of this?

- Monitoring menstruation?
- Side effects?

Do you think that there is a difference between older and younger women in terms of knowledge of how their bodies work? ...intelligence/knowledge?

Being aware of side effects seems to be important, but do you think there is a danger of women becoming too observant of every little thing?

Keeping to time seems to be important with contraception, in what ways do you try to encourage this with women?

<u>Nurses views</u>

Do you feel that contraceptive methods have good and bad aspects to them, can you give me any examples?

Possible prompts: 'lesser of two evils...side effects'

'weight gain'

'No periods'

Control their bodies

Do some methods suit some women more than others?

- Prompts – any examples of this?

I have noticed protocols are involved in your practice and would like to ask some questions about them...

- protocols

How do you think the protocols affect your practice...? prompts:

Restrict?
Guide?
Remind?
Keep on track?

Do you ever feel as though you are just going through the same old routine when seeing clients?

Have you ever worked in a clinic with a computerised system?

If so- what did you think?

If not - Do you think that computers would affect your practice?

If so – how?

How do you assess whether women have been at risk of STI's

Does your approach vary depending on the woman's age or anything?

Do you think we pay enough attention to sexually transmitted infections in family planning?

Is there anything else you would like to say?

Appendix VIII

Consultation 6: Complete transcript

Nurse: Have a seat, how can we help

Woman: Yes, erm I just want to go back on the pill

Nurse: You've been on it before

Woman: Yes

Nurse: Yes and when was that

Woman: Erm I can't actually remember, it was from here I can tell you that but I don't know when

Nurse: Right so you feel you're ready to go back on

Woman: Yes, yes

Nurse: I see that's great. What we need to do is just go through all the necessary sort of information, check your blood pressure, weight

Woman: Things have changed so

Nurse: Yes that's great so I'll just type you on the computer ....keyboard.....

Woman: I've got a terrible cough

Nurse: Oh yes, so this is you, that's your address

Woman: Yes that's right

Nurse: And Doctor

Woman: That's right

Nurse: Lovely, right so all these details are still

Woman: Er..

Nurse: You're not allergic to anything

Woman: No, I do smoke

Nurse: You do do you, how many a day

Woman: Erm about 10 a day

Nurse: I shall put that in the next bit, but not excessively .....keyboard....

Woman: When was it I last came then

Nurse: I'll just see, according to this 21/2 years ago you may have come in between

Woman: I think I came once

Nurse: Yes .....keyboard.... first day of your last period

Woman: I don't know, but I know I'm due on in about 2 days, so I know I had more than 28 days, I had a few days on

Nurse: Right, so sometime beginning of June then would it be a weekend or

Woman: It was actually at the weekend yes I'd say Friday or Saturday somewhere like that it was last time

Nurse: That's fine

Woman: I can't remember

Nurse: Right that's fine

Woman: I know I should keep check but I never do

Nurse: Which is smashing 'cause if you're coming up to starting your period, you can start the pill on the first day of your period, which is great

Woman: Weight

Nurse: Yes please, O you know the routine here we go, I'll just check your blood pressure, here we go ....(BP cuff noise).... you're up to date with smears?

Woman: Yes

Nurse: Do you come here for those

Woman: No I go to my Doctor

Nurse: Lovely, so when the er letter comes through for it you make your appointment there and, that's good

Woman: Yes

Nurse: You say you smoke about 10 a day

Woman: Yes

Nurse: You don't need me to tell you about the health risks that are associated with smoking and many other things

Woman: Well I'm trying

Nurse: It's well advertised, so as I say think about it seriously OK, right so you say you've been on the pill before and you're wanting to start again because you've got a new relationship that's smashing and usually ...?..... that's the 21 they've got the days on them as you'll see as you know and so what we suggest you do is start the pill from whatever date of your period starts and from then on you are sort of protected

Woman start them now....?

Nurse: No ...first day of your period, so whatever day of the week that is and then you carry on for all your 21 we suggest that you take it at the same time everyday, it doesn't matter what time of day it is, it's whatever suits you in your lifestyle, it's best if you get up at the same time every morning and are able to remember to take it with your first cup of coffee at 8 O'clock in the morning with breakfast

Woman: Yes

Nurse: Then you can erm or if you find it better in the evening is the best time for you, that's fine what we suggest you do is just take it at the same time every day within a few hours

Woman: I tend to do that now

Nurse: That's great. This is the leaflet we'll be giving you to go through. Asking how effective the pill is it is over 99% effective but that also depends on how well you take it, if you forget to take it and go messing around the times when it is not as effective is when you are taking other medicines often antibiotics can cause a change in gut. It can effect the erm absorption of the pill, so we suggest you use some other form of contraception like using condoms or whatever for 7 days and again if you've got diarrhoea or being sick use something. We also advise you to use condoms anyway because of the er sexually transmitted diseases, infections that.....

Woman: Right.....

Nurse: Lovely, great and so that.....

Woman: I would actually like some

Nurse: You certainly can have some, we can provide them for you that's great. So it's sort of over 99% effective erm slight disadvantages you may gain some weight or may loose weight you can feel a bit sick er, breast tenderness because of the hormones there it can effect you, so give it chance to get into your systems to see whether.....

Woman: its working....

Nurse: Yes that's fine OK now there not all the same but they do have the general hormones in them we often give Microgynon which is the sort of broad everyday sort of used one and here's how to take it, so you start the pack on your first day of your period there you're bleeding, yes and you take your pills so you bleed and your taking your pills and you've taken 21 and then you stop your pills and then usually within the next couple of days during your pill fee week as you can see there you start your bleeding again Ok and then just after 7, you might still be bleeding but you start on the 7 days on the same day of the week

Woman: Yes

Nurse: Yes, OK then you continue there all right. That's smashing. Then you're asking are you protected during the 7 days, yes you are and as long as you've taken them correctly that's fine. Now one thing, if you forget to take a pill, hopefully you're not going to because you know, you're wanting to use it as a form of contraception

and the best way to make it effective is to take it on a regular basis

Woman: Yes

Nurse: So here's just a little run down here, more than 12 hours late you take the last pill you've remembered and leave any earlier one in your pack and you must use extra contraception for the next 7 days and if there's more than 7 pills left in your pack when you've finished this pack leave the 7 days normal break, but if you find you missed more than 1 or 2 or more than 12 hours late and you've only got like 6 pills left before you have your break don't have that 7 day break, start your next pack straight away because the hormones need to be kept up, 'cause you're making that 7 day break longer as you can imagine

Woman: Yes

Nurse: But if you're less than 7 hours late say if you're less than 12 hours late sorry if you say take it to the morning and then at teatime and then think Oh I forgot it this morning you're in 12 hours just take that pill and then you'll take the next one the next morning, so you're that little bit longer taking between 1 and 1 but then you're sure to taking it from remembering to when you're take you're next one, does that make sense

Woman: Yes that's fine

*Nurse: And then just take the rest of them as normal, right I can give you that as a little thing, there you are (*gives pill leaflet*)*

Woman: Thanks a lot..

Nurse: You're welcome.

Appendix IX

Method/category	Body education	Body surveillance	Regimen
Combined pill	*Education about hormones and reproductive system. Side-effects education. Menstruation changes.*	*Side-effect monitoring. Menstruation monitoring. Clinic record keeping. Body measurements. Monitoring for pregnancy. Breast examination.*	*Pill rules. Leaflets. Emergency contraception/ contingency management. Time of pill taking. Stoicism – bearing discomfort/side effects.*
Progestorone only pill	*Education about hormones and reproductive system. Sid- effects. Menstruation changes.*	*Side-effect monitoring. Menstruation monitoring. Clinic record keeping. Body measurements. Monitoring for pregnancy. Breast examination.*	*Pill rules. Leaflets. Emergency contraception/ contingency management. Time of pill taking. Stoicism – bearing discomfort/side effects.*
Condoms	*Education about sperm barrier. Education about male and female anatomy.*	*Side-effects/latex allergy. Monitoring condom for damage. Condom using techniques. Monitoring for pregnancy.*	*Timing of use during sex. Having supplies with you. 'backing up with pills'. Emergency contraception/contingency management. Avoiding damage to condoms. Remembering to use.*
Emergency contraception (E/C)	*Hormone and reproductive system education. How E/C works.*	*Clinic record keeping. Timings of sexual intercourse. Body measurements. Pregnancy tests. Monitoring for side-effects and menstruation. Monitoring for pregnancy.*	*Timings of pill taking. Impact upon other regimens used. Contingency management. Stoicism – bearing discomfort/side effects.*

Method/category	Body education	Body surveillance	Regimen
Diaphragm	*Anatomy and physiology of vagina and cervix.* *Sperm and barriers.* *Need for spermicidal cream.* *Reproductive system education*	*Monitoring diaphragm in correct place.* *Techniques for inserting diaphragm.* *Monitoring for pregnancy.* *Diagrams and models.*	*Leaflets and written regimens.* *Timings of use, before and after sex.* *Emergency contraception/contingency management.* *'Practice' diaphragms.*
Coil	*Anatomy and physiology of vagina and cervix.* *Coil position and method of working.* *Models, diagrams and examples.* *Reproductive system education*	*Monitoring for coil position: vaginal examination.* *Monitoring for pregnancy.* *Side-effects monitoring.* *Monitoring menstruation.* *Clinic record keeping.* *Body measurements.*	*Timing of checking coil position.* *Coil check appointments at clinic.* *Life expectancy of coil and replacement awareness.* *Stoicism – bearing discomfort/side effects.*
Depo-Provera	*Hormone and method of use education.* *Reproductive system education.*	*Side-effects monitoring.* *Monitoring menstruation.* *Body.* *Clinic record keeping.* *Body measurements.*	*Keeping to time with top up injections.* *Emergency contraception/contingency management.* *Timings of protection after injection.* *Stoicism – bearing discomfort/side effects.*